



**PEDIATRIC NEUROLOGY, P.A.**  
**PEDIATRIC EPILEPSY CENTER OF CENTRAL FLORIDA**  
**PATIENT REGISTRATION**

Date: \_\_\_\_\_

PLEASE PRINT CAREFULLY

**PATIENT INFORMATION:**

Patient name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: M F Home #: \_\_\_\_\_

**PEDIATRICIAN/PRIMARY CARE PHYSICIAN:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Tel #: \_\_\_\_\_

**REFERRING PHYSICIAN:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Tel #: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Mother's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

Father's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_  
Social Security: \_\_\_\_\_ DOB \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group: \_\_\_\_\_

**OTHER INFORMATION**

Pharmacy Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Any known allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT**

Relationship to patient: \_\_\_\_\_ Name: \_\_\_\_\_  
Tel #: \_\_\_\_\_ Cell #: \_\_\_\_\_

PEDIATRIC NEUROLOGY, P.A.

FINANCIAL POLICY

MUST BE SIGNED BY THE RESPONSIBLE PARTY

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

I understand that if my insurance policy requires pre-authorization by the referring agency, it is my responsibility to obtain and provide it to Pediatric Neurology, P.A.

I understand that it is my responsibility to supply the most current primary insurance coverage or any changes in insurance coverage and provide it to Pediatric Neurology P.A. prior to services rendered. I understand that I am required to pay any copay, coinsurance, and/or deductible in full prior to services rendered. I understand that I am responsible for the entire amount due for professional services if my child is registered as **Self Pay** or if I have failed to provide correct and current coverage or regardless of insurance coverage that is retroactive back to the date services were rendered.

Pediatric Neurology DOES NOT file secondary insurance claims.

In the event Pediatric Neurology, P.A. is not contracted with my insurance company or my insurance denies payment for any reason, I am responsible for the entire amount due for professional services rendered.

I understand payment is due in full prior to services rendered and that I will be provided a receipt so that I may file with my insurance company, if I choose to do so.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** If insurance is terminated after the date of service or incorrect primary insurance is given at time of service and insurance denies payment or requests reimbursement of payment, patient will be responsible for full amount (entire balance) within 30 days or be sent to collections.

**PEDIATRIC NEUROLOGY, P.A.**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**MEDICAL RECORDS RELEASE & INSURANCE  
ASSIGNMENT**

**I permit a copy of these authorizations and assignments to be used in place for this original that is on file at Pediatric Neurology, P.A.**

\_\_\_\_\_ (initials)

**I authorize Pediatric Neurology, P.A. to release to any third party (such as an insurance company or government agency) any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment.**

\_\_\_\_\_ (initials)

**I authorize Pediatric Neurology, P.A. to release my medical records to healthcare providers involved in my child's continuing care and treatment.**

\_\_\_\_\_ (initials)

**I authorize the release of my child's medical records to Pediatric Neurology, P.A. to release them from all responsibility and/or liability that may arise from this authorization.**

\_\_\_\_\_ (initials)

**Responsible Party's Signature \_\_\_\_\_ Date \_\_\_\_\_**

## PEDIATRIC NEUROLOGY, P.A.

### Office Policies and Procedures

- ❖ Our office hours are Monday thru Friday 8:30 am to 4:00 pm. We are closed for lunch from 11:30 am to 1:00pm.
- ❖ Please arrive 30 minutes prior to your appointment time. If you are not here at the required time, your appointment may be rescheduled.
- ❖ If you are unable to keep an appointment, notify us at least 24 hours in advance.
- ❖ If you do not show up for 3 scheduled appointments without notifying us at least 24 hours in advance you will receive notification that you will need to follow up with another doctor.
- ❖ Your phone calls made during business hours will be returned within 24 hours.
- ❖ After hours calls are as follows: If your call is an **EMERGENCY- call 911** or go to the nearest emergency room. If your call is an urgent one that **cannot wait** until regular business hours you can page the on-call physician/nurse practitioner/nurse at 407-293-1122 through our answering service.
- ❖ Please call us 48 hours in advance for any prescription refill needs.
- ❖ You will be notified by MAIL of your lab/MRI/EEG results. If you have not received the results within 2 weeks, please feel free to contact us at 407-293-1122 option "5" for the nurse.
- ❖ Payment for services is payable in full prior to services rendered and is the responsibility of the responsible party. Please refer to our financial policy attachment.
- ❖ **It is the patient responsibility to obtain a referral or authorization from the PCP/Pediatrician for the visit. It is the patient's insurance company policy that determines whether or not you need a referral, if you are unsure you will need to contact your insurance carrier prior to your visit. If you do not have a referral or authorization for the visit and the insurance requires you to have one, the appointment may be rescheduled.**
- ❖ **All returned checks will result in a \$25.00 returned check fee.**
- ❖ Knowledge of authorization, benefits and payments are up to the responsible person and/or policy holder. Please refer to our financial policy attachment.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2/14/2008

**Pediatric Neurology, P.A.**  
**Pediatric Epilepsy Center Of Central Florida**  
**7485 Sandlake Commons BLVD**  
**Orlando, FL 32819**

Phone Number: (407)293-1122

Fax Number: (407)253-2170

**Privacy Practices Acknowledgement**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patients Name: \_\_\_\_\_

Patient Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PEDIATRIC NEUROLOGY P.A.

AUTHORIZATION FOR RELEASE

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Can we disclose detailed medical information such as, but not limited to, results, diagnosis and findings at the numbers listed below? Please specify and initial.

Home #	_____ YES	_____ NO	Initials _____
Home # Voicemail	_____ YES	_____ NO	Initials _____
Cell #	_____ YES	_____ NO	Initials _____
Work #	_____ YES	_____ NO	Initials _____
Work # Voicemail	_____ YES	_____ NO	Initials _____
Fax #	_____ YES	_____ NO	Initials _____

I hereby authorize the release of my child's medical records to Pediatric Neurology P.A. and release them from all responsibility and/or liability that may arise from this authorization.

Responsibility Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_