BAPTIST Primary Care

Patient Registration & Insurance Information

Please present insurance card and photo ID for us to copy.

Date _____ Physician _____

Person Responsible for Bill

Guarantor Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____ Guarantor Email _____

Patient Information

Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email _____

Date of Birth _____ Sex _____ Marital Status _____

Race: ❑ Black, African American ❑ Asian ❑ White ❑ American Indian, Alaska Native ❑ Native Hawaiian, Other Pacific Islander ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not-Hispanic or Latino ❑ Unknown ❑ Declined

Primary Language _____

Social Security Number _____

(If a minor): Mother's Name _____ Home Phone # _____

Father's Name _____ Home Phone # _____

Emergency Contact Information

Contact Name _____

Relationship to Patient _____

Address _____

City, State, ZIP _____

Home Phone # _____ Work Phone # _____

Primary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Secondary Insurance Name

Insurance Name _____

Group # _____ Policy # _____

Subscriber Name _____

Patient Relation to Subscriber _____ Date of Birth _____

Social Security Number _____

Employer _____ Work Phone # _____

Referred by _____

BAPTIST Primary Care

Authorizations and Acknowledgments

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask us if you have any questions about our fees, financial policy, or your payment responsibility.

All new patients will be asked to provide patient information prior to being seen by the physician. We also may ask to make a copy of any type of picture identification to remain a permanent part of your chart.

Insurance/Billing Information

- As a courtesy we will file your insurance claim on your behalf. You are responsible for any patient portion at the time of your visit. If we do not participate with your insurance plan or you are uninsured you will be responsible for full payment at the time of your visit. In the event that your insurance company does not pay our claim then the ultimate payment responsibility rests with the patient.
- We use an electronic invoicing process to notify you of any outstanding personal balances.
- Once you receive your first e-statement you will also gain access to our online bill pay service to quickly and easily resolve your account.
- To assist with timely payment, please notify the office personnel of any changes to your insurance policy, and mailing or e-mail addresses. Unresolved patient balances could be referred to a collection agency and the patient is responsible for any additional costs incurred.
- Accepted Methods of Payment: **Cash, Check, Visa, Mastercard, Discover, American Express.**

Worker's Compensation

Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.

Unaccompanied Minors

The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Completion of Forms

Baptist Health reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Authorization for Treatment and Payment

I consent to examination, diagnosis and general medical care and treatment to be performed by office personnel, including physicians, nurses and assistants.

I hereby authorize Baptist Health to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorized any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.

Responsible Party Signature _____ Date _____

Patient's Name (Please Print)) _____ Date of Birth _____

Notice of Privacy Practices

I acknowledge receipt of a copy of the Baptist Health Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at Baptist Health, I authorize Baptist Health to use and disclose information from and release copies of my (the patient's) medical records in accordance with Baptist Health's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers.

Patient or Parent (Guardian) _____ Date _____

Baptist Primary Care - Mandarin Pediatrics
14810 Old St. Augustine Road, Suite 106
Jacksonville, FL 32258
(904) 268-7701

Medical History

Child's Name _____ 1st Visit Date _____

Date of Birth _____

Race _____ Sex _____ Parent's Marital Status (M) _____ (D) _____(S) _____

Birth History:

Hospital of Birth? _____

Vaginal ☐ C-Section ☐ Reason for C-Section? _____

Term _____ (wks) Birth Weight ____ lbs ____ oz Discharge Weight ____ lbs ____ oz

Resuscitation or Oxygen required? _____ NICU required? _____ Length of Stay? _____

Any problems during the pregnancy? _____

Past Medical History: (Has your child ever had):

Seizures: _____
Asthma: _____
Recurrent Ear Infections (more than 4 per year): _____
Surgery: _____
Medication Allergies: _____
Hospitalization for 1 night or more: _____
Delayed Development: _____

Family Medical History: (Siblings, Parents, Aunts, Uncles and Grandparents – Maternal & Paternal)

Allergies: _____
Asthma: _____
Bleeding Disorders _____
Cancer _____
Cardiovascular Disease _____
Childhood Deaths _____
Cystic Fibrosis _____
Diabetes (Type I / II) _____
Eczema _____
Sickle Cell Disease _____
Seizures _____
Stroke _____
Thalassemia _____
Thyroid Disease _____
Psychiatric Illness: _____
* Bipolar _____
* Depression _____
* Schizophrenia _____
High Cholesterol _____
Hypertension _____
Other _____

