Internal MEDicine & PEDiatrics
MEDPEDS ASSOCIATES OF SARASOTA, PA

Patient Registration Form
MedPeds Associates of Sarasota, PA
1931 S. Tuttle Ave., Sarasota, FL 34239-3115
Phone: (941) 955-8800 ~ Fax: (941) 955-8842

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:

Preferred name:	Birth date: / /	Social Security no.:	Marital status (circle one) Single / Mar / Div / Sep / Wid	Sex: ❑ M ❑ F

Language: ❑ English ❑ Spanish ❑ Other ______________

Race: ❑ White ❑ Black/Afr Am ❑ Hispanic ❑ Asian ❑ Multiracial ❑ Decline ❑ Other ________________

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Other or Undetermined ❑ Decline

Street address:	Apt:

City:	State:	Zip:

Out of town address (if any):

Home phone: ( )	Cell phone: ( )	Work phone: ( ) Ext:

Confidential e-Mail	Preferred method of contact: ❑ e-Mail ❑ Mail ❑ Cell ph ❑ Home ph ❑ Work ph

GUARANTOR INFORMATION

Responsible party/guarantor: ❑ Patient ❑ Not patient – List all responsible party/guarantor information below

* Responsible party is the person financially responsible for any amount due to MedPeds Associates

Responsible party/guarantor name:	SSN:	Birth date: / /	Sex: ❑ M ❑ F

Street address:	Apt:	City:	State:	Zip:

Home phone: ( )	Cell phone: ( )	Work phone: ( ) Ext:

Patient's relationship to responsible party/guarantor: ❑ Spouse ❑ Child ❑ Other

NEW PATIENTS: HOW DID YOU HEAR ABOUT OUR OFFICE?

❑ Dr. ______________________ ❑ Patient ______________________ ❑ Insurance plan

❑ Internet ❑ Word of mouth ❑ SMH Referral Line ❑ Other ______________

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INSURANCE INFORMATION			
Name of primary insurance:			
Subscriber's name:	SSN:		Birth date: / /
Address (if different):		Phone number: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):			
Subscriber's name:	SSN:		Birth date: / /
Address (if different):		Phone number: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY		
Name of local friend or relative:	Relationship:	Phone number: ( )

_______________________________ _______________
Patient/Guardian signature *Date*

Consent Form
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May we leave messages & lab results on your home answering machine or with a family member? ❑ Yes ❑ No

Family Member:

Full Name	**Relationship**

Financial Policy:
I understand that I must provide MedPeds Associates with my insurance card at each visit and as a courtesy to me, Medpeds will file a claim to my insurance company with the insurance information I have provided. I accept responsibility for the remainder of charges that are not fully reimbursed by my insurance company or for amounts deemed my responsibility by my Managed Care Plan. I understand that payment of these amounts will be due upon receipt of a billing statement. The initial statement for patient responsibility will not have an assessment. The second and final statements will be assessed a **$10.00 rebilling service charge each month**. If incorrect or incomplete insurance information was given at the time of service, I will be responsible for the full charges incurred and realize it is my responsibility to contact my insurance company to resolve the issue. Co-payments, deductibles, and outstanding balances are due prior to time of service; otherwise, I understand the appointment will be rescheduled. I understand that if no insurance is to be billed, payment in full is expected at the time services are rendered. If no payment was made at time of service and a statement is sent out, there will be a **$10.00 service charge** assessed. *Cancellation Fees*: Cancellation of appointment prior to appointment time ***(at least 24 hours in advance)*** is required; otherwise, there is a **$25.00 no show/cancellation fee** for reserving unused time with the doctor**.** Appointments made same day and cancelled same day are subject to a **$25.00 no show/cancellation fee**. *Insufficient Funds*: Returned checks will have a **$25.00** check fee added and must be paid prior to any pending appointments. *Non-Payment of Services*: In the event that it is necessary for my account to be sent to an outside collection agency, I understand that I will be responsible for a **$20.00 collection handling charge and any associated collection fees**. In addition, I understand that I will be dismissed from the practice along with all family members**.** Any further contact or correspondence regarding the account, will be directed to, and handled by the outside collection agency. *Medical Records*: I understand I may obtain a copy of my Medpeds medical records, after providing 72 hours notice and a **$5.00 fee** has been collected. All records are provided via cd.
Consent for Treatment: I authorize the physicians of MedPeds Associates of Sarasota, P.A. to provide medical care and treatment for my dependent or me.
Photo Documentation: To provide excellent care to its patients, MedPeds Associates of Sarasota, P.A. uses photography for patient identification and documentation of physical findings. I, the undersigned, understand that all photo-documentation becomes a part of the medical record.
Insurance Verification: I understand it is my responsibility to present my insurance cards and photo ID upon each appointment.
Assignment of Benefits: I request that payment of insurance or authorized Medicare benefits be made to MedPeds Associates of Sarasota, P.A. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company, the Center for Medicare and Medicaid Services, or any agent for these entities any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to MedPeds Associates of Sarasota, P.A. in applying for payment by my insurance or under the Medicare or Medicaid program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
Release of Medical Record: By my signature below, I am authorizing the release of my Protected Health Information to MedPeds Associates of Sarasota, P.A. Furthermore, to ensure proper follow up and continuity of care, I authorize MedPeds Associates of Sarasota, P.A. to release my Protected Health Information to other healthcare providers (including, but not limited to: specialists, diagnostic testing centers, laboratories, and hospitals) to which I may be referred or from which I may be receiving concurrent care.
Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy or provided the opportunity to read a copy of the Notice of Privacy Practices for MedPeds Associates of Sarasota, P.A. that describes how my health information is used and shared. I understand that MedPeds Associates of Sarasota, P.A. has the right to change this notice at any time. I also understand the responsibility of Medpeds to change the Notice to comply with current law. I may obtain the current copy effective September 23, 2013 by contacting MedPeds Associates of Sarasota.
Email Correspondence Authorization: In compliance with the HIPAA privacy rule, by signing below, I am *authorizing in advance* use of my confidential email to receive Medpeds email notifications regarding future appointments as well as disease-specific health-related products/services. See our privacy policy. **CONFIDENTIAL EMAIL**________________________________
Hospital Services: I understand that the physicians of MedPeds Associates of Sarasota, P.A. have admitting hospital privileges at Sarasota Memorial Hospital. They do not provide inpatient services at any other hospital, nursing home, or any other healthcare facility. When transferred or admitted to an alternative institution, I understand that I will be under the total care of the admitting facility's physician.
Chronic Care Management Services for Medicare Patients: I understand that if I have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place me at significant risk of further decline I will be enrolled in Chronic Care Management Services offered by MedPeds Associates of Sarasota, P.A.

