THE PEDIATRIC SPECIALISTS Medical Group

**Douglass M. Hasell, MD, FAAP**
*Diplomate*
*American Board of Pediatrics*

**Thuy T. Pham, MD, FAAP**
*Diplomate*
*American Board of Pediatrics*
International Board Certified
Lactation Consultant

**Christopher Pope, ARNP**
*Board Certified*
*Pediatric Nurse Practitioner*

**Sheridan Hernandez, MD, FAAP**
*Diplomate*
*American Board of Pediatrics*

## PATIENT INFORMATION

Today's Date_____

Name of Child_____ Sex ☐ M ☐ F Age _____

Date of Birth _____ Grade in School _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Ethnicity: (circle one) Hispanic or Latino / Not Hispanic or Latino Language Spoken in Home _____

Race: (circle one) American Indian or Alaskan Native / Asian / Black / Hawaiian or Pacific Islander / White

Email _____ Home Phone _____ Cell Phone _____

## FAMILY INFORMATION

Father's / Guardian's Name_____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone _____

Occupation _____

Employer _____

Soc. Sec. #_____ Birthdate _____

Driver's License # _____ State_____

Do you have insurance coverage for child? ☐ Yes ☐ No

Stepfather's Name_____

Mother's / Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone_____

Occupation _____

Employer _____

Soc. Sec. #_____ Birthdate_____

Driver's License # _____ State_____

Do you have insurance coverage for child? ☐ Yes ☐ No

Stepmother's Name _____

## SIBLING INFORMATION

| Name | Age | Date of Birth | Sex |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## EMERGENCY CONTACT / EMERGENCY TREATMENT

In the event of an emergency, whom should we contact (other than Parents/Guardians)?

Contact #1: _____ Relationship: _____ Phone: _____

**Separate** Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized**: (Circle One) No Yes Date:_____
(Allows this emergency contact to bring your child to our office for treatment)

Contact #2: _____ Relationship: _____ Phone: _____

**Separate** Authorization to Treat Form has been **Completed, Signed by Legal Guardian & Notarized:** (Circle One) No Yes Date:_____
(Allows this emergency contact to bring your child to our office for treatment)

# The Pediatric Specialists Medical Group

**LEAD RISK ASSESSMENT (Check all that apply)**

__ Home or daycare built before 1950?

__ Home built before 1978 with recent renovations? _____ Has chipping peeling/ paint?

__ Child eats dirt, clay, or paint chips? _____ Likes to suck on windowsills or blinds?

__ Child's friends, playmates, or neighbors with high lead levels or history of lead poisoning?

__ Has your child had a Lead Level done? _____ Date of last Lead Level?

**TB RISK ASSESSMENT** (Check if your child has had close contact with an adult who.....)

__ Is homeless or living in a shelter. _____

__ Is living or working in a prison. _____

__ Is living or working in a nursing home. _____

__ Has TB, HIV, AIDS, or abuses drugs. _____

__ Immigrated from Central, or South America, Haiti, Russia, E. Europe, India, or SE Asia.

# The Pediatric Specialists Medical Group
# Financial Policy

**Patient Name:**_____ **Date of Birth:**_____

**Basic Policy:** Payment for services rendered is due at time of service.

**For Patients with Insurance:** As a courtesy, we will bill your primary insurance for you if **all** the necessary information is provided. **Co-payments and all outstanding account balances are due at time of service**. If your co-pay or balance is not paid at time of service **there will be a $5.00 charge to bill it**. As a courtesy, we research why an insurance company has not paid. If an insurance carrier held payment of a clean claim after 60 days of billing, fees are due and payable in full from you. All outstanding balances are due within 30 days of the statement. **Bills not paid within 30 days of the statement will be assessed a $25.00 per month re-billing charge** unless prior written arrangements have been made. All balances that reach 90 days past due will be sent to our lawyer for collections. You will be responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

**Payment Method:** We accept cash, Visa, MasterCard, debit cards, and local (non-starter) checks. Any account having a check returned for insufficient funds will be charged $30.00 and no future check payments will be accepted.

**Minor Patients:** The adult accompanying a minor will be responsible for full payment or insurance co-payments.

**Divorce Decrees:** This office is not party to your divorce decree. The adult accompanying a minor is responsible for any co-payments or balances on accounts.

**Noncovered Services:** Any care not paid for by your insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

**Wellcare and/or Preventative Care:** Periodic preventative health services are recommended by the American Academy of Pediatrics may or may not be covered under your health insurance policy (It is your responsibility to check your coverage). For your child's well being, your physician will require them.

**Insurance Patients:** Signature on file & assignment of benefits.

I request and assign to **The Pediatric Specialists Medical Group** all insurance benefits otherwise payable to me for services rendered. I authorize the doctor to release all information necessary to secure the payment of benefits.

I understand my signature requests that payment be made to the provider of services, and authorize the release of medical information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____ _____

Parent/Guardian Name (please print) Parent/Guardian Signature

I have read, understood, and agreed to the terms of the above financial policy for payment of professional fees. As the parent/legal guardian requesting medical services, I understand that I am accepting financial responsibility for any charges for visits that are not covered by insurance. I also understand and agree that the terms of this financial agreement may be amended by the practice at any time without prior notification to the responsible party.

_____ _____

Signature Date

2044 Trinity Oaks Blvd., Suite 235 • Trinity, FL 34655
(727) 375-KIDS (5437) • Fax (727) 375-0502

# THE PEDIATRIC SPECIALISTS MEDICAL GROUP P.A.

**Douglass M. Hasell, M.D.** **Thuy T. Pham, M.D.**
**Sheridan Hernandez, M.D.** **Christopher Pope, A.R.N.P.**

2044 Trinity Oaks Blvd., Suite 235
New Port Richey, FL 34655
Phone # 727-375-5437 Fax # 727-375-0502

## MEDICAL RELEASE AUTHORIZATION FORM

I hereby authorize and request you to release any and all medical records and other pertinent patient information which may include but is not limited to complete history & physical, lab, and x-ray reports, immunizations, alcohol or drug abuse, HIV, mental health, or communicable disease information or any treatment or examination rendered.

***Records Requested from:***

Name:_____

Address: _____

_____

**Phone #:**_____

**Fax #:**_____

***Release Records to:***

**The Pediatric Specialists Medical Group**

**2044 Trinity Oaks Blvd., Suite 235**

**New Port Richey, FL 34655**

**Phone #: 727-375-5437**

**Fax #: 727-375-0502**

Medical Records Requested:_____

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. This form must be received within 90 days of signing and it is valid for 90 days after receipt.

**Patient Name:**_____ **DOB:** _____

**Patient Address:** _____

**Patient Phone #:** _____

**Signature:** _____

**Print Name:**_____ **Relationship to Patient:**_____

**Witness:** _____ **Date:** _____