List All Family Members:	Date of Birth	Name (First and Last	Health Problems?
Mother			
Father			
Sibling Male/Female			
Sibling Male/Female			
Sibling Male/Female			
Sibling Male/Female			
Sibling Male/Female			
Sibling Male/Female			

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PARENTAL AUTHORIZATION FORM

Today's Date: _____

To Whom It May Concern:

I, _____, the parent/guardian of _____, hereby authorize the following person/persons to bring my child in for care and authorize treatment for medical services (listed below).

_____

_____

_____

_____

_____

****** Well Child Visits require the presence of the parent or guardian only ******

_____ _____
Parent/Guardian Signature Today's Date

_____ _____
Witness Signature Today's Date

Baptist Primary Care

MANDARIN PEDIATRICS

Health Care Authorization for Minors

One form per child.

Declaration

I, _____ (name of natural or adoptive parent, legal custodian, or legal guardian patient), hereby give authorization to Baptist Health, to provide medical services and treatment to _____ (name of minor), date of birth:_____

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

_____
Name of Authorized Individual and Relationship

☐ _____ Please check and initial here if you give permission for minor to be seen/treated unaccompanied by an adult.

I understand that I may revoke this authorization at any time.

_____
Print name of natural or adoptive parent, legal custodian, or legal guardian patient

_____
Signature Date

_____
Witness Date

BAPTIST Primary Care

Authorization for Use of Answering Machines

Declaration

I, _____ (name of patient), authorize Baptist Health to provide detailed information to me via my home and/or work answering machine or cell phone voice mail concerning appointment, referral and test information. I understand that I may revoke this authorization at any time.

_____

Patient (Parent) Signature

_____

Date

BAPTIST HEALTH

Medical Records Request or Release

Release of Records

Please mail All records - NO CD

Records to be sent to the following address:

Name _____

Street Address _____ MANDARIN PEDIATRICS Affiliated with Baptist Primary Care 14810 Old St. Augustine Rd., Ste. 106 Jacksonville, FL 32258 phone 904-268-7701

City, State, ZIP _____ Fax 904-268-9708

Reason for Release of Records _____

Request for Records

Records to be received from:

Physician/Facility _____

Address _____

City, State, ZIP _____

Release from my medical records the following information for the following dates:

From _____ To _____

_____

_____

As part of the medical record, the following information will be released unless crossed out:

SEXUAL ABUSE INFORMATION

DRUG & ALCOHOL ABUSE INFORMATION

CHILD ABUSE & NEGLECT INFORMATION

PSYCHIATRIC INFORMATION

AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed _____ Date _____

Patient, Parent or Guardian

Patient Name _____

Date of Birth _____ SS # _____

Witness _____ Date _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.

This form is to be used for Patient Portal Access Requests placed by: 1) Parents 2) Legal Guardians 3) Adolescents and 4) Emancipated Minors

PATIENT INFORMATION

PATIENT NAME: LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH: MM/DD/YYYY	GENDER:
ADDRESS:		
CITY:	STATE/PROVINCE:	ZIP CODE:
EMAIL ADDRESS: ☐ NA	HOME PHONE:	MOBILE PHONE:

Please select the box(es) below that best describes the patient portal access/delegate access requested

For all types of delegate access, the patient's chart will be accessed through the delegate's Patient Portal account.

MINOR PATIENT (age 0-11)

Access to patient age 0-11 Patient Portal record.

- ❖ Individuals requesting access must have parental rights or permanent legal guardianship.

