


WHOLE CHILD
PEDIATRICS
REGISTRATION FORM

PRIMARY LANGUAGE _____
TRANSLATOR REQUIRED? YES ___ NO ___

PATIENT INFORMATION:

PATIENT'S NAME _____
LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY NUMBER _____ - _____ - _____ D.O.B. _____ AGE _____ SEX _____ RACE _____

PHONE _____ ALTERNATE PHONE _____ MARITAL STATUS _____

PATIENT'S ADDRESS _____
STREET ADDRESS CITY STATE ZIP

ALTERNATE ADDRESS _____
MAILING / PO BOX CITY STATE ZIP

GUARANTOR INFORMATION: (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME _____
LAST FIRST MIDDLE INITIAL

GUARANTOR D.O.B. _____ GUARANTOR SOCIAL SECURITY NUMBER _____ - _____ - _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT: PATIENT OR GUARANTOR (CIRCLE ONE)

EMPLOYER'S NAME _____

ADDRESS _____ PHONE _____

METHOD OF PAYMENT:

- CASH OR CHECK
- MEDICARE # _____
- MEDICAL INSURANCE NAME AND ID # _____
- VISA/MASTERCARE/OTHER # _____
- OTHER _____
- SLIDING FEE SCALE
- MEDICAID # _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE _____

ADDRESS _____

Patient Last Name _____, First Name _____



RELATIONSHIP TO PATIENT _____

I hereby give permission for the medical and /or dental staff of Whole Child Pediatrics to treat and prescribe medications, as they feel necessary on me or my Child Children Spouse. I, as parent, legal guardian or responsible adult, must accompany all children to the clinic and stay with them throughout the entire examination.

Under penalties of perjury, I declare the information contained herein to be true and correct, and consent to verification by Whole Child Pediatrics, Inc. and authorize Whole Child Pediatrics to release any information to the below named Insurance company in order that direct payment can be made to the above institution on my behalf. I hereby agree and covenant that in consideration for the treatment of me or my

Child Children Spouse, I will pay the cost of treatment.

Signature _____  _____ DATE _____

Relationship to Patient _____

Witness _____  _____ DATE _____

MEDICAID RELEASE OF INFORMATION (Copy of Card Must Accompany Release Form)

I certify that I am a recipient of Medicaid Program and request that payment and authorized benefits be made on my behalf. I authorize the clinic and clinic insurance carrier to make available to the Florida Division of Family Services and requested information concerning medical insurance and financial records relating to my medical care. I hereby certify all insurance shall be assigned to the clinic for services provided.

Signature _____  _____ DATE _____

Witness _____  _____ DATE _____

MEDICARE LIFETIME AUTHORIZATION (Copy of Card Must Accompany Release Form)

I request that payment of Authorized Medicare benefits be made to either me or on my behalf for the services furnished me by Whole Child Pediatrics I authorize any holder of medical or other information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature _____  _____ DATE _____

Witness _____  _____ DATE _____

Patient Last Name _____, First Name _____



Notice of Acknowledgement & Receipt of Patient Identification Number

PATIENT NAME _____

DOB _____

Acknowledgment:

I acknowledge that I have received the Notice of Privacy Practices.

Patient or *Personal Representative – Printed Name

Date



Signature of Patient or *Personal Representative

Relationship to Patient

Receipt of Patient Identification Number

I, _____, further acknowledge I have received a patient ID number. I understand that I must give the number when requesting Patient Health Information (PHI) relating to but not limited to: treatment, labs, charges, payments and billing issues.

I designate, _____, as the person(s), to which my PHI may be disclosed.



Patient Signature or *Personal Representative

Date



Witness Signature (Must be an employee of Whole Child)

Date

***If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.**

PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES

We, WHOLE CHILD PEDIATRICS, are pleased to be your provider of health care and related services. As our patient, you have many “RIGHTS,” as well as having certain “RESPONSIBILITIES” which will help us serve you more promptly and efficiently. This is a mutual partnership established between you, our patient (parent or custodian of our patient) and us, your professional staff of Whole Child Pediatrics. This agreement is called the PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES. It is an acknowledgement of our mutual agreement. Thank you for the opportunity to serve you.

As a patient of Whole Child Pediatrics you have the RIGHT to:

1. Be treated with courtesy, respect, consideration, dignity and with privacy and confidentiality by all who provide health care and other services to you at Whole Child Pediatrics
2. Be given information concerning available services of Whole Child Pediatrics including after-hours, emergency services, and any patient support services which we have available.
3. Prompt and reasonable response to your questions and requests.
4. Choose your health care providers and know who is responsible for your care by being given proper identification by name and title of everyone who provides health care or other related services to you.
5. Be given information of Whole Child Pediatrics’ policies and charges for services including your eligibility for third party reimbursement, the Centers acceptance of assignment for Medicaid and Medicare, and any other financial assistance known to us.
6. Be given complete and current information by Whole Child Pediatrics concerning your diagnosis, treatment, alternatives, risks and prognosis as required by your physician’s legal duty to disclose in terms and language you can reasonably be expected to understand.
7. Refuse treatment within the confines of the law.
8. Refuse to participate in experimental research.
9. Voice grievance with and/or suggest change in health care services without being threatened, restrained or discriminated against.
10. Be given appropriate and professional quality health care and other services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap or age.
11. A health care regime, developed to meet your personal health care needs, with periodic assessments/updates which will be reviewed with you.
12. Participate in the development of our health care regime.
13. Receive a timely appointment from Whole Child Pediatrics, regarding your request for health care and/or other services.
14. Be given complete and current information by Whole Child Pediatrics so you will be able to give informed consent for your treatment prior to the start of any treatment.
15. Review your clinical record at your request within the policies of Whole Child Pediatrics.
16. Be given information regarding anticipated transfer of your health care to another health care facility and/or termination or health care services to you.
17. Be given information by Whole Child Pediatrics concerning the consequences of refusing treatment or not complying with therapy.
18. Receive an itemized bill and explanation of charges.
19. Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
20. Know rules which apply to your conduct.

