98 Terra Mango Loop
Suite 12
Orlando, FL 32835
(407) 612-4007

Office and Financial Policy

In order to maximize your time with our providers, please fill out all forms **completely** and bring them with you or submit them electronically prior to the day of your appointment. This is invaluable information for our team. If you are unable to submit all of your paperwork prior to your appointment day, please be sure to **arrive at least 20 minutes prior** to your appointment time to complete the registration process. This will enable you to get your full scheduled time with the physicians.

Phone: (407) 612-4007
Mail: 98 Terra Mango Loop, Suite 12 Orlando, FL 32835

I have read, understand and agree to the following. Please initial in each space provided below.

(   ) 1. Consent for Treatment, Financial Policy Authorization & Acknowledgements
(   ) 2. HIPAA Rules and Regulations
(   ) 3. Acknowledgement of Advanced Kids Care office policies

You are acknowledging that you have read, understood, and agree to our office policies.

Parent Signature: ______________________________ Date: ______________________

Parent Name: ____

Patient Name: ____

Patient Name: ____

Patient Name: ____

Office Personnel Signature: ____

CONSENT FOR TREATMENT, FINANCIAL POLICY AUTHORIZATION & ACKNOWLEDGEMENTS

AUTHORIZATION OF TREATMENT

I, ___________________________________, hereby authorize medical treatment of my minor child(ren) (___________________________________DOB ___________) within the scope of practice afforded by the licensed healthcare professionals, other clinical and non-clinical staff at Advanced Kids Care.

NOTICE AS TO NATURE OF SERVICES

Office-Based Care
I understand this practice exclusively office-based and not affiliated with a hospital. If I become so ill that I require hospitalization, I will be under the care of the hospitalist on call. The providers will work in conjunction with the hospitalist as permitted. I also understand that it is my responsibility to inform Advanced Kids Care of any hospital admissions, any knowledge of any diagnoses my child has received, as well as any treatments they have had or are undergoing for current conditions, and that I should keep their physicians and any practitioners I see informed on an ongoing basis.

REVOCATION OF AUTHORIZATIONS
These authorizations will remain active unless revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

INSURANCE CLAIM MANAGEMENT
Advanced Kids Care is actively working to contract as in-network providers with all insurance companies. There are some insurance plans that will only send out invites once a year as needed in there determined market. It is advised that I contact my insurance provider to inquire on the network status of the office. The office tax identification number and provider's National Provider number can be obtained from the office receptionist. An encounter will be submitted to your insurance company in a timely manner. My treating practitioner(s) is not obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.
I am responsible for the payment of fees deemed necessary by my insurance company for the services provided by Advanced Kids Care at the time of service or when my insurance provider determines my patient financial responsibility. I am entitled to know the cost of all services and procedures in advance and I will ask if they are not told to me.

FINANCIAL RESPONSIBILITY
I understand and agree to the following policies regarding financial and insurance responsibilities. **I am responsible for paying my membership fees annually or quarterly.** I understand that quarterly commitments are paid in monthly increments and automatically renew. I know it is my responsibility to contact the office to cancel my membership if I choose to at that time or prior to the renewal date. A payment method is required to keep on file I know I am responsible for keeping that information up to date. I am responsible for charges incurred for all treatment rendered. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). Advanced Kids Care will not be obligated to take action on my behalf against an insurance carrier to negotiate my insurance claim.

Full payment is expected at the time of services rendered.

In addition to the fee for the office visit, the cost for lab work or other specialized testing deemed appropriate to my case will be applied to my balance.

Our practice is committed to providing the best treatment for patients. All appointments are considered confirmed at the time they are made. I will receive one courtesy phone call as a reminder of the appointment. Because a substantial amount of time has been set-aside for me, I may be charged a $50.00 fee for a missed appointment. I understand that I need to call the office 48 business hours in advance if I cannot keep the appointment in order to avoid this charge.