Relationship of Delegate to Patient is:

- ☐ **Parent** (Photo ID Required & status documented in medical record or legal document)
- ☐ **Permanent Legal Guardian** (Photo ID Required & Copy of Court Order Appointing Guardianship Required)

ADOLESCENT (age 12-17)

- ☐ **Adolescent** (If checked, adolescent must sign on back)

EMANCIPATED MINOR (Access for Self)

- ☐ **Emancipated Minor** (Copy of Court Order of Emancipation Required)

LIFETIME INCAPACITATED ADOLESCENT

- ☐ **Lifetime Incapacitated Adolescent** (Physician Documentation Required)

Relationship of Delegate to Lifetime Incapacitated Adolescent is:

- ☐ **Parent** (Photo ID Required & status documented in medical record or legal document)
- ☐ **Permanent Legal Guardian** (Photo ID Required & Copy of Court Order Appointing Guardianship Required)

ADULT PATIENT

- ☐ **With Permanent Legal Guardian** (Photo ID Required & Copy of Court Order Appointing Guardianship Required)

DELEGATE INFORMATION

☐ **NA** - Check if adolescent or emancipated minor requests access

DELEGATE NAME: LAST, FIRST, MIDDLE INITIAL	DATE OF BIRTH: MM/DD/YYYY	GENDER:
ADDRESS:		
CITY:	STATE/PROVINCE:	ZIP CODE:
EMAIL ADDRESS:	HOME PHONE:	MOBILE PHONE:

Does the Delegate have an active My Baptist Connect Patient Portal account?	**Yes**	**No**
Has the Delegate ever been a patient at Baptist Health or its affiliated entities?	**Yes**	**No**

BAPTIST HEALTH

PATIENT PORTAL ACCESS REQUEST FORM

PATIENT LABEL

PARENT/LEGAL GUARDIAN/ADOLESCENT/EMANCIPATED MINOR ATTESTATION

By signing below, I acknowledge and agree that:

- I will be using my own My Baptist Connect account at Baptist Health to access the Patient's account.
- I will comply with the terms and conditions on the My Baptist Connect web page (located at ***MyBaptistConnect.com***) and this document.
- I will keep my password confidential and not share this information with anyone.
- I have parental rights or legal guardianship rights to access this Patient's record (age 0-11).
- **I am NOT a foster parent or stepparent of this Child.**
- There are no court orders or restraining orders in effect limiting my access to this Patient's medical records and/or information.
- I will notify Baptist Health in writing immediately if my Relationship with the Patient changes (for example, if I am no longer the Legal Guardian of the Patient).
- Communications on behalf of the Patient through My Baptist Connect must be sent from the Patient's record and responses will be received in the Patient's record. My Baptist Connect e-mail alerts will be sent to the e-mail address entered under Delegate Information.
- There are age range limitations for My Baptist Connect. These age range limitations do not affect any legal right I have to access the Patient's record by other means. Copies of the record are available to authorized requestors (subject to other Baptist Health policies) by contacting the Hospital Health Information Management Department or the front office staff at the physician's office.
- For a child age 0 to 11, I will be granted access to the Child's My Baptist Connect record. For our portal to fully comply with certain restrictions in Florida privacy laws, parents of patients 12-17 years will not be granted access to their Child's portal account. On the Child's 12th Birthday, my access to their information will be terminated.
- For an adolescent (age 12-17), the adolescent will be granted access to the My Baptist Connect record.
- Removal of parental delegate access occurs when emancipated minor status is validated.

Signature of Parent/Legal Guardian/Adolescent/Emancipated Minor	Relationship to Patient	Date	Time

Signature of Witness	Printed Name	Date	Time

Submit Form:

1. **DELIVER PAPERWORK IN PERSON TO:** Baptist Medical Center Jacksonville, HIM Department, 800 Prudential Dr., Jacksonville, FL 32207 OR to your Baptist Health Physician Practice.
2. **MAIL NOTARIZED FORM:** Signature must be notarized if not submitting form in person. Mail notarized form to: Baptist Medical Center Jacksonville, HIM Department, Attention Patient Portal, 800 Prudential Dr., Jacksonville, FL 32207 OR to your Physician Practice.

****Note:** This form is **ONLY** to be completed by parents, legal guardians, adolescents, or emancipated minors. Completion of adult to adult portal access is completed by the patient in his/her patient portal.

STATE OF _____

(COUNTY OF _____) SS

On this _____ day of _____ , 20_____ before me, the undersigned Notary Public, personally appeared and proved to me on the basis of satisfactory evidence to be the person whose name is subscribed above, and acknowledged that he/she executed it.

Witness my hand and official seal.

