Timber Creek
Pediatrics

15212 East Colonial Drive, Orlando, FL 32826.
Phone: 407.380.1777 Fax: 407.380.1766
appointments@timbercreekped.com

NEW PATIENT INFORMATION FORM

CHILD

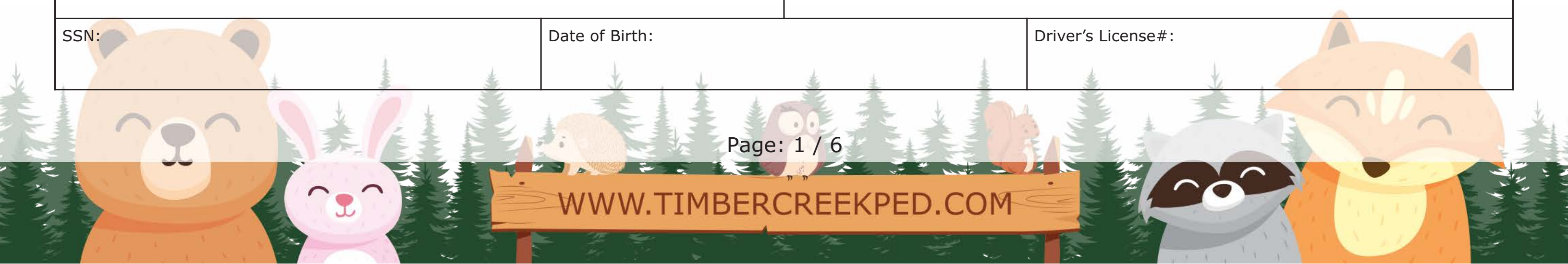
Last Name:	First Name:	Middle:
Date of Birth:	SSN:	Gender: Male: Female:
Medical Insurance Name:		
Policy ID#:	Group#:	
Name of Insured:	Date of Birth:	

FATHER

Last Name:	First Name:	Middle:
Address:		
City:	State:	Zip:
Home Phone Number:	Cell Number:	
E-mail:	Living with child?: Yes: No:	
Place of Employment:	Work Number:	
SSN:	Date of Birth:	Driver's License#:

MOTHER

Last Name:	First Name:	Middle:
Address:		
City:	State:	Zip:
Home Phone Number:	Cell Number:	
E-mail:	Living with child?: Yes: No:	
Place of Employment:	Work Number:	
SSN:	Date of Birth:	Driver's License#:



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EMERGENCY CONTACT INFORMATION

Contact Name:	
Relationship to Contact:	
Phone Number:	

Insurance Assignment and Release:

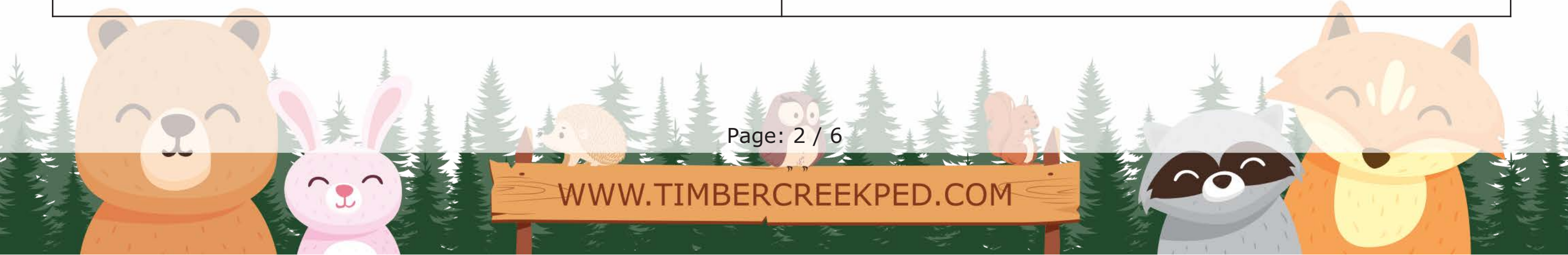
I authorize release of any information containing my child's health care, advice or treatment for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me to the Doctor.

