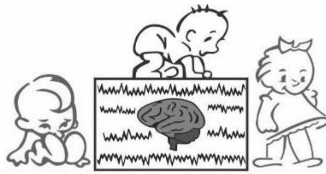


1245 W. Fairbanks Rd. Suite 305Winter Park FL. 32789 (407) 293-1122

PATIENT REGISTRATION PLEASE PRINT CAREFULLY

Date: _______/_______/_______

Patient Information

Patient's Name: ____

Address: ______________________________ City: ____________ State: ______ Zip: _______

Date of birth: ______/______/______ Sex: M F Tel #: ___________________________

Primary Care Physician	**Referring Physician**
Name: ______________________________	Name: ______________________________
Address: ____________________________	Address: ____________________________
City: __________ State: ______ Zip: ________	City: __________ State: ______ Zip: ________
Tel #: _______________ Fax: _______________	Tel #: _______________ Fax: _______________

Responsible Party Information

Mother Name: _________________________	Father Name: _________________________
Address: ____________________________	Address: ____________________________
City: ____________________ State: ________	City: ____________________ State: ________
Zip: ________Home #: ____________________	Zip: ________ Home #: ____________________
Cell: ________________ Work: _____________	Cell: ________________ Work: _____________
Employer/Occupation: ____________________	Employer/Occupation: ____________________
Email: ______________________________	Email: ______________________________

Insurance/OtherInformation	**Pharmacy Information**
Insurance: ____________________________	Pharmacy Name: _______________________
Policy Holder Name: _____________________	Address:______________________________
DOB:____/____/____ S.S.#_____-_____-_____	City: __________ State: _____ Zip: ________
Is illness or injury accident related? ☐ Yes ☐ No	Phone: ______________________________
If yes, do you have an attorney? ☐ Yes ☐ No	Allergies: ____________________________

Emergency Contact

Name: ______________________________ Relationship to Patient: _________________________

Phone: ___________________________________

PEDIATRIC NEUROLOGY, P.A. &
EPILEPSY CENTER OF CENTRAL FLORIDA

Office Policies and Procedures

- Our office hours are Monday through Friday 8:30am to 4:00pm. We are closed for lunch from 12:00pm until 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 you must notify us at least 48 hours in advance.
- **NO SHOWS AND LATE CANCELLATIONS WILL INCUR A $25 FEE FOR DOCTOR VISITS AND $200 FOR PROCEDURE VISITS.**
- If you do not show up for 3 scheduled appointments without proper notification you may be discharged from the practice.
- Any messages left during normal business hours will be returned within 24 hours.
- After hour calls are as followed: If your call is an **EMERGENCY** call 911 or go to the nearest hospital. If your call is an urgent one that can not wait until regular business hours you can page the on call physician/ARNP at (407) 293-1122 through our answering service. There is a fee of $35 and up for any after hours call.
- **NOTE: MEDICATION REFILLS ARE NOT CONSIDERED URGENT.**
- Please call us 48 hours in advance for any prescription refill request.
- You will be notified by MAIL of LAB/MRI/EEG results. If you have not received the results within 2 weeks, you may contact us at (407) 293-1122 option 6 or 9 for the nurse. Abnormal results, especially genetic testing will not be discussed over the phone unless the telephone consent form is on file.
- All payments such as self-pay fees, insurance copayments, co-insurance and deductibles will be collected in full **PRIOR TO SERVICES BEING RENDERED.**
- **It is the responsibilty of the parent to obtain a referral or authorization from the primary care physician. It is the patient's insurance policy that determines if a referral is needed. If you are unsure you will need to contact your insurance carrier prior to your visit. If you are required to have a referral or authorization and you do not have one for a visit your appointment will be rescheduled and will be counted as a "NO SHOW".**
- **All returned checks will result ina $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.
- **PLEASE NOTE WE DO NOT FILE SECONDARY INSURANCES.**
- **THE PATIENT MUST BE PRESENT FOR EVERY APPOINTMENT INCLUDING ONES SCHEDULED TO OBTAIN RESULTS.**

Parent/Guardian Signature: ____________________________________ Date: ____/____/____

PEDIATRIC NEUROLOGY, P.A. &
EPILEPSY CENTER OF CENTRAL FLORIDA
Financial Policy

The doctors and staff of Pediatric Neurology, P.A., would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as conveninet as possible.

