Patient Registration Form
18 Years and Older, Foster

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Today's Date: _____

Patient Information

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile phone: _____ Email: _____

Parent/ Foster Parent Information

Parent Name: _____ Date of Birth: _____

Mobile Phone: ( )_____ Work Phone: ( )_____

Insurance Carrier Information

Insured's Name: _____ Date of Birth: _____

Name of Insurance: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Alternate Contact (relative or friend)

Alternate Contact Phone: ( ) _____

Relationship to patient: _____

Form Completed By:

Name (print): _____

Signature: _____

Date: _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/APRN:

_____

Preferred Language:

_____

Your Child's Race
(select one primary)

☐ American Indian or Alaskan Native
☐ Asian
☐ Black/African American
☐ Middle Eastern or North African
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____
☐ Decline to answer

Your Child's Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.

** Please return this form to the Front Desk before leaving the office. Thank you. **

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Billing Guarantor Acknowledgement (18 years and older/Foster)

Patient Name:_____ Date of Birth:_____
Insurance Plan Name: _____Effective Date: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Sex: ☐ M ☐ F Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

Important Information
Please note that if your parent still maintain healthcare coverage for you, they may have access to billed procedures, including but not limited to office visits, lab tests (including pregnancy, HIV, and tests for sexually transmitted diseases) or other procedures.

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment for all medical care is due at the time of service. The patient, parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pediatric Health Care Alliance, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Health Care Alliance, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Pediatric Health Care Alliance, PA may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about me/ my child (if parent remains guarantor), as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.**

Billing Guarantor Name *(print)*:_____ **Date of Birth** *(mm/dd/yyyy)*: _____ **Sex:** ☐ **F** ☐ **M**

Billing Guarantor Signature:_____ **Today's Date** *mm/dd/yyyy)*:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other:_____

Billing Guidelines

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Patient Name: _____

Date of Birth: _____

Pediatric Health Care Alliance billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

- **CO-PAYS**: It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.
- **CO-INSURANCE/DEDUCTIBLES**: Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service. We will collect $75.00- weekday visits and $100.00- evening and weekend visits if you have not met your deductible or have a co-insurance due.
- **BILLING**: As a courtesy, Pediatric Health Care Alliance bills your health insurance provider on your behalf, with the following guidelines/exceptions:
  - **Insurance Card: It is critical that the most current insurance card is brought to every appointment.** We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
  - **Auto Insurance:** We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and we will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.
  - **Secondary Insurance:** PHCA only bills Tricare and Medicaid from the secondary insurance governmental plans.
- **COMBINED VISITS:** If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
- **EVENING/WEEKEND/HOLIDAY SURCHARGE:** Some health insurance providers bill a surcharge of $100.00 if you see your pediatrician after normal business hours, on the weekend, or on a holiday.
- **ADMINISTRATIVE FEES** : PHCA charges various fees for the following items, which require personnel and resources to address.
  - **Copies** of medical records given to the parent (no charge if sent directly to new provider)- $1.00/per page/first 25 pages, then 25¢/per page thereafter.
  - **Miscellaneous forms completion-** school lunch or medication forms - $10.00
  - **Special request completion** of camp or sports physical forms (free during visit)- $20.00
  - **Other forms or letters-** physician letters, college forms, parking permits- $20.00
  - **Completion of** FMLA paperwork or Tricare transfer form- $25.00
  - **Returned check** (for insufficient funds)- $29.00
  - **No-show / late cancellation fee** when a patient:
    - Sick visit- $25.00- No show or cancellation, less than 2 hours prior to appointment
    - Well Visit- $25.00- No show/same-day cancellation
    - Consultation Visit- $25.00- No show/same-day cancellation
    - EHO visit - $25- No show or cancellation, less than 2 hours prior to appointment
    - Behavioral Health- $50.00 / $100.00 for testing visits

Signature _____ *Date* _____

PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home

Electronic Transmission of Private Health Information (PHI)

Pediatric Health Care Alliance (PHCA) is committed to ensuring the privacy and security of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As part of our commitment to safeguarding your PHI, we have implemented secure methods for transmitting medical records.

HIPAA Compliant Encrypted Email: PHCA utilizes HIPAA-compliant encrypted email services to securely transmit medical records containing PHI. This ensures that your sensitive information remains confidential during electronic transmission.

