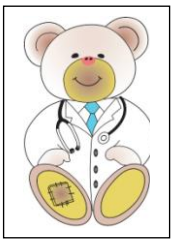
Revised 02/01/13
Orlando Pediatrics
SamerKhaznadar, MD
New Patient Registration
Ages 0-1 Year



Accounting and Insurance Policies

Payment Policy

Full payment for all co-pays, deductible and non-covered services are expected at the time of your appointment. All other payment arrangements must be made with our billing department 24 hours prior to the appointment time.

Cancellation Policy

Time has been specifically reserved for your physician appointment, procedure or treatment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is no charge if you fail to show up for a scheduled appointment or cancel with less than a 24 hour notice, but this prevent us from giving this appointment time to somebody else that needs it.

Medical Record Fees

- HRS 680 (Blue Immunization Form) and HRS3040 (Yellow Physical Form): First Copy - Free; Additional Copies - $1 each.
- Medical Disability Form Completion: $15 per set of forms.
- Copies of Medical Records: $1 per page, up to 25 pages, $0.25 each additional page thereafter. Please Note: We request a one week notice to complete requests for copies of medical records. An additional fee will be charged if copies are required sooner.

Returned Checks/ Insufficient Funds

We do not accept personal checks, but if we take a check in an unusual circumstance, a returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by your bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately.

Outstanding Balances

Deductibles not met for the calendar year will result in a fee being assessed of $100 for new patients and $50 for established patients. If you have a previous outstanding balance, you are responsible for the balance. Full payment is expected in a timely fashion, but no later than 30 days from the receipt of your statement.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Orlando Pediatrics for services rendered by the physicians or organization; I understand that I am responsible for any balances not covered by insurance.

Authorization to Release Information

I hereby authorize Orlando Pediatrics to release any medical or incidental information that may be necessary to either medical care or in processing for financial benefits.

Insurance Signature Authorization Lifetime

I certify that the information given by me in the applying for payment under title XVIII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or its intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies; I permit a copy of this authorization to be used in place of the original

Managed Care Patients

I am aware that it is my responsibility to know and understand the terms and conditions of my insurance policy. I will not hold the staff of Orlando Pediatrics responsible if I do not follow through in obtaining appropriate authorization; in this event I will bear the full responsibility of the services rendered.

I hereby certify that I have read, understand, and agree to all of the policies contained on this page.

Printed Name	Signature	Date	Relation

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Authorization for Consent of Accompaniment

I __________________________ the _______________ of __________________________ ______________
(Parent/Guardian Name) (Relationship to Child) (Patient Name) (DOB)

hereby give my permission for the following individual(s) to bring my child to Orlando Pediatrics for medical attention. I grant this/ these individual(s) the ability to bring my child to any provider rendering services at Orlando Pediatrics for evaluation, immunizations, and any necessary medical treatment that my child may need.

Furthermore, this/these individual(s) will be acting on my behalf and I cannot hold any physician and/or staff member at Orlando Pediatrics liable, or pursue legal action for the healthcare decisions the named individual(s) made regarding my child's healthcare. This consent will be effective as long as I am the legal guardian and I can revoke this consent at any time. This consent is only valid for use in this practice.

I understand a different from is required and must be notarized in order to give this/these person(s) legal medical power of attorney.

CONTACT NAME: ____________________________ **RELATIONSHIP TO CHILD:** ____________________

CONTACT PHONE: ___________________________ **RELATIONSHIP TO ME:** _______________________

- Is this person authorized to be given medical records? **[ ] yes [ ] no**
- Is this person authorized to make appointments and receive patient information over the phone? **[ ] yes [ ] no**

CONTACT NAME: ____________________________ **RELATIONSHIP TO CHILD:** ____________________

CONTACT PHONE: ___________________________ **RELATIONSHIP TO ME:** _______________________

- Is this person authorized to be given medical records? **[ ] yes [ ] no**
- Is this person authorized to make appointments and receive patient information over the phone? **[ ] yes [ ] no**