Responsible Party Signature:	Date:

CONSENT TO VIEW MEDICATION HISTORY

I authorize Timber Creek Pediatrics to download and view my Medication History.

Signature:	Date:



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INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by ____ cannot be confirmed at this time. I wish to receive medical service from Timber Creek Pediatrics. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided including any procedures and vaccinations given to the patient.

Signature of Parent/Legal Guardian:	Date:

Acknowledgment of Receipt of Notice of Privacy Practices:

(You may refuse to sign this Acknowledgment)

I, ___________________________________, have received a copy of this Notice of Privacy Practices.

Please print name:

Signature:	Date:

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

(___) individual refused to sign.

(___) Communication barriers prohibited obtaining the Acknowledgment.

(___) An emergency situation prevented us from obtaining Acknowledgment.

(___) Other (Please Specify): ____

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AUTHORIZATION FOR TREATMENT

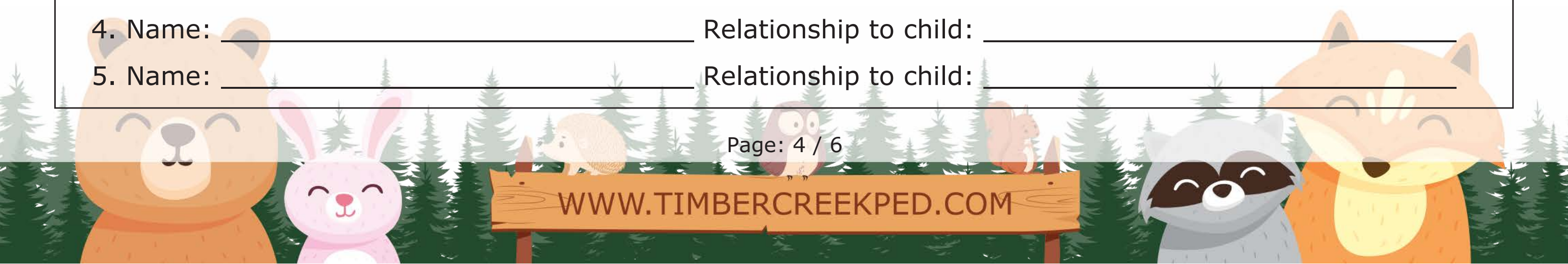
I authorize Austria Rodriguez MD to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Austria Rodriguez for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

I understand that if my child's physician or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to release of these results to the person who is exposed to my child's body fluids.

Parent/Guardian Signature:	Relationship:
	Date:
Witness' Signature:	Date:

In the event that I (parent/guardian) ________________________________ cannot accompany my child to Timber Creek Pediatrics for an appointment, whether that be in person or virtual (via phone/computer/ email/telemedicine platform); I authorize such persons, daycare, school, child care facility, and or staff members of the above listed entities who are entrusted with the care, supervision, and well-being of my child ___________________________________ to initiate and or attend such medical consultations/visits. In the event of my absence, I do hereby consent, authorize, and grant such persons/entities the power and authority to act on my behalf in medical situations that warrant swift action for the health and well-being of my child. Furthermore, authorized persons/entities listed in this document may have complete privity to medical records and or information necessary to act on my behalf in my absence to help facilitate appointments and or patient treatment with the aforementioned medical practice.

1. Name: _____________________________ Relationship to child: _____________________________
2. Name: _____________________________ Relationship to child: _____________________________
3. Name: _____________________________ Relationship to child: _____________________________
4. Name: _____________________________ Relationship to child: _____________________________
5. Name: _____________________________ Relationship to child: _____________________________