PATIENT ACKNOWLEDGEMENT

I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. I have read, understood and agree to the foregoing. I understand that I have the right to review this consent with a lawyer if I choose before accepting any medical services from Advanced Kids Care. I have executed this consent freely and willingly understand its provisions. I recognize that Advanced Kids Care will rely upon my signing of this document in accepting my child as a patient. I acknowledge receipt of a copy of this consent if I have requested it.

I understand that my signature signifies consent for any and all treatments offered and given to me or my minor child at Advanced Kids Care.

Signature of Patient or Responsible Party: ____

DATE:_____________

Patient Name(s): ___________________________ Witness: ___________________________

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICES RENDERED

I have read, understand and agree to the following:

Initials

( ) 1. Because a substantial amount of time has been set aside for me, I will be charged $50.00 for missed appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.

( ) 2. I understand that I am providing Advanced Kids Care with my credit card information below that Advanced Kids Care will keep on file in order to secure my appointment time, and charge my membership fees as well as fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). I also agree that Advanced Kids Care has my authorization to charge my card in the event that I do not give them adequate notice to cancel or reschedule my appointment as per office policy and for my agreed upon membership fee payment plan. I understand that my credit card information will only be used as stated above.

Advanced Kids Care: OFFICE POLICIES & PROCEDURES FOR PATIENTS

FOLLOW-UP APPOINTMENTS :

• Please be sure to arrive 20 minutes before your scheduled appointment. This will enable us to sign you in, perform vitals and ensure you get your allotted time with the doctors.

• Because of the complexity of most cases, treatment protocols may need frequent adjustments in the beginning. Therefore we may require monthly office visits in the first 4-6 months or more often as deemed necessary by your practitioner in order to facilitate wellness.

• Questions are always welcome. Most of the labs and testing ordered by Advanced Kids Care are more specialized. The discussion of these labs and test results are usually in-depth and lengthy. Therefore, a follow-up appointment is always scheduled 2-4 weeks after the initial visit. If an office visit is not possible, a telephone appointment may be scheduled, which will be billed in the same manner to an in office follow-up visit – according to complexity and time spent.

• Results will be discussed only during a scheduled office or phone appointment.

TELEPHONE/VIDEO APPOINTMENTS :

• As a courtesy to those who are not able to come into the center we offer phone/video appointments that are billed at the same rate as an office visit.

MISSED APPOINTMENTS :

• It is understandable if life circumstances cause you to reschedule your appointment.

• Please cancel or reschedule your appointment 48 business hours prior to your scheduled time. We do not double book. As your appointment time is set aside specifically to focus on your individual needs, it impacts our office if cancellations occur in less than 48 hours.

LATE ARRIVALS

• If you arrive more than 10 minutes after your scheduled appointment time, it may be necessary to reschedule. However, the missed appointment fee will still apply.

• If you choose to keep your appointment, your visit time will be shortened accordingly.

• Please call us if you are running late.

COMMUNICATION AND PHONE POLICIES

• Because of HIPPA regulations we communicate only through our office telephones

• During office hours, please call the office and leave a message. Someone from the office will get back to you the same day.

PRESCRIPTION REFILLS :

• At the time of the office visit, you will be given prescriptions with the appropriate number of refills to last until your next follow up visit.

• Please make sure you have all the prescriptions you need before you leave the office.

• Prescription medications such as those for blood pressure, diabetes, pain, weight loss and thyroid conditions need to be monitored closely. An office visit is required at a minimum every 3 months or as indicated by your physician to evaluate your care, order labs and approve additional refills.

• Failure to make and keep scheduled appointments will make it difficult to continue your care and will result in having refills denied.

• Absolutely NO prescriptions for controlled medications (like ADHD meds) will be called into the pharmacy. You will have to be seen in the office by one of our doctors.