_____
Notary Public

BAPTIST HEALTH

PATIENT PORTAL ACCESS REQUEST FORM

PATIENT LABEL

Practice Policies for New Patients

CHECK IN: Upon arrival, please sign in at the reception desk and be prepared to present your picture ID and Insurance card at each visit.

INSURANCE and PAYMENT: Your copay is due at the time of each visit and does not include other charges that your insurance company deems to be your responsibility. This includes, but is not limited to, deductible or co-insurance. Any outside balances are due upon receipt of your statement. If you have questions about what your insurance plan covers please call your insurance carrier.

ARRIVAL/LATE ARRIVAL: Please help us maintain our schedule by being on time for your appointment. If you are going to be late for your scheduled appointment, please call to confirm that your provider will still be able to see you.

NO SHOW/CANCELLATIONS: If you find you cannot keep your scheduled appointment, we require a notification of 24 hours in advance or you may be charged a fee of $30.00. In consideration of other patients and staff, it is necessary that no shows are avoided. If you do not show up for your appointment, it is our policy to charge the $30.00 fee each time it occurs. These fees are not covered by your insurance and are due and payable upon your return visit. If you have numerous cancellations or No-Show appointments, this can result in dismissal from this practice.

PRESCRIPTIONS/REFILLS: At the time of your office visit, our providers make every effort to ensure you are provided with enough refills to last until you next scheduled appointment. If a situation should arise in which you are not able to make your scheduled follow up appointment, please contact our office as soon as possible. If you are unable to reschedule your appointment before you run out of medications, your provider will consider whether or not an exception can be made. If a prescription is written by a physician outside of your primary care physician's office, it will only be authorized for refill after evaluation and management of that condition by one of our medical providers. Please allow 3-5 days to process refills.

MEDICAL PROBLEMS WE DO NOT MANAGE: For chronic pain, you will need to be managed by pain management. If we manage your child's mood disorder, the child will also need to be followed by a psychologist. More complex mood disorders will be referred to psychiatry. We do not see children that are unvaccinated. We will be happy to work with parents to have their children's vaccine's schedule caught up.

MEDICAL FORM/LETTER: Our office requires that ALL patients are up to date on physical wellness exams before physical forms are completed. Forms are completed during your office visit. Some forms are not able to be completed during your visit may require a $25.00 fee (FMLA) or $5.00 fee (physical forms after first set).

REFERRALS: To process a referral for a new complaint or complaint that has not been recently evaluated you will need to schedule an appointment. If you are referred to a specialist for either treatment or a diagnostic test, please allow 3-5 business days for this information to be processed with your insurance company. The information will be sent directly to the specialist and the specialist will be contacting you for an appointment. If you have NOT heard from the specialist in 7-10 business days of being seen in our office, please contact our office so that we may assist you in getting the necessary appointment.

AFTER HOURS: If you child is in need of medical attention when our office is closed, please call our office line 904-268-7701 and speak with the After Hours Service. These calls are handled by a Nurse Practitioner Answering Service who can advise you until you can either obtain an appointment in our office or to seek immediate attention in the nearest emergency facility.

APPOINTMENTS: For new medical issues or to review labs that require speaking to the provider, you will need an appointment. This allows you to be appropriately evaluated and treated. All requests for oral antibiotics require appointments. For most chronic stable medical problems, you will need to be seen every 3-6 months. ADHD visits require appointments every 3 months of on medication. This allows for appropriate monitoring and management of your medical problems. For unstable problems, you will need to be seen more frequently.

COMPLAINCE EXPECTATIONS: Providing quality patient care is our top priority. During your visit a treatment plan will be agreed upon by you and your provider. It is important that for both preventative and therapeutic purposes that you comply with completing any orders, testing, referrals, follow-up appointments, etc. that were outlined by your provider and within a timely manner. Patients who are noncompliant may be dismissed from the practice.

BEHAVIORAL EXPECTATIONS: Our staff and doctors believe respect is the basis of a good relationship. We will treat you with respect and compassion. We have an expectation that our

patients will also be respectful toward our staff and physicians. If you are not able to comply with this courtesy you may be asked to leave the practice.

Patient Name (printed): _____

Signature: _____ Date: _____-