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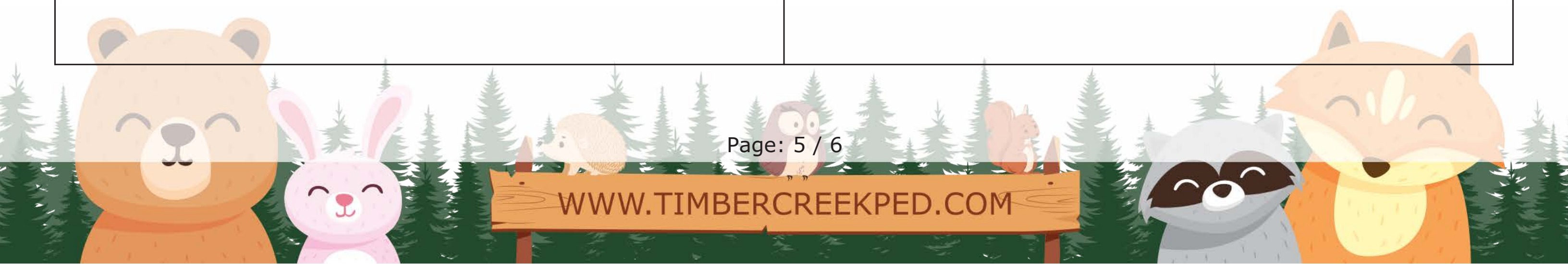
OUR FINANCIAL POLICY

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of reimbursing the patient for professional services fees paid to the doctor and is not substitute for your responsibility of payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance policy benefits and obligations, this includes your financial obligations for the services provided, by the participating physician, and to obtain prior authorization when necessary. **Initials:** __________
- Health care regulations require the collection of all co-payments, deductibles, balances and non-covered professional fees at the time of the service. It is your responsibility to pay the deductible amount, co-insurance, or any other balance not paid by your insurance company. **Initials:** __________
- If your insurance company does not pay for professional services within a reasonable time period, we have the right to bill you for the balance on your account. **Initials:** __________
- All co-payments are collected at the time that you receive services. Insurance co-payments are collected at every visit. **Initials:** __________
- Some insurance companies only pay a portion of the professional fees (fixed allowances or percentages). Depending on your plan, you may be required to pay any outstanding balance on your account. **Initials:** __________

By signing below, I acknowledge that I have read and understand the financial policy of Timber Creek Pediatrics. I accept financial responsibility for the professional services and understand that I will be responsible for any unpaid balance on my account; in the event that my insurance plan does not fulfill their contract obligation.

Signature:	Print Name:
	Date:



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AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Current Phone:	Current Address:

RELEASE MEDICAL RECORDS FROM:	**DISCLOSE MEDICAL RECORDS TO:**
Name or Facility: ____________________	Name or Facility: ____________________
Address: ____________________	Address: ____________________
Phone: __________ Fax: __________	Phone: __________ Fax: __________

I AM REQUESTING MEDICAL RECORDS FROM DATES: FROM: ____________ TO: ____________

Please send my requested information by:

Fax: ____________ Mail: ____________ Email: ____________

Note: It is preferred to send records via fax.

I AUTHORIZE THE FOLLOWING TYPES OF INFORMATION TO BE RELEASED

All medical records	Operative Notes	Your initials are required to release the following:
Labs/Pathology/Imaging	Growth Charts	_________ Psychiatric/Psychological Evaluations and Notes
Immunizations/Vaccines	Medications	_________ Drug/Alcohol Results
History/Physicals	Photos	_________ HIV/STD Report
Specialist Consultations	Billing Statements	*If Requesting Adolescent Encounters Minor Must Sign:
Hospital Records	Other:______________	

PURPOSE OF DISCLOSURE (PLEASE SPECIFY)

Transfer of Care	Personal Use	**Expiration Date: ____________________**
Continuity of Treatment	Other:______________	*If left blank, this authorization will expire one year from the date signed.

I recognize that the health information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes, and will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing to Timber Creek Pediatrics at any time. A written cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. Information released may be subject to re-disclosure by the recipient. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. I understand that a copy of this release is as valid as the original and I may also receive a copy of this form after I sign it. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Signature of Patient/Parent/Legal Guardian:	Print Name of Patient/Parent/Legal Guardian:
	Relationship to Patient:
	Date:

Notice: There may be a cost for producing medical records in accordance with State and Federal Law