



Welcome to Pediatric Orthopedics! Our goal is to make your visit run smoothly. We ask that you please fill out the enclosed registration forms and bring them to your child's appointment along with the following items:

- Insurance card
- Driver's license or photo ID for parent/guardian
- Referral script or authorization from the Primary Care Physician
- X-rays taken prior to this appointment
- Co-payment or co-insurance
- Legal Adoption document, Legal Guardianship document, Legal Custody document, if anyone other than the biological parent is bring the patient to the appointment

A PARENT OR LEGAL GUARDIAN/CUSTODIAN MUST ACCOMPANY THE CHILD ON THE PATIENT'S FIRST VISIT. If the patient returns for a follow up visit they must be accompanied by a parent/legal guardian or have written permission from the parent/guardian for another adult to bring the child to the appointment.

For rescheduling or canceling an appointment, please call our office 24 hours in advance at (239) 432-5100.

If a patient arrives more than 30 minutes late for their scheduled appointment, they will be required to reschedule. Please be sure to give yourself ample driving time to reach our office.

Thank you for choosing Pediatric Orthopedics for your child's orthopedic care. If you have any further questions please call (239) 432-5100. We appreciate your cooperation and look forward to building a lasting relationship with you and your child.



**15821 Hollyfern Court
Fort Myers, FL 33908**

From I-75

Take exit 131 and head West on Daniels Pkwy approximately 5 miles to Summerlin Rd.

Take a left on Summerlin Rd. and head South approximately 3 miles to Bass Rd.

Take a right on Bass Rd and we are the 3rd left at Bass Rd. & HealthPark Cir.

From US-41

Take Gladiolus Dr. West to Summerlin Rd.

Take a left on Summerlin Rd and follow it South to the second light at Bass Rd.

Take a right on Bass Rd and we are the 3rd left at Bass Rd. & HealthPark Cir.



PATIENT INFORMATION

Patients Last Name _____ Patients Date of Birth _____
First Name _____ Middle Initial _____ Patients Gender _____ Patients SSN _____
Patients Physical Address _____ City, State, Zip _____
Patients Primary Care Physician/Pediatrician _____

PARENT/GUARDIAN INFORMATION

Who has legal custody of patient? _____ Mother _____ Father _____ Guardian _____ Other, please list relation _____
Mothers/Guardians Last Name _____ Fathers/Guardians Last Name _____
First Name _____ Middle _____ First Name _____ Middle _____
Date of Birth _____ SSN _____ Date of Birth _____ SSN _____
Mailing Address _____ Mailing Address _____
City, State, Zip _____ City, State, Zip _____
Home Phone _____ Home Phone _____
Work Phone _____ Work Phone _____
Mobile Phone _____ Mobile Phone _____

Other Emergency Contact Information

Is this person authorized to bring pt for medical treatment? _____ Yes _____ No
Name _____ Relation to Patient _____
Home Phone _____ Work/Mobile Phone _____
Who else is authorized to bring this child in for medical treatment? _____

INSURANCE INFORMATION

Primary Insurance _____ Patients Policy Number _____
Address _____ Policy Holder Name _____
City, State, Zip _____ Policy Holder Date of Birth _____
Telephone Number _____ Policy Holder Social Security # _____
Secondary Insurance _____ Patients Policy Number _____
Address _____ Policy Holder Name _____
City, State, Zip _____ Policy Holder Date of Birth _____
Telephone Number _____ Policy Holder Social Security # _____

ASSIGNMENT & AUTHORIZATION

I hereby authorize Pediatric Orthopedics of Southwest Florida to release any medical information necessary to process insurance claims. I further authorize all medical and/or surgical benefits to be paid directly to Pediatric Orthopedics of Southwest Florida for any medical care rendered to my dependant. I understand that I am responsible for all charges incurred in the event that my child's insurance does not pay for or cover such expenses.

Signature _____ Date _____



ORTHOPEDIC HEALTH HISTORY

Today's Date: _____

Name _____ Date of Birth _____

New patient? _____ Established patient? _____

Reason For Visit: _____

Past Medical History: List your child's prior and current illnesses and injuries

Past Surgical History/Hospitalizations: _____

Current Medications: _____

Any Allergies: (Medications, Food, Latex, etc.) _____

Family History (Parents/Siblings ages and health) _____

Review of Symptoms

(Please indicate if your child has a health problem in any of these areas)

Eyes (glaucoma, glasses) _____

Ear/Nose/Throat (deafness, otitis, sinusitis) _____

Heart (murmur, valve defect) _____

Lungs (asthma, bronchitis, tuberculosis) _____

Abdomen (hepatitis, colitis) _____

Kidneys/Bladder (reflux, incontinence) _____

Muscles/Bones (fractures, joint problems) _____

Skin (rashes, burns) _____

Neurologic (seizures, headaches, delay, shunt) _____

Psychologic (ADD, ADHD) _____

Endocrine (diabetes, thyroid disease) _____

Hematologic (anemic, leukemia, lymphoma) _____

Infectious/Inflammatory Disease (HIV, eczema, latex allergy) _____

Please fill out appropriate column for your child's age

0-2 years

Gestational period _____ # weeks

Vaginal or C-Section? _____

Breech? Yes/No

Problems with pregnancy? Y/N

Age first: Sat by themselves _____

Crawled _____

Walked _____

2-10 years

What grade is your child in? _____

Involved in athletics? Y/N

List: _____

10+ years

What grade is your child in? in? _____

Age first menstruated _____

Does your child smoke? Y/N

Involved in athletics? Y/N

List: _____

*Pediatric Orthopedics
of SWFL
is firmly committed to
full compliance with
laws and regulations
relating to
patients rights.*

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.



