NEW PATIENT INFORMATION				
Patient Last Name, First Name		Birth Date	Male ☐ Female ☐	Social Security #
Street Address			Apt #	Home Phone
City	State	Zip Code		Email Address?

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	Work Phone	Place of Employment/Occupation
Father's Name	Birth Date	Social Security#
Cell Phone	Work Phone	Place of Employment/Occupation

EMERGENCY CONTACT INFORMATION		
Name	Home Phone	Cell Phone

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 PM Pediatrics/WOP 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
Name	Relationship to Patient

I certify that the above information is correct to the best of my knowledge. I release PM Pediatrics/WOP, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian Signature:_____ **Date:** _____

Signature of Person Responsible for Bill:_____

Staff Initial:_____ Date:_____

Referrals	**Initial**
Your provider must review and approve all referrals. You must be seen for the complaint prior to the referral Authorization. PM Pediatrics participates with different plans and each plan has specific regulations in 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 until your referral is complete. **MOST INSURANCE COMPANIES WILL NOT BACKDATE A REFERRAL:**	_____
Lab Work and X-Ray Results	**Initial**
You will be notified by phone once your results have been reviewed by the provider, if you have not been notified within one week after your test was performed please call and our staff will assist you. You must schedule an appointment for all x-ray and lab work results and patient must be present for all visits. **Please mark your preference below**: Quest ☐ Lab Corp ☐ Florida Pathology ☐ Cognoscenti Lab ☐ Any lab ☐	_____
Financial Policy	**Initial**
For insured patients, should your insurance company require a co-pay for your visit or a deductible, it will be due at the time of service. Please be aware that you are responsible for all co-payments, non-covered services, and deductible amounts. Your insurance company coverage is an agreement between you, the patient, and your insurance company, the insurer. It is your responsibility to know your insurance benefits when you are receiving services. **For uninsured patients**, payment is due at time of service. **For newborns** please request a form to initiate the process. You may also directly call 800-239-7560 to activate your child. We will see your child on the first visit as a courtesy before the child is 1 month age. Future visits will require you to have updated Medicaid. **Divorce/Custody**, The parent and/or legal guardian who brings the child in for medical services will be required to pay the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.	_____
No Show/Canceled Appointments	**Initial**
All appointments require at least a 24hour prior notification or cancellation. No shows or appointments cancelled with less than 24 hours notice may be subject to a missed/cancellation appointment fee of **$25.00**.	_____
Insurance Lifetime Authorization	**Initial**
I hereby request payment of authorized insurance (Medicaid, Managed Care, Commercial) benefits to be made either to me or on my behalf to PM Pediatrics/ World of Pediatrics for any services furnished to me by PM Pediatrics/World of Pediatrics. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid HMO carrier as the full charge, and the patient is responsible only for the coinsurance, and co-pay services. Coinsurance and the deductibles are based upon the charge determination of the Managed Care carrier. I hereby authorize payment of Insurance Benefits Directly to PM Pediatrics for Services Rendered, and release of any Medical Information necessary to process claims. I am responsible for all Co-Payments, Non- covered Services and for Deductible Amounts.	_____
Prescription Refills require a doctor visit	**Initial**
Your provider must review and approve all prescription requests. Therefore, they will not be filled after office hours or on the weekends. Please do not ask for the physician to be paged for medication refills. Providers are on-call for Urgent Care Only.	_____

_____ _____

Patient/Legal Guardian Signature **Date**

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 or PHI) and medical record information by **PM Pediatrics/ World Of Pediatrics** in order to carry out treatment, payment, or health care operations. You should review the Practice's 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 its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

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 to your requested restriction(s), such restrictions are then binding on the Practice.

I agree that the Practice may also disclose the following types of information contained in my medical record:	**Please Initial**
HIV/AIDS Information	
Mental Health Information	
Substance Abuse Information	
Sexually Transmitted Disease Information	
If Patient is under the age of eighteen (18), Pregnancy Information	
I do not agree to any of the above types of information being disclosed by the Practice	

I agree and consent to PM Pediatrics/World of Peds. releasing information to me in the following	**Please Initial**
Via **Mail**	
Via **Telephone**	
Via **Fax** to my designated fax number which is: _____	

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 except to the extent that the Practice has already taken action based on the 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 revokes 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 have read and understand the information in this consent. By signing this consent form, you consent to our use and release of PHI about you for the treatment, payment and health care operations as described in our notice. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

_____ _____

Patient/Legal Guardian Signature **Date**

Thank you for choosing PM Pediatrics/ World of Pediatrics for your child's primary care needs.

Staff Initial:_____ Date:_____ Parent refused to sign ☐

2910 Pleasant Hill Road Kissimmee FL 34746
Phone: 407-343-1221
FAX : 407-343-8228

MEDICAL RELEASE FORM

Patient name _____ DOB: _____

By signing this form, I authorize Aziz Imtiaz MD and Dr. Rafay Khan MD to receive medical information from:

NAME of Physician/ Hospital _____

Address:_____

Telephone: _____ Fax: _____

Documents to be released:

- **Complete records**
- **Discharge Summary**
- **Lab Reports**
- **Other: _____**

** HIV/AIDS: I consent to the release of my positive or negative test result for HIV infection or AIDS with the rest of my medical records**
Initial: _____ Date: _____

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED

Parent/Guardian:_____

Signature: _____

Date: _____