We ask for your help by understanding and cooperating with our financial policy. Please read this policy and sign below confirming you understand the following:

- Our practice participates with multiple insurance companies. **It is your responsibility to understand the requirements and coverage benefits of your plan.**
- Insurance pre-authorization and referrals are the responsibility of the parent. Referrals must be faxed to our office prior to appointments.
- Parents are responsible to supply current insurance coverage information prior to a visit.
- **All changes** including insurance, address, referring physician and phone numbers must be reported to our office prior to appointment.
- Patient accounts are to be kept current.
- A returned check will result in a $25 service charge fee and future payments will only be accepted in the form of cash or credit card.
- If you do not have your payment(s) your appointment will be rescheduled.
- Refunds will be issued within 6 weeks from date requested if there is no pending insurance claim.
- There is a $40.00 charge for completion of paperwork (ex. Disability, FMLA, Parking Permit etc.) Paperwork may take 7-14 days for completion.
- A fee of $35 and up will be billed to you or your insurance company for calls placed to our after hour answering service.
- Any balance over 90 days may be sent to collection.
- **You are responsible for any non-covered and/or denied claims. You will receive a statement of denied charges and payment will be due within 30 days of statement. This includes any charges denied due to insurance changes or primary insurance policies that are not reported to our office. It is imperative we have correct information so we may submit timely claims. We DO NOT file secondary insurances.**
- **If an office visit needs to be rescheduled or cancelled we require24 hour notice prior toappointment to avoid a $25 late cancellation fee. For EEG's and Video Monitoring we require 48 hournotice to avoida $200 late cancellation fee.__________ (INITIAL)**

We understand that temporary finance problems may arise affecting timely payments. Please call (407) 293-1122 ext. 204 to set up the correct management of your account.

Parent/Guardian Signature:_______________________________________ Date: ____/____/____

PEDIATRIC NEUROLOGY, P.A. &
EPILEPSY CENTER OF CENTRAL FLORIDA

Patients Name: ______________________________

D.O.B: _____/_____/________

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.

__________ (INITIAL)

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

__________ (INITIAL)

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

__________ (INITIAL)

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 authorization.

__________ (INITIAL)

Parent/Guardian Signature: ____________________________________ Date: ____/____/____

PEDIATRIC NEUROLOGY, P.A. &
EPILEPSY CENTER OF CENTRAL FLORIDA

Privacy Practice Acknowledgment

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

Patient's Name: ____

Patient's D.O.B: _____/_____/_____

Parent/Guardian Signature: ____

Date: _____/_____/_____

Pediatric Neurology PA & Epilepsy Center of Central Florida

Ronald Davis, M.D., Joseph Cimino, M.D.

Kay Taylor, APRN, Jennifer Hermantin, APRN, Leslie Pedreira, APRN

1245 W. Fairbanks Ave., Suite 305
Winter Park, FL 32789
Phone: (407) 293-1122
Fax: (407) 253-2170

8045 Spyglass Hill Rd, Suite 105
Viera, FL 32940
Phone: (321) 610-7105
Fax: (321) 610-4975

<u>TO THE MOST IMPORTANT PEOPLE IN OUR PRACTICE</u>
<u>OUR PATIENTS</u>

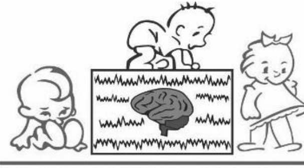
DEPENDING ON THE DIAGNOSIS,INITIAL CONSULTATIONS MAY BE SCHEDULED WITH DR. DAVIS OR ONE OF OUR NURSE PRACTITIONERS (APRN). SUBSEQUENT VISITS SUCH AS FOLLOW UPS AND RESULTS WILL BE BOOKED WITH OUR NURSE PRACTIONERS.

