New Patient Registration Form

Today's Date: ______________ **Account#_________**

Patient Last Name:	Name of Guarantor (Responsible Party):
Patient First Name:	Address:
Patient Middle Name:	City: State: Zip Code:
Address:	Relationship to the patient:
City: State: Zip Code:	Date of Birth:
Social Security No.:	Social Security No.:
Mom cell:	Phone: ( ) ___________- ___________
Dad cell:	Emergency Contact Information:
Home phone:	Name:
Sex (circle one): M F	Relationship to the patient:
Date of Birth:	Phone: ( ) ___________- ____________
Primary contact (circle one) : MOM DAD	Insurance Information:
Require by Government Mandate (although you may Decline):	Insurance Plan name:
Language:	Policy number:
Race:	Preferred Pharmacy:
Ethnicity:	E-mail address:
Other:	Patient Referred by:

By signing below, you are authorizing us to send you text reminders for your upcoming appointments. Providing us with your cell phone number above, you agree to any fees or charges you may incur from your cell phone company. There will not be any reimbursement from Family Tree Medical Group if any charges apply.

Parent Name (Print): ______________________________ Parent Signature: _______________________________

Patient Name: ________________________DOB: ___________Account#:________

Immunization Schedule

Birth to 4 years:

Hepatitis B:

Dose 1 is given at the hospital when the child is born
Dose 2 is given at one month
Dose 3 is given 6mo or 9mo
DTaP is given at 2mo, 4mo, 6mo, 15mo and 4 years of age
IPV is given 2mo, 4mo, 6mo and 4 years of age
HIB is given at 2mo, 4mo, 6mo, 15mo
PCV is given at 2mo, 4mo, 6mo, 15mo
Rotavirus is given at 2mo, 4mo, 6mo
MMR is given at 12mo and 4 years
Varicella is given at 12mo and 4 years of age
Hepatitis A is given at 12mo/#2 is given 6mo from the first dose

11 years and up:

Tdap is given 11 yrs of age
Menveo (Meningitis vaccine) is given at 11 years and 16 years of age
Men B is given at 16years/#2 given one month after first dose
HPV (Gardasil9) 11 years to 18 years/#2 dose 6 mo after (**recommended vaccine**)
Influenza Vaccine 6mo and up (**recommended vaccine**)

Immunization Policy:

At **Family Tree Medical Group** we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Family Tree Medical Group feels that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others. Please be advised that if you desire an "alternate" vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Family Tree Medical Group, the AAP, the AAFP, the CDC and the ACIP. As this decision is believed to put your child at risk for vaccine preventable disease and increases health risks for others.

I have read and understood the following immunization schedule and agree to vaccinate accordingly.

Parent name (Print): ____________________________

Parent signature: ______________________________

Date signed: ________________________

Patient Authorization
Please read, initial and sign below.

(Initial)______**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the most recent version of the Family Tree Medical Group Policy as dated on August 1, 2018.

(Initial)______**Financial Responsibility**: I understand that I am ultimately responsible for payment on my child's/children's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)______**Insurance Coverage**: I understand that I am responsible to provide Family Tree Medical Group with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Family Tree Medical Group will not retroactively file claims due to my failure to provide current insurance information.

(Initial)______**Assignment of Benefits**: I hereby authorize payment directly to Family Tree Medical Group, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Family Tree Medical Group, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial)______**No Show Fee**: I acknowledge that I received, reviewed, and agree to comply with the Family Tree Medical Group No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)______**Fee for Forms**: I understand that I received notice about the fee for all forms to be completed by Family Tree Medical Group and I agree to pay prior to receiving the completed form. (i.e. sports physicals, FMLA)

(Initial)______**Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the Family Tree Medical Group Privacy Policy.

