NEW PATIENT INFORMATION

Patient Last Name, First Name		Birth Date	Sex	Social Security #	
Address: Apt#		City	State	Zip code	Home Phone
Ethnicity	Race(s)	Preferred Language	How did you hear about us?		

SIBLINGS WITH THE SAME RESPONSIBLE PARTY

Last Name, First Name	Birth Date	Male Female
Last Name, First Name	Birth Date	Male Female
Last Name, First Name	Birth Date	Male Female

PARENT/GUARDIAN INFORMATION

Mother's Name	Birth Date	Social Security#
Cell Phone #	Work Phone	Place of Employment/Occupation
Father's Name	Birth Date	Social Security#
Cell Phone #	Work Phone	Place of Employment/Occupation
Email:	**Best time to call:** Morning ○ Afternoon ○ Evening ○	

EMAIL IF YOU WOULD LIKE TO SUBSCRIBE TO THE PATIENT PORTAL AND HAVE ACCESS TO YOUR CHILD'S MEDICAL INFORMATION:

INSURANCE INFORMATION

Insurance Name	Insurance Phone
Responsible Party *(If Medicaid write Self)*	Relationship to Patient *(Please Circle)* Parent / Self / Other:_____
ID# / Policy #	Group #

Preferred Pharmacy:

Address:	
Phone #	Fax #

EMERGENCY CONTACT INFORMATION

Name	Home Phone	Cell Phone
Address		Relationship to Patient

I certify that the above information is correct to the best of my knowledge. I release Bee-Well PEDIATRICS, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian Signature: _____ **Date:**_____

Signature of Person Responsible for Bill:_____

Referrals	Initial
Your provider must receive and approve all referrals. You must be seen for the complaint prior to the referral authorization. BEE-WELL PEDIATRICS participates with different plans and each plan has specific regulations in how a referral is issued. We ask that you understand that in many instances this is a time-consuming process, please allow adequate time for completion. Please do not schedule an appointment until your referral is complete. Most insurance companies will not backdate a referral.	
Lab Work and X-Ray Results	
You will be notified by phone once your results have been reviewed by the provider. We ask that you allow sufficient time to receive your notification: if you have not been notified within one week after your test was performed please call and our staff will assist you.	
Financial Policy	
For insured Patients, should your insurance company require a co-pay for your visit or a deductible, it will be due at the time of service. Please be aware that you are responsible for all co-payments, non-covered services, and deductible amounts. Your insurance company coverage is an agreement between you, the patient, and your insurance company, the insurer. It is your responsibility to know you insurance benefits when you are receiving services. For uninsured patients, Payment is due at the time of service. For newborns please request a form to initiate the process. You may also directly call 866-762-2237 or email at http://www.dcf.state.fl.us/ess/ to activate your child. We will see your child on the first visit as a courtesy. Future visits will require you to have updated Medicaid. **Divorce/Custody, The parent and /or legal guardian who brings the child in for medical services will be required to pay the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.**	
No show/canceled appointment	
All appointments require at least a 24 Hours prior notification for cancellation. No shows or appointments cancelled with less than 24 hours' notice may be subject to a missed/cancellation appointment fee of $25.00 per child/per visit.	
Insurance Lifetime Authorization	
I hereby request payment of authorized insurance (Medicaid, Managed Care, Commercial) benefits to be made either to me or on my behalf to BEE-WELL PEDIATRICS for any services furnished to me by BEE-WELL PEDIATRICS. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release in of the information to the insurer of agency shown. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid MMA carrier as the full charge, and the patient is responsible only for the coinsurance, and co-pay services. Coinsurance and the deductibles are based upon the charge determination of the Managed Care carrier. I hereby authorize payment of Insurance Benefits Directly to BEE-WELL PEDIATRICS for Services Tendered, and release of any Medical Information necessary to process claims. I am responsible for all Copayments, None covered Services and for Deductible Amounts.	
Prescription Refills Require a 24 Notice	
Request for prescription refills should be called in between 10:00 am and 3:00 pm, Monday thru Friday. Calls received after 4:00pm will not be filled after office hours or on the weekends. Please do not ask for the physician to be paged for medication refills. Providers are on-call for Urgent Care Only.	

