Patient Registration
(Newborn- 17-years)

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

Name: ______________________________

Date of Birth: ____________________ Sex: ☐ M ☐ F

Home Address: ______________________________

City: ________________ State: ________ Zip: ________

Sibling Names and Ages *(ex: Jack, 9)*: ______________________________

____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: ______________________________

PRIMARY FAMILY PHONE: (____) ________________ *(OFFICE USE: LABEL AS "MAIN")*

Parent Name: ________________ Date of Birth: ________

Mobile Phone: (____) ________ **Work Phone:** (____) ________

Home Address (*if different from child*): ______________________________

City: ________________ State: ________ Zip: ________

Employer: ______________________________

Parent Name: ________________ Date of Birth: ________

Mobile Phone: (____) ________ **Work Phone:** (____) ________

Home Address (*if different from child*): ______________________________

City: ________________ State: ________ Zip: ________

Employer: ______________________________

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/ARNP:

____

Preferred Language:

____

Your Child's Race
(select one primary)

- ☐ American Indian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Unknown
- ☐ Other ______________
- ☐ Decline to answer

Your Child's Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Unknown
- ☐ Declined to answer

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. *****

Billing Guarantor Acknowledgement (Newborn- 17-years)

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

Patient Name: ______________________________

Date of Birth: ______________________________

INSURANCE INFORMATION

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: ______________

**** PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. ****
The parent/guardian who is present for office visits is the Billing Guarantor - see below for details.

NOTICE OF FINANCIAL RESPONSIBILITY

I understand that payment for all medical care is due at the time of service. The 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.

DIVORCE/CHILD CUSTODY

Pediatric Health Care Alliance, PA will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since PHCA is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at PHCA is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then PHCA will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, PHCA will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

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 my child[ren], 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.**

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

______________________________ ( ) -
Address / City / State / Zip **Primary Phone**

______________________ ______________
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.
- **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 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.
    - **Completion** of additional school physical forms, e.g. blue/yellow forms (1st set free at visit)- $1.00/per page
    - **Special request completion** of camp or sports physical forms (free during visit)- $20.00
    - **Special request** physician letters- $20.00
    - **Completion of** FMLA paperwork- $25.00
    - **Returned check** (for insufficient funds)- $29.00
    - **No-show / late cancellation fee** when a patient:
        - Does not show for their scheduled visit- $25.00
        - Cancels a sick appointment less than 4 hours in advance- $25.00
        - Cancels a well visit less than 24 hours in advance- $25.00
        - Cancels a consult visit less than 24 hours in advance- $35.00
        - Cancels any Behavioral Health visit less than 24 hours in advance- $50.00
        - Cancels less than 24 hours in advance or does not show for any Behavioral Health Testing visit - $100.00
        - Arrival late (15 minutes or more) for scheduled appointment time even if seen later in the day- $25.00

Signature *Date*

Consent For Treatment of Minor Child

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(s) named below (the "Patient") 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"). I understand that except as otherwise provided by law, PHCA cannot provide health care services or prescribe medicinal drugs to a minor child without first obtaining written parental or legal guardian consent, as applicable. My signature below hereby confirms my consent for the PHCA and PHCA Providers to provide health care services and prescribe medicinal drugs to the Patient based on the judgment of the PHCA provider, and includes, without limitation, consent for the Patient 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 Patient's PHCA provider.

TREATMENT SERVICES. I understand that medical care and treatment of the Patient that 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, and the prescribing of medicinal drugs as needed to treat health conditions ("Treatment Services"). By signing below, I acknowledge my consent for the Patient to receive such Treatment Services from PHCA. I acknowledge that this consent specifically expresses my consent for the Patient to receive an external genital exam from a PHCA provider as part of their medical care and treatment. It has been explained to me that I have a choice about the use of Treatment Services at PHCA and other services that may be available or recommended to the Patient during the course of their treatment.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION. To facilitate the treatment services provided by PHCA pursuant to this consent and to coordinate care for the Patient, I hereby authorize and request that copies of prior medical and billing records related to the Patient's 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 either a parent or the legal guardian of the minor child/children named below, with the legal right to consent to medical treatment and medication prescribing and administration on behalf of the Patient. 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 the Patient(s) named below. Additionally, I have listed other people who are authorized to bring my child/children in for medical care and treatment.