(Initial)______ **Immunization Policy & Consent**: I acknowledge that I received, reviewed, and agree to comply with the Family Tree Medical Group Immunization Policy. **Please inform the doctor if the patient had any severe reaction to any medications, including vaccines. Also, if patient has any know allergies (i.e. peanuts, eggs, etc) and/or has a condition for which he/she is receiving medical treatment or has previous treatment. Vaccines may contain minute traces of animal products and other components. If you have any concerns you may address it with your physician. By initialing and signing this form, you will be giving consent for your child to have the vaccines described at the time of the visit and as recommended by the immunization schedule.**

(Initial)_______**Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Family Tree Medical Group believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice. **In the absence of the legal guardian the following person is authorized to bring the minor for medical treatment EXCEPT for routine physicals and vaccines.**

Name (other than parent): ___________________________________ Relationship _______________________________

Name (other than parent): ___________________________________ Relationship _______________________________

Name (other than parent): ___________________________________ Relationship _______________________________

(Initial)_____ **E-Prescribing:** I voluntarily authorize Family Tree Medical Group to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice; furthermore, I review pharmacy benefit information and medical dispense history as long as this child is a patient at this office.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of all agreement with the above policies. A photocopy of this document is as valid as the original.

Patient Name: __________________________________ DOB: _______________ Date: ____________________

Parent Name (Print): ____________________________Parent Signature: ________________________________

Privacy Practice
HIPAA Acknowledgment Form

Patient Name:_____________________________ D.O.B.____________________

I have received the Notice of Privacy Practices for the office of **Family Tree Medical Group** and I have been afforded an opportunity to review it. I acknowledge that this law allows our office to share and disclose protected medical information regarding your child with:

(1) Another physician, (such as a specialist our Providers refer your child to), a hospital (where your child may be admitted), pharmacy, or other provider of medical care, such as a therapist (PT, OT, Speech, etc), or DME company for medical equipment your child may require.

(2) Insurance companies (to process claims or obtain referrals).

(3) For the day to day internal operations of our office (evaluating employee performance, training, etc.)

I understand that in order for me to request a copy of my child's medical records (moving, switching to another PCP, etc), I must complete a different release of information form, which may be provided by our office, or I may submit a letter which includes my child's name, date of birth, reason for release, and one of the parent's signature.

_________________________________ _______________
Parent/Guardian Signature Date

FAMILY TREE MEDICAL GROUP, P.A.
1150 CYPRESS GLEN CIRCLE
KISSIMMEE, FL 34741
OFFICE (407)483-3200 FAX (407)483-3220

PATIENT I.D.____________

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name:________________________________ Social Security # (last 4 digits): ____________________

Address:____

Date of Birth:____/____/____ Date of Service:__________________ Phone #:____________________

Identification Shown:________________________________ Mail ☐ Pick Up ☐

I hereby authorize **Family Tree Medical Group** to use and **disclose to** : ☐ **or obtain from:** ☐ **or allow review:** ☐

____________________________________ ____________________________________

Name of Facility or Person | Phone | Fax

____

Street Address | City | State | Zip Code

the following information contained in my medical record regarding my hospitalizations, care and treatment (please initial):

____ Last Well-Child Exam/Immunization Records/Pt. Problem List & Growth Chart.

____ All Diagnostic Test Results ____Pathology Report(s)

____ Newborn Screening ____Lab Only

____ Therapy Records ____Radiology Only ____Other (please specify)

____ Progress Note(s) ____Operative Report ______________________________

The purpose for the release of information at the request of the individual is:

☐ Insurance ☐ Legal Action ☐ Continued Treatment ☐ Personal Use ☐ Patient Communication (Behavioral Health)

☐ Other (Please Specify) ______________________________

This authorization will expire on the following date, event or condition: ______________________________

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

____ HIV/AIDS ____Mental Health ____Drug and/or Alcohol Abuse ____Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that **Family Tree Medical Group** may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

____ ____________________

Patient/Legal Representative or Parent/Legal Guardian Signature | Date

Official Use Only:____ Date:____________________

☐ Name of Person Releasing Information ☐ Name of Person Assisting with Review Number of pages copied ________

☐ **I wish to revoke this authorization.** Signature:______________________________ Date: ________________

INTERPRETER ONLY

(Please Print)

Name:______________________________ Agency: ______________________________

Telephone:______________________________ Language: ______________________________