We Care Pediatrics 9406 Balm Riverview Road, Riverview, Florida 33569 T: 813-236-9310 **(2/22/2020)**

We Care Pediatrics (WCP)

Demographics	**Patient**	**Patient's Guardian**
Last Name	**1.**	**9.**
First Name	**2.**	**10.**
Date of Birth	**3.**	**11.**
Age	**4.**	**12.**
Male/Female	**5.**	**13.**
Social Security #	**6.**	**14.**
Phone	**7.**	**15.**
Address City, State, Zip	**8.**	**16.**

Primary Insurance: Plan Name:______________________________ I.D. Number: _________________________

Address:____ Group number: _________________________

Policy Holder's Name:______________________________________ Effective Date: ______________

Policy Holder's (Social Security Number): _______/_______/______ (Date of Birth): ___/___/___ (Sex): M / F

Secondary Insurance: Plan Name:______________________________ I.D. Number: _________________________

Address:____ Group number: _________________________

Policy Holder's Name:______________________________________ Effective Date: ______________

Policy Holder's (Social Security Number): _______/_______/______ (Date of Birth): ___/___/___ (Sex): M / F

-Permission is hereby granted for physicians, employees, and agents of this office to render the patient (you or your child) such medical treatment as is deemed necessary and release of medical information as to whom you authorize to treat and inform them about you or your child's medical conditions and/or diagnoses; payment status and make any necessary medical decisions under any circumstances, including emergencies.

Emergency Contacts:

17. Name:____ Cell Phone:___________________

Relation to Patient___________________________________

Name:____ Cell Phone:___________________

Relation to Patient___________________________________

Please List (clearly printed) the Names of All Children (less than 21 year of age) in Your Household

Last Name	***First Name***	***DOB***	***Age***	**Is Your Child a Patient at This Office?**	**If Not a Patient at This Office Would You Like to be?**
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***
				□ ***Yes*** □ ***No***	□ ***Yes*** □ ***No***

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Patient Name: _____ Date of Birth_____

Statement of Financial Responsibility/Assignment of Benefits - We Care Pediatrics (WCP)

a) I am legally responsible, as the guarantor or have been provided written authorization by the legal guardian to make medical decisions for the patient and that I am responsible for all charges in connection with the medical care and treatment provided by representatives of We Care Pediatrics (WCP). In the event that I am no longer the patient's guarantor or there are any changes in my guarantorship status, I agree that I am responsible to inform WCP of any changes and I assign and authorize prompt payment to WCP. **b)** My insurance plan may not approve or reimburse my medical services in full due to: usual and customary rates, benefits exclusions, coverage limits, lack of authorization, or medical necessity yet, I understand that I am still responsible for all fees not paid in full by my insurance carrier including when certain problem-oriented issue/s is/are identified by the parent/patient and/or the provider relating to the patient's overall wellbeing during what appears to be a "well" or even "sick" visits that ultimately require/s further evaluation, management and education (along with the requisite documentation and billing - according to industry standards). Ultimately, I am always responsible for any co-payments, co-insurances, policy deductibles, unforeseen retroactive insurance policy terminations or changes, except where my liability is limited by contract or state/federal laws. **c)** In order to ensure that our patients are seen as efficiently as possible, it is important that all appointment times are kept as scheduled. In the event an appointment is missed, WCP has the right to charge the patient a "no show" or missed appointment fee of $25 (if canceled less than 24-hour prior to the scheduled appointment time) and assign the patient to a lower "tier" access category that could result in the patient being ineligible for appointments and only seen on a "walk-in" basis. The office reserves the right to dismiss patients who miss a total of three appointments. **d)** I agree to keep scheduled follow-up appointments as well the expected age appropriate well visits at 2, 4, 6, 9, 12, 15, 18 months and the annual exams starting at two years of age and every year after (as well as comply with the AAP authorized vaccine schedule). Failure to keep appointments and/or deviate from the recommended vaccine schedule will be construed as non-compliance with medical care and could be grounds for termination from the practice. **e)** WCP reserves the right to charge guarantor and/or family of patients for any: missed appointments; destruction or vandalism of office property; wastage of vaccines due to responsible patient /guardian / family member deciding not to have the vaccine/s administered after initially giving verbal approval and/or after the vaccine/s being drawn up and patient /guardian / family member physically interfering with the administration of the vaccine/s resulting in any spoiling or wasting the vaccine/s. **f)** As per WCP's contract with insurance companies WCP is required to collect your co-payment / co-insurance and/or deductible at the time of the office visit/service and/or upon receipt of the insurance's evidence of benefits (EOB). WCP accepts cash and the VISA credit card as forms of payment and WCP requires you to keep a funded, non-expired credit card on file at all times given we **automatically collect those charges as soon as your insurance carrier adjudicates the appropriate amount of patient responsibility for the claim. g)** Insufficiently funded credit cards on file and/or payments that require 3 attempts to contact you (phone and/or statements) and/or are later than 60 days after our first attempt to contact you are considered "late payments" and will be subject to an additional $50 service fee (a final statement may be rendered with a letter informing you that our relationship is subject to cancellation after 30 more days) and as a result all further services will be provided on a cash-only basis. **h)** After all efforts to obtain payment have been exhausted, we reserve the right to place your account with a collection agency and you will then be responsible for any collection costs in addition to your outstanding bill. If you are presently in collections, the practice will use its discretion as to providing you with further treatment or asking you to find another physician. **i)** WCP reserves the right to charge patients with certain insurances *an after-hours fee* at the time of service when visits occur ***after 5:00pm*** *and on* ***Saturdays*** *and for* ***all Federal holiday*** according to the insurance plan's contract. **j)** If your child is covered by more than one insurance policy, be sure you communicate to us which insurance policy is considered **primary and secondary along with the respective insurance cards** given we must submit claims to the appropriate plan(s) in the right order. **k)** If your child is seen in our office for concerns related to a motor vehicle accident please provide us with the appropriate motor vehicle accident information and the claim number at the time of the visit. **l) We reserves the right to reschedule appointments if the correct demographic and insurance updates along with the actual insurance card/s are not made available at every visit and/or if the expected payment is not received and/or a valid credit card is not allowed to be filed at the time of the visit**. We will attempt to validate your insurance benefits at the time of service, however, if we cannot, we will assign your account to the "self-paid" status and request full payment before the end of your visit. We will refund any amounts subsequently paid by your insurance carrier pending receipt of the EOB. **m)** I understand and agree with the chart copying policies including: advanced notice of the request by at least 5 business days (office may take up to 30 days to process request) and receipt of the payment in full at time of request ($1.00 each page for the first 25 pages, then $.25 for each page thereafter and in the case of electronic copies, the charge is $20 which covers the cost of an encrypted CD). I have read all of the above and understand/agree to all provisions above and agree to adhere to the above terms of service.

