Heraud
PEDIATRICS

Welcome

Thank you for choosing Heraud Pediatrics for your child's care. We appreciate the trust you have placed in us and we look forward to watching your child and family grow with us. Our goal is to attentively treat your child with exceptional care and compassion in a comfortable environment.

At Heraud Pediatrics, we believe that the best treatment is delivered in partnership with your family, so that together we can ensure the health and happiness of your child. Not all children are identical. We believe that good medicine is as much measured in compassion and empathy, as it is in science and practice. That's why we encourage you to be an active participant in the treatment process and we welcome your questions about our treatment plans, practices, and philosophy. Open communication and understanding are the basis of a strong doctor/patient relationship.

We always do our best to be respectful of your time. Although we make every effort to keep to the schedule, minor wait times do arise on occasion as we pay close attention to each every patient's medical needs. In such events, we will make you aware of any delays and provide you the best estimates of wait times. Your understanding and patience are greatly appreciated.

Our office hours are Monday through Friday 8:30am to 5:00pm. You can call us at any time to set an appointment. We also make every effort to keep some openings for same-day appointments and walk-ins should the need arise.

Please review the following general policies we have established for your convenience and to ensure the highest level of care:

Prescription Refills: Your provider must review and approve all prescription requests. Due to processing time, refill requests must be called in between 10 am and 3 pm, Monday through Friday. Any requests received after 3 pm will need to be handled the following workday.

Referrals: Your child must be seen for the complaint prior to referral authorization. Your provider must review and approve all referrals. Please note that each insurance plan has specific regulations on how a referral is issued. We ask that you understand that in many instances this is a time-consuming process, please allow adequate time for completion. Please do not schedule an appointment with the specialist until your referral is complete. **Most insurance companies will not backdate referrals.**

Lab Work & X-Ray Results: You will be notified by phone once your results have been reviewed by the provider. We ask that you allow sufficient time to receive your notification, if you have not been notified *within one week* after your test was performed please call and our staff will assist you. Your insurance company normally has strict guidelines to use their **contracted** labs. Please inform us of your preference. Heraud Pediatrics is not responsible if labs are sent to a non-contracted facility.

I prefer my labs go to:
Quest Diagnostics □ LabCare □ LabCorp □ No Preference □ *Initials* _____

Financial Policy: Please review our complete financial policy. At your first visit, please be prepared to present your insurance card upon arrival. Please note that any co-pay or deductible payment is due at the time of service. For uninsured patients, payment in full is due at time of service.

I have read and I acknowledge all of the above _____ *(Please Initial)*

Welcome to our Heraud Pediatrics family.

5068 S. Apopka Vineland Rd. Suite 10 Orlando, FL 32819
(407) 730-7084 ■ F: (407) 730-7090 info@heraudpediatrics.com

New Patient Registration

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NEW PATIENT INFORMATION				
Patient Last Name, First Name		Birth Date	Male ☐ Female ☐	Social Security #
Street Address			Apt #	Home Phone
City	State	Zip Code		How did you hear about us?

SIBLINGS WITH SAME RESPONSIBLE PARTY			
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #
Last Name, First Name	Birth Date	Male ☐ Female ☐	Social Security #

PARENT/GUARDIAN INFORMATION		
Mother's Name	Birth Date	Social Security#
Cell Phone Office may send me text messages ☐	Work Phone	E-mail Office may send e-mail messages ☐
Father's Name	Birth Date	Social Security#
Cell Phone Office may send me text messages ☐	Work Phone	E-mail Office may send me e-mail messages ☐

EMERGENCY CONTACT INFORMATION		
Name	Home Phone	Cell Phone

Are there any legal restrictions that would restrict a non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? No ☐ Yes ☐, if yes please provide documentation

INSURANCE INFORMATION	
Insurance Name	Insurance Phone
PolicyHolder Name (*If Medicaid write Self*)	PolicyHolder Relationship to Patient (*Please Circle*) Parent / Self / Other:_____
ID#/Policy #	Group#
Insurance Address	City and State

Who *if* anyone other than parents or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in to Heraud Pediatrics without your presence and making medical decisions for his or her treatment.	☐ N/A	☐ Yes the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient

Preferred Pharmacy Name:_____ Phone:_____

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Authorization to Release or Use Information for Treatment, Payment, or Health Care Operations

* I hereby authorize the release or use of my individually identifiable health information ("protected health information") and medical record information by Heraud Pediatrics (the Practice) in order to carry out treatment, payment, or health care operations.