____	______________________
Print Patient Name	**Date of Authorization**
____	______________________
Signature of Patient/Guardian/Legal Representative	**Relationship to Patient**

Authorization to Obtain Medical Records

MedPeds Associates of Sarasota, PA
1931 S. Tuttle Ave., Sarasota, FL 34239-3115
Phone: (941) 955-8800 ~ Fax: (941) 955-8842
John Collins, MD; Steven Grogg, DO
Paula Hopper, ARNP; Erin Butler, ARNP

Informed consent:

I, ________________________________ DOB _____________ SSN ________________

Address ____ Phone ________________

Hereby authorize MedPeds Associates, PA to obtain my medical records from:

____

____

Purpose or need for disclosure:
_____ Further medical care
_____ Changing primary care
_____ Payment of insurance claim
_____ Personal
_____ Other: _______________________

Information to be released:
_____ Complete copy of all records
_____ Laboratory/pathology reports
_____ X-ray/radiology reports
_____ Consult/follow-up care notes
_____ Other: _______________________

Additional authorization is required for certain privileged information. Please release records pertaining to (**Initial All Applicable Categories**):

_____ Mental health
_____ Drug treatment/evaluation
_____ HIV/STD results
_____ Developmental disabilities
_____ Alcohol treatment/evaluation

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

I acknowledge that I have read this release and fully understand its contents. This release will remain in effect for either one year after it is signed or it will expire on ___________________.

____ _______________________

Signature of Patient/Guardian/Legal Representative **Date of Authorization**

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Referral Policy
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Patients with MEDICARE and COMMERCIAL Insurance:

It is Your Responsibility to Know Your Insurance Policy

In the event that our physician orders any diagnostic testing or refers you to a specialist, our Referral Coordinator will schedule an appointment for you and contact you with the appointment information. For laboratory testing, the office nurse will provide you with a requisition to take to your assigned lab.

However, physicians and other healthcare providers obtain insurance contracts, change their insurance contracts, and terminate their insurance contracts periodically, often without much notice. Although we will make every effort to refer to in-network providers (specialists, diagnostic facilities, labs, etc.), it is ultimately the patient's responsibility to ensure that they are receiving services from a contracted provider.

It is always best, and we highly recommend, that you contact your insurance company for contract status verification prior to receiving services from any healthcare provider or facility. Failure to do so may result in greater out-of-pocket expenses for you!

I have read the MedPeds Referral Policy as stated above and I understand the consequences of receiving care from a non-network provider or facility. Furthermore, I understand that MedPeds Associates of Sarasota cannot be responsible for non-covered services I obtain from any other provider or facility to which I am referred.

____
Patient Name (PRINT)

____
Guarantor Name (PRINT)

____
Signature of Patient/Guardian/Legal Representative

____
Date