HIPAA Compliant Encrypted Email and Fax Transmission: PHCA utilizes HIPAA-compliant encrypted email services to securely transmit medical records containing PHI. This ensures that your sensitive information remains confidential during electronic transmission. In addition to encrypted email, PHCA may also transmit medical records via fax using secure fax machines. This method complies with HIPAA guidelines for safeguarding PHI during transmission.

Use of Artificial Intelligence (AI) in Healthcare: This practice may utilize artificial intelligence (AI) tools to assist with tasks such as documenting patient encounters, analyzing medical images, and identifying potential health risks. These AI tools are designed to assist healthcare providers, not replace them. All AI-generated information will be reviewed and verified by a qualified healthcare provider. Your privacy and the security of your health information will be protected in accordance with HIPAA regulations. By signing this form, you acknowledge and authorize the use of AI tools in your healthcare.
I grant permission for PHCA to record my child's health information using A.I. generated dictation to the EMR system. I understand that all transcriptions will be handled in accordance with HIPAA regulations to ensure privacy and confidentiality. *By employing these secure methods, Pediatric Health Care Alliance aims to protect the confidentiality, integrity, and availability of your medical records. If you have any questions or concerns regarding the transmission of your PHI, please contact our Privacy Officer at 813.262.9341.*

Digital Updates and Communication: I acknowledge that PHCA may contact me for various purposes through email or text messaging, including but not limited to updates, reminders, and other relevant communications.

Purpose of Transmission: I understand that my health information will be transmitted electronically for the purpose of facilitating medical care, treatment, and related administrative functions.

Types of Information: I acknowledge that the information transmitted may include sensitive and confidential details about my health condition, medical history, medications, and other relevant data necessary for healthcare provision.

Security Measures/Potential Risks: I understand that PHCA will take appropriate security measures to safeguard my health information during transmission. However, I acknowledge that no electronic transmission can be guaranteed to be 100% secure. I am aware of the potential risks associated with electronic transmission, including but not limited to interception by unauthorized parties, data breaches, and loss of confidentiality.

Revocation/Duration of Consent: I understand that I have the right to revoke this consent at any time by providing written notice to PHCA. However, I acknowledge that revocation will not apply to actions already taken in reliance on this consent. This consent shall remain valid until revoked by me in writing or until the completion of the purposes for which it was provided, whichever comes first.

Signature: By signing this form, I affirm that I have read and understood the contents of this consent form, and I voluntarily authorize the electronic transmission of my private health information as described herein.

Patient Signature: _____ Date: _____

Patient Name (please print): _____

Acknowledgement of Pediatric Health Care Alliance Vaccine Policy

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Dear Parents,

As part of our commitment to patient-centered care, we are dedicated to protecting the health of our patients and the community through vaccination. Vaccinating children and young adults is one of the most important health-promoting interventions we can perform as healthcare providers, and you can perform as caregivers. Routine childhood immunizations have resulted in a tremendous decline in serious infections, disability, and death. Unfortunately, these illnesses are still present in the United States and other countries and are often just a short plane ride away. We understand that parents have reservations about certain vaccines, and our pediatricians will be happy to discuss those concerns with you as a new patient.

At PHCA our vaccine policy requires that medically able patients need to be fully vaccinated, based on the CDC Recommended Immunization Schedule for Children and Adolescents.

We believe that failure to follow the recommendations about vaccination may endanger the health and life of a child, and others with whom a non-vaccinated child may come into contact. Failure to adhere to this policy will result in dismissal from PHCA. **Therefore, if you have already decided with absolute certainty that you will not vaccinate your child(ren), we encourage you to find another healthcare provider who shares your views.**

NOTE: In accordance with this policy, PHCA requires vaccine records/history prior to the first appointment for any transferring patient.

PHCA Standards for Vaccine Compliance	Vaccines Needed**			
By the age of 12 mos: Patients must have received these vaccinations recommended for ages 0-9 months	Hep B DTaP	Hib IPV	Pneumococcal	
By the age of 24 mos: Patient must have received these vaccinations recommended by 18 months of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 5 yrs & 11 mos: patient must have received these vaccinations recommended by 6 years of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 12 yrs & 11 mos: patient must have received these vaccinations recommended by 13 years of age	All of the above, plus Tdap			

***Please note: While PHCA strongly recommends all childhood vaccines, we are allowing limited exceptions to the vaccine compliance policy. Rotavirus, Hep A, Influenza, Meningococcal, COVID, and HPV vaccines are recommended but not required as part of our policy.*

The decision to adopt a more stringent policy regarding vaccination stems from the risk that a non-vaccinated child poses to other patients in our office, and vulnerable families such as newborns or children with weakened immune systems. As a pediatric group, we feel a powerful responsibility to work towards protecting our community from illness as much as possible.