* I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

You should review the Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes, you may request a copy of the revised notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree in writing to your requested restriction(s), such restrictions are then binding on the Practice.

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective upon receipt by the Practice, except to the extent that the Practice has already taken action based on prior consent.

The Practice may refuse to treat you if you (or an authorized representative) does not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial** the appropriate categories listed below):

_____ HIV/AIDS
_____ Mental Health
_____ Pregnancy (if Patient is under the age of 18)
_____ Substance Abuse
_____ Sexually Transmitted Disease

I agree and consent to the Practice releasing information to me via: (please initial the appropriate spaces below)

_____ Regular mail with any envelopes marked "Personal and Confidential" and addressed to me.
_____ Telephone, if the Practice verifies (Name, SSN, and/or unique personal identifier).
_____ Fax to my private number, which is: _____
_____ Email to my private address, which is: _____

I have read and understand the information in this consent. I have received a copy of this consent. I am the patient or the authorized party to act on the behalf of the patient.

Signature of Patient or Authorized Representative	Print Name	Date	Time

If representative, please explain relationship to Patient:

Relationship	Print Name of Patient

Witness

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Financial Policy

PLEASE READ CAREFULLY

We at Heraud Pediatrics appreciate that you have chosen us to care of your child. We are dedicated to providing the best possible care and service to your child. The financial aspects of the medical field can be complex. It is important that you understand your insurance contract and our financial policies as well. If you need further clarification or if you have any questions, please ask us.

***Co-payments and deductibles must be paid at the time of service.** This is part of your contract with your insurance company. We accept cash, checks, and all major credit cards.

***We will file your claim with your insurance company as a courtesy to you.** However, you are responsible for all charges incurred at Herauds Pediatrics. If your claim is not paid by your insurance company within a reasonable period, you will be responsible for payment.

***It is your responsibility to keep us updated with your correct insurance information.** Upon arrival we ask that you come prepared to present your insurance card at every visit to verify that our office has the most updated card on file. If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement. As we are your primary care provider, make sure our name/phone number appears on your most up to date card. If your insurance has not been informed that we are your primary care provider and we cannot confirm that we are, you must pay for the visit or reschedule. *It is your responsibility to understand your benefit plan.*

***Newborns must be added to your insurance policy as soon as possible.** Most insurance companies require that they are added within thirty (30) days after a baby is born. All newborns are considered SELF PAY until we can verify insurance. If your newborn is covered by insurance, please contact us with the name of the plan, the subscriber name, and ID number. Most insurance plans give you 15 - 30 days to add newborns to family plans. If your newborn has not been added to your plan at their 2-months checkup, your child will be treated as a self-paying patient until insurance coverage is confirmed.

***All health plans are not the same and do not cover the same services.** In the event your health plan determines a service to be **"not covered"** you will be responsible for the charges. Payment is due upon receipt of a statement from our office.

***Well Appointments** – According to children's age there are surveys that will be required for you or your child to complete. They are a necessary part of the visit and are standard of care. The survey must be billed and charged under individual billing codes separate from the well visit code. If these services are not covered, you will be responsible for payment. Not all plans cover well child visits, vision/hearing screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment. If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

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***Failure to cancel or reschedule appointments**, at least, 12 hours in advance of the appointment time will result in a $25.00 "no-show" fee. Returned/NSF checks will result in a $30.00 fee. Unpaid/delinquent invoices, after 60 (sixty) days of invoice date, will be charged a weekly $5 late fee. *If there are 3 no shows within one year you may be asked to transfer care to another practice.* If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment. All children under the age of 18 must be accompanied by an adult for well visits, chronic illnesses, lab follow-ups, and allergy testing. Children 16 and older may be unaccompanied for sick visits with a signed authorization for treatment on file.