ALL PATIENTS ARE STILL UNDER THE CARE OF DR. DAVIS REGARDLESS OF WHO THE APPOINTMENT IS BOOKED WITH.OUR APRN'S CONSULT WITH DR. DAVIS ON EVERY ASPECT OF OUR PATIENTS TREATMENT. IF DR. DAVIS FINDS IT NECESSARY, HE MAY VISIT WITH THE PATIENT AT THE TIME OF THE APPOINTMENT. HOWEVER, GIVEN THE SIZE AND SCOPE OF OUR PRACTICE, WE COULD NOT CONTINUE WITHOUT THE HELP OF OUR APRN'S.

PLEASE UNDERSTAND IN ORDER TO KEEP PEDIATRIC NEUROLOGY & EPILEPSY CENTER OF CENTRAL FLORIDA A VIABLE PRACTICE, WE ASK THAT ALL PATIENTS (PARENTS AND GUARDIANS) BE PREPARED TO VISIT WITH ONE OF OUR APRN'S DURING ROUTINE VISITS.

SINCERELY,
Emmanuel Vega
Practice Administrator

Parent/Guardian Signature: ______________________________________ Date: ____/____/____



Consent to Leave Phone Messages

I understand that as part of my child's health care and treatment, Pediatric Neurology P.A. may need to reach me by phone.

(   ) **I DO** authorize Pediatric Neurology P.A. to leave a message on my home and/or cell phone regarding communication of my child's health care/treatment such as instructions for procedures, clinical, test results, billing and/or appointment needs, etc.

(   ) **I DO NOT** authorize Pediatric Neurology P.A. to leave a message on my home and/or cell phone regarding communication of my child's health care/treatment such as instructions for procedures, clinical, test results, billing and/or appointment needs, etc.

I understand that by selecting this option it may result in delayed communication of pertinent treatment information such as medication changes, appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.

List below any persons/family member whom you authorize access to your child's medical records and/or authorize us to leave a detailed message regarding all aspects of your child's medical chart, health condition, medications and financial history etc. This includes your information if you agree to the terms above.

Patient Name: _______________________________________ D.O.B: ____/____/____

Name of authorized: ____

Phone # (_____) ________-_________ Relationship to Patient: ____________________

May we leave a detailed message on voice mail/answering machine? ☐ Yes ☐ No

Alternate Person (optional): ____

Phone # (_____) ________-_________ Relationship to Patient: ____________________

May we leave a detailed message on voice mail/answering machine? ☐ Yes ☐ No

Patient or Legal Guardian Signature: ____

If you have any questions regarding this notice or any of our office policies please contact the Practice Administrator at (407) 293-1122 ext. 207

You must arrive **30 minutes** prior to your appointment time for **every visit.** This includes follow-up and EEG's. If you are not here at the required time your appointment may be rescheduled.

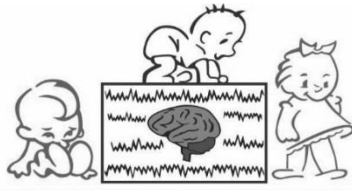
Patient Name:

____

Parent Signature:

____

Date: _____/_____/_____



Dear Parent,

You have been referred to our office by your physician for further evaluation. Below is a list of items required for your initial appointment.

1. Copy of referral given by your primary physician
2. Insurance card and photo ID
3. Any medical records that are pertinent to your visit with the specialist
4. Diagnostic test reports such as CT scans, EEG's and/or MRI of the brain. (Only applies if you had test completed prior to your visit in our office, reports must be picked up at the facility where they were done)

NOTE: If you do not bring your referral, insurance card ID and/or diagnostic reports with you we may choose to reschedule your appointment or hold you financially responsible for all charges incurred during your visit.

Thank you,
Laly Montero
Administrative Supervisor
Pediatric Neurology PA &
Epilepsy Center of Central Florida