**Pediatric Orthopedics
of SWFL**

15821 Hollyfern Court
Fort Myers, FL 33908
(239) 432-5100
Fax (239) 432-0629

Privacy Officer
Telephone: (239) 432-5100



**Pediatric Orthopedics
of SWFL**

NOTICE of PRIVACY PRACTICES

If you have any questions about this Notice please contact our Privacy Officer. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices on our website**, send a revised copy to you in the mail or provide you with a copy at the time of your next appointment.

*(239) 432-5100

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

Your Rights

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice from us upon request.

Questions or Concerns about our Privacy Practices

You may contact our Privacy Officer at (239) 936-2316 for further information about the complaint process. Federal Statute prohibits all medical care providers from taking any retaliatory action against you if you file a complaint about privacy practices.



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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Child Name _____ Child Birthdate _____

Parent Signature X _____

Date _____

Pediatric Orthopedics of Southwest Florida

Financial Policy

Thank you for choosing Pediatric Orthopedics of Southwest Florida as your healthcare provider. We are committed to providing your child with the best orthopedic treatment possible. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Participating Insurance Plans:

We accept assignment on some insurance, but not all. Due to the frequent changes in health insurances, we are not able to keep up with the task of knowing all insurances, or your specific plan's details. It is your responsibility to confirm with your insurance whether or not our physicians are network providers. Please remember that an insurance policy is a contract between you and the insurance company. We are not a party in that contract.

We will file your claims to your insurance company. In order to do so, we must have a copy of the following information: INSURANCE CARD AND DRIVER'S LICENSE. We reserve the right to refuse to file claims to out of state insurances. Upon request, we can provide you with a copy of a detailed receipt with which you may file your claim.

Non-participating Insurance Plans:

Patients who are insured by carriers that the practice does not participate with are considered self-pay. As a courtesy to the patient, the insurance company will be billed as a non-assigned claim with the patient paying the practice the amount in full at the time of service. The insurance company will reimburse the patient on non-assigned claims. For surgical procedures please ask to speak to a billing representative prior to the procedure. If the practice receives payment for a non-assigned claim, the patient will receive a refund.

Referrals and Authorizations:

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If authorization is not provided, you will be asked to either reschedule your appointment or pay for the visit in full at the time of service. As a courtesy, we will assist you in obtaining authorization for subsequent visits. It is imperative that you keep our office, as well as your primary care providers up to date on any changes in insurance information.

Co-payments:

Co-payments and co-insurance charges are due at the time of service. Failure to pay these charges repeatedly will result in a rescheduling of your appointment, and possible discharge from our practice. Effective September 1, 2005 there will be a \$7.00 processing fee applied to your account if the payment is not made at the time of service.

Durable Medical Equipment:

Payment for durable medical equipment and supply costs (cast cover, water-proof cast, sling, cast shoe, etc.) is due at the time of service. Insurance companies do not reimburse our practice for these products.

Self-pay accounts:

Self-pay patients are expected to pay in full for their charges at the time of visit, unless prior financial arrangements have been made with our billing office. We accept Cash, Checks, Visa, and MasterCard for your convenience. Statements for Guarantor Balances will be mailed monthly, and are due upon receipt.

Extended Payment Arrangements:

For charges exceeding \$300.00 we require a deposit of 75% of the total charges at the time of service. The remaining balance is to be paid over the next three months in equal monthly payments due by the first of every month. Pediatric Orthopedics of Southwest Florida reserves the right to add a service charge or interest to any extended payments. Patients who fail to make a monthly payment will be sent to a collection agency and may be terminated from the practice. If your account has been turned over to collections a 30% fee will be added to your balance to cover the service cost. Alternative payment schedules must be arranged with the billing department prior to treatment.

Patient Refunds:

The following criteria must be met prior to Pediatric Orthopedics issuing a patient refund: 1) there are no outstanding insurance claims on the patients account 2) there are no outstanding patient balances on the account.

Financial Responsibility:

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the financial policy outlined on the previous page. If someone other than the parent or legal guardian will be bringing the patient to subsequent appointments, we must have a written consent to treat the child from the parent.

Medical Records:

There is a charge for medical records. Records are \$1.00 per page for the first 25 pages and .25 cents thereafter. Please allow 2-3 days to obtain school forms, 1-2 days for prescription refills and 4-7 days for other requests.

X-rays:

There is a charge for copies of X-rays. Small films are \$7.00 per film and large films are \$12.00 per film. All copies are completed on Tuesday mornings and can be picked up in the afternoon.

Missed appointments:

For rescheduling or canceling an appointment, please call our office 24 hours in advance. A \$20.00 fee may be charged for missed visits that were previously confirmed.

As with any orthopedic practice, we are on call with the hospitals on any given day. This requires us to see emergency appointments at any given day or time. This also backs up our office hours and the wait time may be extensive. We will try to keep you informed of wait times at the time of check in and you are welcome to wait or reschedule your appointment. Please be patient with the staff, they are doing their best to keep you updated. Thank you for your patience.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

AUTHORIZATION FOR PAYMENT

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA for services rendered. In the event that my medical insurance does not pay for services rendered, I agree to pay PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA for these services.

Signature of Parent/Guardian

Date