***We reserve the right to change fees without notice**.

***Any families asked to transfer care for non-compliance** of our policies will not be accepted back in to our practice.

***We require 3 business days to complete requested forms**. No charge for Health/Immunization Forms requested at time of well visit; Additional copies are available at no charge via your patient portal. $10 fee for additional printed copies of Health/Immunization Forms requested at times other than at well visit appointment. $25 Convenience Fee for "rush" same day/next day forms.

***Medical Records**: No charge for medical records sent via fax to another physician's office. Printed copies of medical records provided to patient are charged based on current Florida guidelines ($1 per page for the first 25 pages and $0.25 per page for each page in excess of 25 pages). The fee must be paid at time of receipt. If the patient is over the age of 18 we will only release the records to the patient unless there is a written permission to release to other individuals.

I hereby assign my insurance benefits to be paid directly to Heraud Pediatrics. I authorize Heraud Pediatrics to release medical information required to process my claims for services received. I also authorize Heraud Pediatrics to pursue any unpaid or incorrectly adjudicated claims.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-responsible Party Date

_____

Please Print the Name of the Patient

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CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. PLEASE NOTE we do not see patients under the age of 18 years old for checkups without an adult accompanying them and strongly encourage a parent or legal guardian to attend all well-child visits. Please sign the first authorization below to allow us to care for your child. *If you would like us to care for your child if the child comes in alone or brought in by another person, please sign the second authorization below as well.*

Patients Name _____ Date of Birth _____

Patients Name _____ Date of Birth _____

Patients Name _____ Date of Birth _____

1. *Authorization to treat a minor patient when accompanied by a parent or legal guardian*

I am the parent or legal guardian of the patient(s) named above. I authorize and consent to the patient(s) receiving medical, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Heraud Pediatrics.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____ Date:_____

2. *Advance authorization to treat a minor patient when not accompanied by a parent or legal guardian*

I am the parent or legal guardian of the patient(s) named above. If the patient comes into the clinic alone (if over 16, for a sick visit only) or is brought in by any other person, I give advance authorization and consent to the patient receiving routine or emergency medical, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Heraud Pediatrics. If the patient is being seen for a well check visit or follow-up vaccine visit, and is due for vaccines, I understand that the vaccines that are appropriate for the visit will be given per vaccine schedule.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____ Date:_____

The following people are also involved in my child's care (including bringing them for office visits):

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

Heraud PEDIATRICS

6068 S Apopka Vineland Rd.
Ste. 10 Orlando, FL 32819
t. 407.730.7084 f. 407.730.7090

Authorization for Release of Medical Information

Please mail or e-mail records that are 25 or more pages

Patients Name _____ Date of Birth _____

Patients Name _____ Date of Birth _____

Patients Name _____ Date of Birth _____

Address: _____ City _____ State _____ Zip Code _____

Phone Number _____ Date of Request _____

☐ I authorize Heraud Pediatrics **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Heraud Pediatrics **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST (check one) Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐Personal (Release Fee)

TYPE OF RECORDS REQUESTED (check one)

☐ Complete medical record (Printout of each visit (2-4 pages per visit), labs, consult letters, immunization, growth chart)

☐ Summary of records (Includes: Immunizations, last well check, detailed summary of all visits, growth chart, allergies, and medication list)

☐ All Medical Records related to a specific illness or injury _____
Specific illness /injury Date of treatment

☐ Immunization History

☐ Specific Treatment (select one or more, as applicable)

☐ Procedure Report ☐History & Physical ☐Physical Therapy ☐X-Ray Reports ☐Lab Results

☐ I authorize the release or disclosure of information relation to sexually transmitted diseases, AIDS, HIV, and alcohol or drug abuse.

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.

☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐This request and for medical records of any **future** treatment of the type described above until :_____(insert date)

I understand that: *See CFR §164.508(c)(2)(i-iii)*

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (If requester is not the patient) _____

Heraud Pediatrics, LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally was offered and/or received a copy of Heraud Pediatrics, LLC's Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

FOR OFFICE USE ONLY

☐ Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

☐ Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

☐ Other _____

–

Signature: _____ Date: _____

Print Name: _____