18. Signature of guardian =(guarantor) **19.** Phone Number **20.** Email **21.**Date

22. Printed name of guardian =(guarantor) **23.**Relationship to Patient = (□ Self / □Mother /□Father / □Guardian)

Witness by Office Staff: Sign _____ Date _____

Patient Name: _____ Date of Birth_____

NOTICE OF PRIVACY PRACTICES FORM- We Care Pediatrics (WCP)

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices.
(*This information is made available on request*)

This notice describes how medical information about (you/your) child may be used and disclosed and how you can get access to this information. Please review it carefully. We understand that (you/your child's) **medical information is personal,** and we are committed to protecting it. We create medical records about (you/your child's) health care and the services and/or items we provide to (you/your child) as our patient. By law, we are required to make sure that this information is protected and kept private. **How will we use or disclose your information? Here are a few examples (for more details please refer to the Notice of Privacy Practices that follow this summary):** for medical treatment; to obtain payment for our services; in emergency situations; for appointment and patient recall reminders; research; to prevent a serious threat to health or safety; in response to certain requests arising out of lawsuits /governmental requests; to run our practice more efficiently and ensure all our patients receive quality care. **If you believe (your/your child's) privacy rights have been violated,** you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint. Your rights regarding the information we maintain about you/your child's record include your ability to:
-inspect and copy, request restrictions, amend, request a paper copy of this notice, do an accounting of disclosures and request confidential communications

PATIENT ACKNOWLEDGEMENT

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about (you/your child). The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. I understand that the information in my medical record may include information relating to sexually transmitted disease, HIV and/or mental health services and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation. I understand that revocation will not apply to my insurance company when the law provides my insurers with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event or **(optional)** condition

24. -(optional to complete) (_____)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosures and the information may not be protected by federal confidentiality rules and that the practice may condition treatment upon the execution of this Consent.

25.-Full name: _____ Signature:_____
26.-Relation to the patient =□ Self / □Mother /□Father / □Guardian acknowledging the above
Documentation of Good Faith Effort to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

The patient presented for his/her service on this date and was provided with a copy of the **Notice of Privacy Practices**. A good faith effort was made to obtain a written acknowledgment of receipt of the **Notice**. However, an acknowledgement of receipt was not obtained because of the following reason(s):
□ Patient refused to sign the Acknowledgement of Receipt above.
□ Patient was unable to sign or initial the Acknowledgement of Receipt.

Witness by Office Staff: Sign _____ Date _____

We Care Pediatrics (WCP)

MEDICAL RECORD RELEASE:

WHOSE Records to be Disclosed to We Care Pediatrics

Patient: 27. Last: _____28. First:_____29. Date of Birth: _____
I voluntarily authorize and request disclosure (including paper, oral and electronic interchange):
*** *Of What?*-all my medical/educational records including: all records and other information regarding my treatment, hospitalization, and out patient care for any reason including, and not limited to: physical, psychological, psychiatric, or other mental impairment(s), drug abuse, alcoholism, or other substance abuse, communicable or venereal disease, or gene-related impairments (including genetic test results).**
**** *From Whom?*-all medical sources (hospitals, clinics, labs, physicians, psychologists, etc: including mental health, educational sources, social workers, and rehabilitation professionals.**

Parent or Guardian Fills This Side Out

30. Name of Past Practice or MD Who Has Medical Records _____ **31.** Tel:_____ **32.** FAX _____ **33.** Address _____ **34.** Signature _____ **35.** First and Last Name _____ **36.** Relation to Patient =□ **Self /** □**Mother /**□**Father /** □**Guardian** _____ **37.** Date Signed _____ **38.** Tel:_____	***We Fill this side Out!*** ***Please Send information TO:*** ***WE CARE PEDIATRICS*** □ ***Mail: 9406 Balm Riverview Road, Riverview, Fl 33569*** **Typically** □ ***Fax: 813-236-9311*** ***ONLY NEED ■VACCINE RECORDS***

I am satisfied of this person's identity who is signing the form:

Name of Staff Witness:_____ Signature _____ Date_____

Important confidential notice: This facsimile transmission may contain information that is property, subject to attorney/client medical confidentiality, or is otherwise confidential. It is entered only for the use of the addressee named above. If you are not the intended recipient of this communication, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately.

Thank You,
Peter Kaseff, **M.D., M.P.H., F.A.A.P.**