As a patient of Whole Child Pediatrics you are RESPONSIBLE for:

1. Giving accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies and other pertinent items such as your past providers.
2. Reporting any unexpected change in condition
3. Participating in the development and updates of your personal health care regime (or that of your child/dependent) and requesting further information concerning anything you do not understand.
4. Following your developed/updated health care regime.
5. Your actions if you refuse treatment or do not follow recommendations of Whole Child Pediatrics for your health care.
6. Keeping appointments for any scheduled service at the Center, its referrals including clinical and financial referrals, or if unable to do so for any reason notifying the Center of your inability.
7. Providing Whole Child Pediatrics, Inc. with accurate and complete financial information and paying any amounts which are required for your financial classification.
8. Assisting in maintaining a safe and clean environment and following the Center’s rules for patient care and conduct.

Walter L. “Mickey” Presha, Chief Executive Officer

PATIENT / GUARANTOR SIGNATURE _____



Date _____

Patient Last Name _____, First Name _____

(Migrant/Seasonal Farm Workers Only)



EMPLOYMENT STATUS REGISTRATION FORM

PATIENT NAME: _____ DOB _____

In the past two years or prior to retirement or disability have “you or your head of household”:

(Please check all that apply)

- 1. Worked in agricultural; planting, tilling, harvesting, or packing crops grown on the land such as fruits and vegetables?
- 2. Moved from this area to another county or state in search of agricultural work?
- 3. Lived in this area and earned more than half their income from seasonal agriculture?

Patient / Guarantor Signature _____  _____ Date _____

OFFICE USE ONLY

Type of employment Entered: Migrant _____ Seasonal _____ Other _____

Entered in system by _____ Date _____



**IF YOU ARE APPLYING
FOR REDUCED FEES,
PLEASE COMPLETE
THE FOLLOWING
FORMS:**

(Reduced Fee Applicants Only)



ELIGIBILITY FOR REDUCED FEES

PATIENT NAME _____ **DOB** _____

Any patient who desires reduced fees for services will be interviewed to determine eligibility. Appropriate documentation of financial information is required. You must provide the following:

1. Proof of identification – Drivers license, Employee ID, Resident card.
2. Proof of address – Phone bill, Light bill, etc.
3. Proof of income – 2-4 most recent pay stubs, Letter from Employer, Social Security, etc.

Also the following must be provided if it pertains to you:

- Medicaid Card
- Medicare Card
- Medical Insurance Card

Patients are charged according to their ability to pay as determined by a sliding fee scale, which is based upon most recent Federal Poverty Guidelines.

Eligibility will be updated on an annual basis, unless there is a change in current income status.

I do not desire the reduced fees. By checking the box you are declining the reduced fees and are not required to provide financial information.

Patient/Guarantor Signature  _____ Date _____

Interviewer Signature  _____ Date _____

Patient Last Name _____, First Name _____

(Reduced Fee Applicants Only)



INCOME DETERMINATION WORKSHEET

PATIENT NAME: _____ **DOB** _____

NUMBER IN HOUSEHOLD: _____ ***Family Size** _____
Only Include Head of Household, Spouse, Children, Including Foster Children

NAME	AGE	NAME	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL HOUSEHOLD INCOME	WHO'S INCOME IS BEING REPORTED	SOURCE OF HOUSEHOLD INCOME (Please check all that apply)
Hourly \$ _____ x 2080 = _____	_____	<input type="checkbox"/> WAGES <input type="checkbox"/> DISABILITY <input type="checkbox"/> SOCIAL SECURITY <input type="checkbox"/> SSI <input type="checkbox"/> RETIREMENT <input type="checkbox"/> CHILD SUPPORT <input type="checkbox"/> AFDC
Weekly \$ _____ x 52 = _____	_____	
Monthly \$ _____ x 12 = _____	_____	
Other \$ _____ x _____ = _____	_____	

IS PROOF OF INCOME ATTACHED Yes No (If the answer is no please complete the following)

I, _____, have an income of \$ _____ every:
Week Bi-Week Month, but I am unable to provide proof of income.



PATIENT / GUARANTOR SIGNATURE

SOCIAL SECURITY NUMBER



INTERVIEWER

DATE

Patient Last Name _____, First Name _____

* **Family Size-** Only Include Head of Household, Spouse, Children, Including Foster Children and any legal dependents.
(Reduced Fee Applicants Only)



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

CLIENT NAME _____ SS# _____ - _____ - _____

I hereby authorize: Whole Child Pediatrics

To Release to: **Grantor of Ryan White Funding or Manatee Board of County Commissioner – Community Services Department or Florida Department of Health or Manatee County Health Department**

The Following information:

- All Medical information/reports Laboratory Reports HIV Test Results
- X-Ray Reports Physical Examination Reports Mental Health
- Alcohol/Substance Abuse All HIV/AIDS Case Management files and documents

Other _____

Except for the following which expressly may not be disclosed (if none, write none)

For the purpose of: Monitoring or Auditing

All information I hereby authorize to be released to this agency will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that I may withdraw this consent at any time.



Signature of client or legal guardian

Date



Witness

Date

Use this space only if client withdraws consent



Signature of Client

Date consent revoked