Please note, that if you feel your child has a health condition that does not allow vaccination, please Let us know.

Patient Name:_____

Date of Birth: _____

Parent/Patient Signature:_____ **Date:**_____

Consent For Treatment (18 Years and Older)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

MEDICATION AND TREATMENT CONSENT. This Consent Form is intended to confirm written consent for the patient named below (me) to receive medical treatment at Pediatric Health Care Alliance, P.A. to include services rendered by its employed or contracted providers, and other medical professionals, (collectively "PHCA").

By signing below, I confirm my consent for the PHCA and PHCA Providers to provide health care services and prescribe medicinal drugs to myself based on the judgment of the PHCA provider. This includes, without limitation, consent for me to be evaluated and treated for medical conditions, including physical or mental health conditions and other sensitive matters, as deemed ordinary and necessary, and advisable, in the judgment of the PHCA provider.

TREATMENT SERVICES. I understand that medical care and treatment I am consenting to will typically include, as determined by the health care practitioner, ordinary and necessary medical treatment, including a full physical examination (including an external genital examination), diagnostic testing, vaccination and the prescribing of medicinal drugs as needed to treat health conditions ("Treatment Services"). By signing below, I acknowledge such Treatment Services from PHCA. I also acknowledge and provide my consent to receive additional services that may be available or recommended to me during the course of my treatment.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION. To facilitate the treatment services provided by PHCA pursuant to this consent and to coordinate care for me, I hereby authorize and request that copies of my prior medical and billing records related to my treatment services be provided to PHCA. This consent to disclosure specifically includes without limitation, complete psychological and assessment records, most recent plans of treatment, progress summaries, discharge summaries, treatment notes, including mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use, or abuse information, genetic information, and any other appropriately related documents or information reasonably requested by PHCA.

ACKNOWLEDGMENT. By signing below, I represent that I am the patient with the legal right to consent to medical treatment and medication prescribing and administration. I consent to Pediatric Health Care Alliance, P.A. physicians, providers, and other employed or contracted medical professionals to provide, solicit and arrange for health care services, and prescribe medicinal drugs when determined necessary in the professional opinion of the treating PHCA provider, to me.

Person(s) to be contacted in case of an emergency:

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Print Patient Name: _____ D.O.B: _____

Signature: _____ Date: _____

PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home℠

Permission to Release Medical Information

18 years and Older, Married or Pregnant and under 18 years of age, Emancipated Minor, Certified Homeless

Under the federal Health Information Portability and Accountability Act, or HIPAA, medical records are private information that is kept between you and your health care provider. Access to your health records and any discussion about your health is only provided to people you consent to, **including your parents**. This form will allow your **parents** or anyone else that you have identified access to your medical information.

Patient Name: _____ Date of Birth: _____

Please list the person(s) that you are allowing access to your medical information:

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

Important Information

Please note that if your parent still maintain healthcare coverage for you, they may have access to billed procedures, including but not limited to office visits, lab tests (including pregnancy, HIV, and tests for sexually transmitted diseases) or other procedures.

I authorize Pediatric Health Care Alliance to release the following information (check all that apply):

- ☐ Access to all medical records **excluding** diagnosis for mental health, HIV, other STD, or pregnancy
- ☐ Access to all medical records **including** diagnosis for mental health, HIV, other STD, or pregnancy*
- ☐ Discuss my care with my Pediatric Health Care Alliance provider.
- ☐ Schedule or inquire about scheduled appointments (well, sick or consultations).
- ☐ X-Ray or other radiology reports
- ☐ Laboratory results (including HIV or other STD results)*
- ☐ Pharmacy/ Prescription records*
- ☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

This form does not expire: In the event I would like to append my authorization, it is my responsibility to update this information.

I, _____ (please print), authorize the above listed person(s) access to my medical information (specific approval access above).

Patient Signature:_____ Date: _____