Child/Children:

Print Name of Minor Child: ______________________ Date of Birth: ____________

Print Name of Minor Child: ______________________ Date of Birth: ____________

Print Name of Minor Child: ______________________ Date of Birth: ____________

Print Name of Minor Child: ______________________ Date of Birth: ____________

I/We authorize the following people to bring my child/children in for medical care and treatment, and to be contacted in case of an emergency:

Name: ______________ Phone: ( ) ________ Relationship: ____________

Name: ______________ Phone: ( ) ________ Relationship: ____________

Name: ______________ Phone: ( ) ________ Relationship: ____________

Name: ______________ Phone: ( ) ________ Relationship: ____________

Parent/Guardian: THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED.

Print Name: ______________________ Relationship: ______________________

Signature: ______________________ Date: ______________________

For individuals/representatives acting on behalf of the Patient, you must indicate your relationship to the Patient, and provide proof of your authority to act on the patient's behalf (other than natural parents).

PATIENT HISTORY
(Newborn and Older)

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

Today's Date:______________________________

PATIENT NAME: ________________________ **DATE OF BIRTH:** ________ **SEX:** ☐M ☐F

HOME & SCHOOL

Who lives at home? ______________________________

If age appropriate does your child attend: ☐ Daycare ☐ Preschool ☐ Elementary school or higher ☐ None of the above

Name of School/Preschool/Daycare: ______________________________

If none, who cares for your child[ren] during the day? ______________________________

ILLNESSES

Have there been any hospitalizations? ☐ Y ☐ N

Have there been any major medical problems? ☐ Y ☐ N

Any childhood illnesses? (ex: chickenpox, measles, etc.) ☐ Y ☐ N

Fracture or other injury? ☐ Y ☐ N

If yes, please describe: ______________________________

____

GENERAL HEALTH

Medications: ______________________________

Allergies: ______________________________

Special Dietary Needs: ______________________________

REVIEW OF SYSTEMS

Has she/he had frequent problems with any of the following *(please check and/or write in all that apply)*:

☐ **Head-** Headaches, dizziness, injury, other: ____________________

☐ **Eyes-** Vision problems, infection, pain, other: ____________________

☐ **Ears**- Hearing problems infections, pain, other: ____________________

☐ **Nose**- Frequent stuffiness, easy bleeding, other: ____________________

☐ **Mouth-** Tooth decay, poor bite, other: ____________________

☐ **Throat- F**requent sore throat, trouble with swallowing, other: ____________________

☐ **Neck**-Stiffness, swelling, swollen glands, other: ____________________

☐ **Chest**- Deformity, pneumonia, cough, asthma, other: ____________________

☐ **Heart-** Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other: ____________________

☐ **Abdomen**- Vomiting, frequent pain, diarrhea, constipation, other: ____________________

☐ **Urinary**- Pain on voiding, voiding frequently, bed wetting, other: ____________________

☐ **Skin**- Rash, infection, other: ____________________

☐ **Neurological** Development problems, seizures, meningitis, other: ____________________

☐ **Endocrine**- Weight gain/loss, intolerance to heat/cold, thirst, hair changes (thinning, falling out), other: ____________________

☐ **Arms & Legs**- Deformity, abnormal walking, joint pain, joint swelling, other: ____________________

☐ **Hematological- An**emia, abnormal bleeding, other: ____________________

FAMILY HISTORY
(All patients)

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

PATIENT NAME: ______________________ **DATE OF BIRTH:** __________ **SEX:** ☐M ☐F

Previous Pediatrician Name, City/State *(if any)*: ______________________

Are there specific concerns you wish to discuss? If so, please explain: ______________________

____

PRENATAL HISTORY

Birth weight: __________ Length: __________ Did the infant stay longer than the mother? ☐ Y ☐ N

If so, why? ______________________

Did mother have any illness during pregnancy? *(ex: German measles/rubella, flu, bladder/kidney infection)*

Type of infection: __________ *Month of pregnancy:* __________

Medication/treatment: ______________________

Were there any complications of the pregnancy? *(ex: diabetes, thyroid disease, toxemia, excessive bleeding)*

____

Were there any complications of the labor or delivery? *(ex: prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breathe)* ______________________

