Orange Park Pediatrics

Baptist Primary Care

Please present insurance card and photo ID for us to copy.

Date _____

Patient Information:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone #: _____

Date of Birth: _____ Sex: _____

Social Security Number: _____

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native ❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown ❑ Declined

Person Responsible For Bill:

Guarantor Name: _____

Date of Birth: _____ SS#: _____

Street Address: _____

City, State, Zip: _____

Email: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Relation to Patient: _____

Other Parent Information:

Name: _____

Date of Birth: _____ SS#: _____

Street Address: _____

City, State, Zip: _____

Email: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

Relation to Patient: _____

Primary Insurance:

Name: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Date of Birth: _____ SS#: _____

Patient Relation to Subscriber: _____

Baptist Primary Care

AUTHORIZATIONS AND ACKNOWLEDGMENTS

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

INSURANCE INFORMATION

- If you are covered by Medicare, Champus or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.
- All self-pay patients are expected to pay for services in full at the time that services are rendered.
- We will file all insurance plans for our professional fees for any hospital admissions.
- In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.
- Please advise the office personnel of any changes in your insurance or mailing address.
- Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.

WORKER'S COMPENSATION

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

UNACCOMPANIED MINORS

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

COMPLETION OF FORMS

Baptist Primary Care reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

I hereby authorize Baptist Primary Care to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

Responsible Party Signature	Patient's Name (Please Print)	DOB	Date

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Baptist Primary Care (BPC) Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at BPC, I authorize BPC to use and disclose information from and release copies of my (the patient's) medical records in accordance with BPC's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

PATIENT or PARENT (GUARDIAN)

METHODS OF PAYMENT

CASH, CHECK, VISA, MASTERCARD and DISCOVER

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Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Drug / Medication Allergies: _____

Current Medications: _____

Past Medical History: *(Please describe any major medical problems and their dates)*

_____

_____

_____

Hospitalizations / Operations (with dates): _____

_____

Family History:

FAMILY HISTORY	Mom	Dad	Maternal Grand mom	Maternal Grand dad	Paternal Grand mom	Paternal Grand dad	Sibling	Other
ADD / ADHD								
Arthritis								
Asperger's Syndrome								
Asthma								
Autism								
Bleeding Disorder								
Cancer _____								
Developmental Delay								
Diabetes Type I / II								
Hepatitis B / C								
Thyroid Disorder								
Mental Illness / Depression								
Migraine								
Seizure Disorder _____								
Skin Problems								
Hypertension								
Heart Disease								
Genetic Disease								
Kidney Disease								
High Cholesterol								
Tuberculosis								
Anemia								
Auto Immune Disorder								
Other _____								

Social History:

Birthplace: _____ Birth Weight: _____ ❑ Vaginal / ❑ C-Section

Members of Immediate Family:

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Is the child ❑ SENSITIVE / ❑ INTOLERANT / ❑ ALLERGIC to any of the following foods?

❑ Milk/Dairy ❑ Wheat/Gluten ❑ Peanuts ❑ Soy ❑ Eggs ❑ Corn ❑ Yeast ❑ Chocolate ❑ Citrus ❑ Fish/Shellfish ❑ Strawberries

❑ Other: _____

Please list any other allergies your child has been diagnosed with or that you suspect:

_____

Does anyone in the home smoke? ❑ No ❑ Yes Type: ❑ Cigarettes ❑ Cigars ❑ Pipes ❑ Other: _____

Number/day: _____

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

HEALTHCARE AUTHORIZATION & CONSENT FOR TREATMENT OF MINORS

I, _____ (name of natural or adoptive parent, legal custodian, or legal guardian patient), hereby gives authorization and consent to Baptist Health to provide medical services and treatment to _____ (name of minor) date of birth: _____ while they are accompanied by the following individuals in my absence.

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

I understand that I may revoke this authorization at any time.

_____
Print name of natural or adoptive parent, legal custodian, or legal guardian patient

_____
Signature Date Time

TELEPHONE CONSENT
by PARENT or GUARDIAN
for TREATMENT of MINOR CHILD

Date: _____

I, _____, the ❑ parent ❑ guardian, verbally authorize Baptist Physician Practices to provide medical and/or surgical care necessary in the treatment of my child or ward, _____ .
PATIENT NAME AND DATE OF BIRTH

Witness: _____ _____ _____
Name and Title Date Time

Witness: _____ _____ _____
Name and Title Date Time

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MEDICAL RECORDS RELEASE TO ORANGE PARK PEDIATRICS

Records to be sent to the following address:

NAME: Orange Park Pediatrics, Baptist Primary Care
(Please check below the correct address for your selected location.)

	Address				Phone	FAX
☐	2140 Smith Street	Orange Park	FL	32073	904/269-2140	904/264-3018
☐	6353 Argyle Forest Blvd., #4	Jacksonville	FL	32244	904/908-0200	904/908-3915
☐	1747 Baptist Clay Dr., #110	Fleming Island	FL	32003	904/520-6620	904/215-2981

****PLEASE MAIL ALL RECORDS TO ABOVE CHECKED ADDRESS AND FAX IMMUNIZATION TO ASSOCIATED FAX NUMBER**

Reason for Release of Records: _____

Records to be received from:

Physician/facility: _____

Address: _____

Phone: _____ **Fax:** _____

Release from my medical records the following information for the following dates:

From: _____ **To:** _____

As part of the medical record, the following information will be released unless stricken:

SEXUAL ABUSE INFORMATION, DRUG & ALCOHOL ABUSE INFORMATION, CHILD ABUSE & NEGLECT INFORMATION, PSYCHIATRIC INFORMATION, AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: _____ Date: _____

Patient Name: _____ DOB: _____ SS#: _____

Witness: _____ Date: _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.

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PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

I wish to be contacted in the following manner (check all that apply) concerning the patients shown above.

☐ **E-Mail** _____

☐ **Home Phone #** _____

☐ **Cell Phone #** _____

☐ **Work Phone #** _____

☐ **OK to leave / send detailed information via my home and/or work answering machine or cell phone voicemail or e-mail concerning appointment, referral and test information.**

I understand that I may revoke this authorization at any time.

☐ **Leave / send message with callback information only.**

If the patient is 18 years of age or older, please list names of those that your medical information can be released to below.

Name: **Relationship:** **Name:** **Relationship:**

_____ _____

_____ _____

_____ _____

SIGNATURE OF PATIENT or PARENT (GUARDIAN) DATE