Patient/Legal Guardian Signature

Date

Authorization to release or use information for treatment, payment or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical record information by BEE-WELL PEDIATRICS in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

You reserve the right to file a complaint with the Secretary, U.S. Department of Health and Human Services (HHS).

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. By signing this consent form, you consent to our use and release of PHI about you for the treatment, payment and health care operations as described in our notice. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____ _____

Parent/Legal Guardian Signature Date

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or Practice Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For you convenience we will accept VISA, MASTER CARD, DISCOVER AND AMERICAN EXPRESS.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor – in order words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer we will refund any over payment to you.
- Our office has made prior arrangements with many insurers and health plans to accept assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the copayment at the time of service. Copayments are collected at the time of the appointment.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we well prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same service. In the event your health plan determines a service to be **"not covered"** you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with primary custody for payment.
- Lab work ordered at our facility will be submitted to, Quest or Labcorp. The insured party is solely responsible to know where their contracted labs go too. We will not pay your bill from any LAB Company. Please provide your preferred lab company name:_____/if not provided we will choose one for you.
- *I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.*

_____ _____

Signature of Patient or Guarantor Date

_____

Patient's name

AUTORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

To Doctor/Facility: _____

Address: _____

_____

Phone #_____ Fax : _____

Patient's Name:_____ **DOB:**_____

SNN:_____ Phone:_____

I hereby authorize and request the release of the following information to **BEE-WELL PEDIATRICS**:

- ☐ Full Medical Records
- ☐ Immunization Records
- ☐ Physical Exams & Growth Charts
- ☐ Specified Items Requested

_____

_____

Please only fax the requested information to:

Bee-Well Pediatrics

Phone Number: 772-873-7114

Fax Number: 772-873-7115

Any information, including diagnosis and records of treatment or examination rendered to me including any Federal and State protected information under appropriate Statute, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) test results and treatment. I understand that this authorization will remain in effect for (1) year or until I revoke it in writing, to an authorized employee of Bee Well Pediatrics.

I have read Bee Well Pediatrics notice of privacy. I hereby release Bee Well Pediatrics and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____ _____

Signature of Patient or Guardian | Date | Relationship

Authorization for medical treatment
Of a minor child in absence of parent/legal guardian

By my signature below and as the parent or legal guardian of: Name of Minor Child

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I hereby authorize **Bee-Well Pediatrics** Provider(s) to treat my child when I am unavailable. I further authorize the following person(s) to bring my child to Bee Well Pediatrics for medical attention if necessary. I understand and have communicated to each person that their personal identification documents must be available for inspection by KPP staff each time they accompany my child for a medical visit.

The person(s) that I authorize to bring my child in for treatment in my absence are:

_____ Relationship: _____

Name

_____ Relationship: _____

Name

_____ Relationship: _____

Name

This consent is valid unless I choose to revoke it in writing otherwise.

_____ _____

Print Name Relationship to patient

_____ _____

Signature Date

_____ _____

Name of Witness Title

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Bee Well Pediatrics, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office or by visiting our website at www.beewell-pediatrics.com

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read the Bee Well Pediatrics, Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____

_____ _____

Print Name of Patient/ Patient Date of Birth

Vaccine Splitters

For parents that choose to split vaccines at the time of Wellness appointments and come back at another time, there is a charge of $20. This does not apply to FLU or HPV vaccines or if patient is sick at the time of the Wellness appointment.

_____ I have read and understand the statement above.

_____	_____
Patient's Name	Date of Birth
_____	_____
Print Name	Relationship to patient
_____	_____
Signature	Date