FAMILY HEALTH HISTORY

Please check all that apply	**Patient's Mother**	**Patient's Father**	**Patient's Sibling**	**Relative** *Please write in*
SKIN: ☐ eczema ☐ psoriasis ☐ ichthyosis	☐	☐	☐	
EYES: ☐ blindness ☐ cataracts ☐ lazy eye	☐	☐	☐	
EARS: ☐ deafness ☐ ear infections ☐ deformities	☐	☐	☐	
NOSE/THROAT: ☐ sinus problems ☐ tonsillitis ☐ lack of sense of smell	☐	☐	☐	
MOUTH: ☐ cleft palate ☐ cleft lip	☐	☐	☐	
GLANDS: ☐ thyroid trouble ☐ diabetes (adult) ☐ diabetes (juvenile)	☐	☐	☐	
LUNGS: ☐ asthma ☐ cystic fibrosis	☐	☐	☐	
HEART: ☐ murmurs ☐ heart attacks ☐ congenital abnormalities ☐ high blood pressure	☐	☐	☐	
STOMACH/BOWEL: ☐ ulcers ☐ colitis ☐ lactose intolerance	☐	☐	☐	
KIDNEY/BLADDER: ☐ congenital abnormalities ☐ infections ☐ kidney stones	☐	☐	☐	
BONE/JOINT DISEASE: ☐ rheumatoid arthritis ☐ osteoarthritis ☐ osteogenesis imperfecta	☐	☐	☐	
NEUROLOGICAL PROBLEMS: ☐ seizures ☐ paralysis ☐ strokes	☐	☐	☐	
CANCER: ☐ type(s):	☐	☐	☐	
DEVELOPMENT PROBLEMS:	☐	☐	☐	
PSYCHIATRIC: ☐schizophrenia ☐ manic depressive (bipolar) disorder	☐	☐	☐	
OTHER:	☐	☐	☐	

PEDIATRIC HEALTH CARE ALLIANCE, P.A.

"Your Child's Medical Home"

☐ Apollo Beach Office	116 Harbor Village Lane	Apollo Beach, FL 33572	[illegible]
☐ Big Bend Office	10729 Queens Town Dr	Riverview, FL 33579	(813) 672-3497
☐ Brandon Community Office	811 S Parsons Ave	Brandon, FL 33511	(813) 685-4553
☐ Citrus Park Office	6550 Gunn Hwy	Tampa, FL 33625	(813) 968-2710
☐ Crossroads Office	6671 13th Avenue N #1D	St. Petersburg, FL 33710	(727) 381-1147
☐ FishHawk Office	5621 Skytop Dr	Lithia, FL 33547	(813) 571-6800
☐ Lutz Office	1854 Oak Grove Blvd.	Lutz, FL 33559	(813) 948-6133
☐ North Carrollwood Office	3638 Madaca Lane	Tampa, FL 33618	(813) 968-6610
☐ Northside Office	4446 E Fletcher Ave Ste A	Tampa, FL 33613	(813) 971-6700
☐ South Tampa Office	3222 W Azeele St	Tampa, FL 33609	(813) 872-8491
☐ South Manhattan	4911 S. Manhattan Ave.	Tampa, FL 33611	(813) 755-4025
☐ Suncoast Office	1850 Crossings Blvd #100	Odessa, FL 33556	(813) 475-7100
☐ Trinity Office	1812 Health Care Dr.	Trinity, FL 34655	(813) 731-0944
☐ Walsingham Office	12951 Walsingham Rd	Largo, FL 33774	(727) 391-0158
☐ Wesley Chapel Office	5259 Village Market	Wesley Chapel, FL 33544	(813) 973-0333

Release of Medical Records TO Pediatric Health Care Alliance

***** Immediate: Please fax immunization records only to (_____) ______ - _________*****

Please mail full records to the office location and address checked above.

Notes: ____

____

Patient Information

Patient Name:____ DOB:___/___/_____

Patient Name:____ DOB:___/___/_____

Patient Name:____ DOB:___/___/_____

Patient Name:____ DOB:___/___/_____

Patient Name:____ DOB:___/___/_____

Release Records FROM *(doctor or facility name)*: _____________________________________

Address:____

City / State / Zip:______________________Phone: (____) ______ - _______Fax: (___) ______ - _______

Authorization *(initial each item below)*

___ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

___ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

___ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

___ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): ________________________________

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

____

Name (print) **Signature** **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other (please specify): ______________

________________________ ________________________ __________

Witness Name (print) **Witness Signature** **Date**

Acknowledgement of
Pediatric Health Care Alliance Vaccine Policy

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 24 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 Signature:__________________________ **Date:**__________