CONTACT NAME: ____________________________ **RELATIONSHIP TO CHILD:** ____________________

CONTACT PHONE: ___________________________ **RELATIONSHIP TO ME:** _______________________

- Is this person authorized to be given medical records? **[ ] yes [ ] no**
- Is this person authorized to make appointments and receive patient information over the phone? **[ ] yes [ ] no**

_______________________________ _________________
(Parent/ Legal Guardian Signature) (Date)

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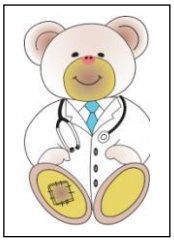

Health History

Patient Information:
Patient Name: _____ DOB: _____ Age: _____Sex: _____
Primary language spoken at home: _____ Secondary language: _____
Child lives with mother, father, both, or other? Please specify: _____
Who cares for the child during the day? _____

Birth History:
Place of Birth: _____ Type of Delivery: _____-_____
Full Term? [ ] Yes [ ] No Birth Weight: _____ lbs. _____ oz. Birth Length: _____ in.
Number of pregnancies: _____ Number of Miscarriages: _____

Family History:
Has there been a family history of:

[ ] Diabetes	[ ] Tuberculosis	[ ] Hay Fever	[ ] HIV/AIDS
[ ] Heart Disease	[ ] Cancer	[ ] Kidney Disease	[ ] Thyroid Disease
[ ] Convulsions	[ ] Asthma	[ ] Genetic Defects	[ ] Other: _____

Nutrition History:
Is the child breast fed or on formula? _____ Please specify which formula: _____
Any feeding problems? _____
Current medications: _____
Known –Environmental Allergies: _____
–Food Allergies: _____
–Allergies to Medications: _____

Safety & Accident Prevention:
Please answer yes or no:

Are all medicines, cleaning products, and other dangerous substances locked up and kept out of reach?	[ ] Yes [ ] No
Is your home equipped with smoke alarms?	[ ] Yes [ ] No
Do you have safety plugs in unused wall sockets?	[ ] Yes [ ] No
Do you have the telephone number of Poison Control?	[ ] Yes [ ] No
Is your child protected from entering a swimming pool?	[ ] Yes [ ] No
Does your child always use a car seat or safety belt?	[ ] Yes [ ] No
Have you had first aid training?	[ ] Yes [ ] No

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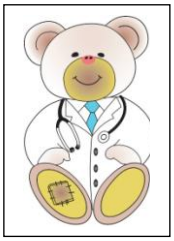

Notice of Privacy Practices

Our practice is committed to educating our patients about health care issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPAA's regulations.

What is HIPAA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable Health Information (IIHI)?
Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another health care provider that relates to treatment, payment and/or that identifies you as an individual.

The following categories describe the different ways in which we may use and disclose your IIHI:
Treatment Billing and Payment Health Care Operations Appointment Reminders Patient Contact Information Treatment Options Health-Related Benefits and Services Release of Information to Family/Friends Disclosures Required by Law Treatment Review by Specialist Progress Report Requests by Insurance Carrier

The following categories describe unique situations in which we may use or disclose your identifiable health information:
Public Health Risks Deceased Patients Military Health Oversight Activities Organ and Tissue Donation National Security Inmates Lawsuits and Similar Proceedings Serious Threats to Health or Safety Worker's Compensation Law Enforcement Research Sale of Practice

What are your rights concerning your individually identifiable Health Information (IIHI)?
You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of This Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures
9. Right to Transfer Medical Records to another Provider(s).

Please list names of people we may discuss the patient's medical care with:

Spouse's Name: _____
Other Parent's Name:_____
Other Name: _____ Relationship to Patient: _____

Do you authorize Orlando Pediatrics to leave brief messages containing minimal patient information at the phone numbers you have provided on all registration forms?
[ ] yes [ ] no

If you have any questions regarding this notice, please contact our privacy officer: SamerKhaznadarat (407) 483-7925
I have read the short notice provided by the Orlando Pediatrics practice and have been informed of how to obtain more information regarding our Notice of Privacy.

_____ _____ _____ _____
(Printed Name) (Signature) (Date) (Relation)