The purpose of Meaningful Use is to improve patient care by providing practitioners with access to accurate and complete information about their patients. For the patient, this means improved care and greater ability to make informed decisions about their health care.
Please complete the following information regarding the patient and return it to Check-In

Who has legal custody of this patient? Mother ___ Father___ other, please list relation: _____

Mother's Name: _____ Date of Birth_____ SSN: _____

Mailing Address: _____ City, State, and Zip _____

Phone Number: _____ Email: _____

Father's Name: _____ Date of Birth_____ SSN: _____

Mailing Address: _____ City, State, and Zip _____

Phone Number: _____ Email: _____

Who else is authorized to bring patient for medical treatment? _____

Do you wish to have access to your records through a patient portal on our website?

Yes _____ No _____ Email: _____

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Pediatric Orthopedics of SWFL

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 the best pediatric orthopedic treatment possible.
The following is a statement of our **Financial Policy**, which we require you to read and sign prior to treatment.

Participating Insurance Plans
We participate in many insurance plans, however if your insurance plan is not accepted by this office, payment is expected in full at the time of service. It is your responsibility to confirm with your insurance company whether our physicians are in-network providers.
Please remember that an insurance policy is a contract between you and your insurance company.
We are not a party in that contract.

The following information is required:
INSURANCE CARD(s) and a VALID DRIVER'S LICENSE or other form of government-issued photo identification.
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, so you may file your own claim.
If your insurance plan changes, it is your responsibility to update that information with our office, failure to do so, will result in balance of the claim becoming your responsibility. It is also your responsibility to update change of address and phone number.

Non-participating Insurance Plans
Patients, who are insured by a carrier that our practice is not contracted with, are considered self-pay. And
Payment is expected in full, at the time of service. Upon request, we can provide you with a detailed history of your child's visit(s) so that you can submit it to your carrier. As a courtesy, the insurance company will be billed, by us, as a non-assigned claim. If the carrier chooses to pay our practice for a non-assigned claim, the patient will receive a refund.
Our practice issues refund checks once a month. If you are due a refund, it will be mailed at that time.

There is a $5.00 fee to complete all accident claim forms – including, but not limited to, Aflac and Colonial Penn.

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 provider up to date with any changes in insurance information. This is your responsibility.

Financial Responsibility
A parent or legal guardian with a valid photo ID must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for all payments of the account. If someone other than the parent or legal guardian will be bringing the patient to subsequent appointments, they must be listed on the patient's demographic form .
And they must be prepared to pay any co-pays or remaining balances from the guarantor.

Divorced Parents of Patients
By signing this agreement, the adult who signs a minor child into our practice, accepts all financial responsibility. This office does not communicate, forward statements, medical records or give any treatment status to the other parent or legal guardian. That is your responsibility.

Payments
Payment is expected at time of service. We accept Visa, MasterCard, Discover and Care Credit.
Payments and credits are applied to the oldest charge's first, except for insurance payment.
Bad Checks A fee of $35.00 will be assessed for returned checks and must be paid by another form of payment.
Stop payment checks constitute a breach of contract and a $30.00 fee will be issued and it will be turned over to the State Attorney Office.
We will also utilize our right to terminate the relationship from our office.

Co-payments
Co-payments and Co-insurance charges are due at the time of service. Failure to pay these charges will result in a possible rescheduling of your appointment. Unpaid fees beyond 60 days, without prior arrangements may result in 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.

Self-pay accounts
Self-pay patients are expected to pay in full for their charges at the time of visit; exceptions require prior financial arrangements with our billing office. Statements for Guarantor Balances will be mailed monthly, and are due upon receipt.

Durable Medical Equipment
Durable **M**edical **E**quipment and supplies charges (cast cover, water-proof cast, sling, cast shoe, etc.) are due at the time of service. Insurance companies do not reimburse our practice for these products.

Extended Payment Arrangements
For charges exceeding $300.00 we require a deposit of a minimum of 50% of the total charges at the time of service. The remaining balance is to be paid over the next 90 days, in equal monthly payments, due by the first of each month.
Pediatric Orthopedics of Southwest Florida reserves the right to add a service charge or an interest fee to any extended payments Patients, who fail to make a monthly payment, will be sent to a collection agency which will include termination from the practice. All accounts that are turned over to collections carry a 30% fee that will be added to your balance to cover the service cost. Alternative payment schedules must be arranged, in advance, with the Billing Department prior to treatment.

Patient Refunds
Prerequisites for patient refunds: (1) No outstanding insurance claims on the account(s).
(2) No outstanding balances on the account(s). The account(s) shows a 0.00 balance.

Medical Records
The charge for medical records is $1.00 per page, for the first 25 pages and 0.25 cents thereafter, with a minimum charge of $5.00. 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 X-Rays copies. CD's, containing films, are $10.00 each.

Missed Appointments
A $20.00 fee will be charged for missed appointments. This includes No-Show's

Appointment Changes and Cancelations
Appointment changes and cancelations must be made 24 hours in advance or a fee of 20.00 will be fined.

As with any orthopedic practice, our Doctors are on call with the hospitals on any given day.
This requires us to see emergency appointments at any given time.
This will also back up our office hours and wait times may be extensive.
We will try to keep you updated of wait times at the time of check in.

AUTHORIZATION FOR PAYMENT AGREEMENT
I authorize the release of all medical information necessary to process insurance claims, as well as, the release of information back to my Primary Care Physician. I also authorize payment of medical benefits to **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services rendered.
In the event, my medical insurance does not pay for services rendered, I agree to pay **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services provided, per the agreements as stated above.

_____
Print your First and Last Name

X_____ _____
Signature Date

Pediatric Orthopedics of SWFL

ORTHOPEDIC HEALTH HISTORY

Today's Date _____

Name _____ Date of Birth _____

Is your child a new patient? ❒ Yes ❒ No...if no, is this a new problem? ❒ No ❒ Yes

Reason for Visit: _____

Birth History

Born on time? ❒ Yes ❒ No...if no,at how many weeks gestation was patient born? _____ weeks

What was the birth weight? _____ Pounds _____ Ounces

Was patient born via C-section? ❒ No ❒ Yes...if yes why? _____

Did baby present Breech? ❒ No ❒ Yes

Were there any complications with the pregnancy/delivery? ❒ No ❒ Yes...if yes why? _____

Developmental History

Age when first:

Sat independently _____

Crawled _____

Walked _____

Talked _____

What Grade is your child in? _____

Hand your child writes with? ❒ Right ❒ Left

Girls: Age at first menstration? _____

Does your child smoke? ❒ No ❒ Yes

Involved in sports? ❒ No ❒ Yes..if so, please list

_____

List of Current Medications

Medication	Dose	Reason for Taking	Date Started	Prescriber

Name of pharmacy you use: _____

Phone Number: _____