• Refills of prescription medications require at least a 48 hour notification. Please ask your pharmacy to fax our office a refill request at (407)240-5554

• If you have not been seen in our office within 6 months, prescriptions will not be refilled without an office visit.

LAB PROCEDURES AND RESULTS:

• It is imperative that all lab work ordered by the practitioner be completed within the time frame discussed. This ensures that the results are available for discussion during your next scheduled appointment and eliminates the need to reschedule as it may become difficult to accommodate your family's schedule needs.
• Because of the wide variety of testing and companies we use, the receipt of results can vary from several days to several weeks. We routinely do not call you when they arrive unless the practitioners need to speak to you immediately. We will let you know the status of lab results when we call to confirm your appointment.
• Allow two full weeks for the results to arrive at our facility.
• In order to ensure the best understanding of your lab results and to answer all of your questions, a follow-up appointment is required. Not all results will be discussed over the phone.
• Our staff is not allowed to discuss results over the phone, unless the physician has already reviewed and signed off on them.
• We ask that you wait until your appointment to request a copy of your labs to avoid any confusion about the results.
• Fasting blood work requires that you have no food by mouth for 12 hours before your blood draw.
Drinking water is encouraged on the day of your lab draw. Prescription medications are allowed unless otherwise directed by your physician.

MEDICAL RECORDS RELEASE

• A signed release is required before any information in your chart can be mailed/faxed to you, another physician or third party.
• If you require the office to print your records, the cost of copying of your medical records for yourself will be a minimum of $10.
• Records are sent to another physician at no charge.
• One copy of your labs is given to you at your follow up visit. Additional copies will be available through your online electronic medical record.
• If you are having records sent to our office, we prefer to have them mailed or emailed to our office. Faxed copies are sometimes difficult to read.

PAYMENT POLICY

• Please make sure that your credit card is up to date with front office.
• Payments are due in full at the times of service.

I have read and understand the office policies.

Patient initials (   )

RELEASE OF CONFIDENTIAL INFORMATION

This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act of 1996, also known as Kennedy-Kassebaum Act. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present and future. Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstances, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company you already signed for the release of relevant records if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax or mail or give verbal knowledge of your medical history to the specialist.

(Initials)
__________ This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

1.) Healthcare providers involved in your care
2.) Insurance companies to secure payment
3.) Laboratories involved in your care
4.) Attorneys with your permission

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse, significant other, or adult children. Please indicate if you would like us to speak with your spouse/significant other, or adult child if and when the need arises. Note: if you decide to revoke your permission at any time, we will need a written revocation.

You have my permission to discuss any medical matters pertaining to my health with:

• NAME ____Relationship ________________________

• NAME ____Relationship ________________________

• NAME ____Relationship ________________________

• NAME ____Relationship ________________________

• NAME ____Relationship ________________________

Signature:

____Date:_______________________________________

By HIPAA standards, we are not allowed to leave results of your lab tests, x-rays, diagnostics, medications, etc., related to your specific health condition on your voicemail, answering machine, fax, etc. However, if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us to leave your information on your messaging systems.

Please choose one of the options below. Note: if you would like to revoke your option at any time, we will need your written notification.

(Initials)
__________ Appointment reminders and any information regarding my treatment may be called to my
☐ HOME Phone
☐ CELL Phone
☐ Other ______________________________

__________ A copy of “Notice of Privacy Practices” is available for your review.

Financial Authorization Form

__________ (initial)

I hereby authorize Advanced Kids Care to charge my credit card (please circle one)

☐ **Monthly** ☐ **Annually**

Credit card information (visa/mastercard):

Card number____

CVC number________________ expiration date________________

Billing address for credit card ____

____

Name as it appears on card ____

Card holder signature ____

_________________(initial)

I will be paying by check

☐ **Monthly** ☐ **Annually**

Patient's Name	**DOB**

I understand that it is my responsibility to notify Advanced Kids Care of any financial changes that may occur, fees subject to change.

____

Parent/Guardian Signature