Welcome to Advanced Kid's Care

Thank you for visiting **Advanced Kid's Care** for the first time.

Can you tell us how you heard about us?

____ **Drive By**	____ **Mail**	____ **Physician**	____ **TV/Radio**
____ **Friend/Family**	____ **Pharmacy**	____ **Job**	____ **Internet**
____ **Hotel Name** ______________________		____ **Other** ______________________	

Advanced Kid's Care- Your preferred alternative to the ER

Every effort will be made to ensure that your wait time is kept to a minimum. However, since we are an urgent care center, it is necessary for us to sometimes see patients according to severity level. Since emergencies may take longer than anticipated, your patience is greatly appreciated.

Date: ______________ Time: ________ Phone #: ______________________________

Patient Name: ______________________________ DOB: ______________

Relationship to Patient: ____________ Pediatrician Name: ______________________

Insurance: ____________________ Would you like paperless E-Statements: ☐ yes ☐ no

Email Address: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Why are we seeing your child today? ______________________________

Does your child have a history of **Seizures**? ☐ yes ☐ no

Is your child **allergic** to any <u>medications</u>? ☐ yes ☐ no Name: ______________

If yes what happens when they take this medication: ______________________

Is your child in respiratory distress? ☐ yes ☐ no

Does your child have a **fever**? ☐ yes ☐ no Temperature: ________ °

Circle last medication given **if** any: **Tylenol/Motrin** given @ ______ am/pm

Has your child **vomited** today? ☐ Yes ☐ no

Please list your pharmacy below so we may submit your prescription electronically:

____

<u>List additional children below: (Full name and Date of Birth)</u>

Name: ______________________ DOB: ______________ ☐ M ☐ F

Name: ______________________ DOB: ______________ ☐ M ☐ F

Name: ______________________ DOB: ______________ ☐ M ☐ F

Name: ______________________ DOB: ______________ ☐ M ☐ F

Name: ______________________ DOB: ______________ ☐ M ☐ F

Name: ______________________ DOB: ______________ ☐ M ☐ F

ADVANCED KIDS CARE

Welcome to our practice. Advanced Kid's Care shares a common goal of providing you with our very best care. We encourage you to ask questions about your care, your treatment and our policies. We make every effort to make your visit here as pleasant as possible. At Advanced Kid's Care, we are committed to delivering quality care in the most effective manner **365 days a year**.

NEW PATIENT INFORMATION				
Patient Last Name, First Name		**Birth Date**	**Male** ☐ **Female** ☐	**Social Security #**
Street Address Apt #			**Home Phone**	**Physician Who Referred You**
City	**State**	**Zip Code**	**Email Address**	
Preferred Language		**Race**		**Ethnic Background**

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**

EMERGENCY CONTACT INFORMATION			
Name	**Relationship to Patient**	**Home Phone**	**Cell Phone**

PRIMARY INSURANCE INFORMATION	**Paperless Bills/Statements**
Insurance Name	At Advanced Kid's Care, we are always looking to provide resourceful and convenient ways in assisting our families with fast and reliable service.
Policy Holder Name (*If Medicaid write Self*)	Please provide us with your email address above so we may be able to send you your monthly statements in a timely fashion. This will allow you a quick way to resolve your bill if one is issued to you.
Policy Holder Relationship to Patient (*Please Circle*) Parent / Self / Other:________________	In the event you do not have access to the internet or prefer a paper statement issued to you, please check the appropriate box below.
ID#/Policy #	☐ **Yes** I want my statements emailed to me
Group#	☐ **No** I want my bill/statements sent to me through mail.
Insurance Address	
City and State	
Insurance Phone	**Signature:**

Who *if* anyone other than parents or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in to Advanced Kid's Care without your presence and making medical decisions for his or her treatment.	☐**N/A**	☐**Yes the following individuals:**
Name	**Relationship to Patient**	
Name	**Relationship to Patient**	
Name	**Relationship to Patient**	

I certify that the above information is correct to the best of my knowledge. I release Advanced Kid's Care, 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:____________________________________

Staff Initial:___________ Date:_________

Referrals	**Please Initial**
Your Primary Care Physician must review and approve referrals based on medical necessity. Advanced Kid's Care participates with many different plans and each plan has specific regulations in how a referral is issued. Please contact your physician on the next business day, and inform them of your recent visit at Advanced Kid's Care. **MOST INSURANCE COMPANIES WILL NOT BACKDATE A REFERRAL: PLEASE NOTE IF YOU FAIL TO OBTAIN ONE YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED**.	____________
Lab Work and X-Ray Results	**Please Initial**
You will be notified by phone of **abnormal results**. We ask that you allow sufficient time to receive your notification. In most cases, your Primary Care Physician will have received a fax from our facility about the results. Lab work performed at Advanced Kid's Care is normally submitted to Florida Pathology. Florida Pathology has accommodated our late evening hours in obtaining **STAT** results therefore, we prefer to utilize them. However, your insurance company normally has strict guidelines to use "***their contracted***" labs. Please inform us if your insurance company has such a guideline. **We will not be held accountable if lab work is sent to a non contracted facility. You will receive a separate bill from the laboratory company.** **Please mark your preference below**: Quest ☐ Lab Corp ☐ Florida Pathology ☐ Any lab ☐	____________
Financial Policy	**Please Initial**
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 your insurance benefits when you are receiving services from an urgent care center or labs. **Please note "Urgent Care Centers" have higher co-pays and deductibles. Our charges will be higher than your normal pediatrician, but significantly less than the emergency room.** *UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS IS NOT A GUARANTEE OF PAYMENTS COLLECTED TODAY. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. EVERY EFFORT IS MADE TO COLLECT MEMBERS COPAYS AND DEDUCTIBLES BASED ON URGENT CARE BENEFITS. ACCUMULATED AMOUNTS MAY CHANGE.* AS CLAIMS ARE PROCESSED BY YOUR INSURANCE. **For uninsured patients**, payment is due at time of service. A substantial discount will be offered to **Self Pay** Patients. We will charge a **minimum of $160.00 with a maximum of $400.00** depending on the severity of the case.	____________
Insurance Lifetime Authorization	**Please Initial**
I hereby request payment of authorized insurance (Medicaid, Managed Care, Commercial) benefits to be made either to me or on my behalf to Advanced Kid's Care for any services furnished to me by AKC. 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 requests 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 releasing of the information to the insurer or agency shown. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid HMO 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 Advanced Kid's Care for Services Rendered, and release of any Medical Information necessary to process claims. I am responsible for all Co-Payments, Non covered Services and for Deductible Amounts.	____________

____ ________________________ Staff Initial:____________

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 **Advanced Kid's Care** 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.

I agree that the Practice may also disclose the following types of information contained in my medical record:	**Please Initial**
HIV/AIDS Information	
Mental Health Information	
Substance Abuse Information	
Sexually Transmitted Disease Information	
If Patient is under the age of eighteen (18), Pregnancy Information	
I do not agree to any of the above types of information being disclosed by the Practice	

I agree and consent to Advanced Kid's Care releasing information to me in the following manners:	**Please Initial**
Via **Mail**	
Via **Telephone**	
Via **Fax** to my designated fax number which is: ______________________________	

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) does 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.

____ _____________________

Patient/Legal Guardian Signature **Date**

Thank you for choosing Advanced Kid's Care for your child's urgent care needs.

Staff Initial:___________ Date:_________ Parent refused to sign ☐