



# Pediatric Orthopedics of Southwest Florida Orthopedic Health History

Today's Date: \_\_\_\_\_

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

Is your child a new patient? Yes No...if so, is this a new problem? No Yes

REASON FOR VISIT: \_\_\_\_\_

PAST MEDICAL HISTORY: None Yes...if so, please list child's prior and current illnesses and injuries.

PAST SURGERIES OR HOSPITALIZATIONS: None Yes...if so, please provide procedures and dates performed.

CURRENT MEDICATIONS: None Yes...if so, please list: \_\_\_\_\_

Name of Pharmacy you use: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ALLERGIES to Medications, Foods, Latex, Other: No Yes...if so, please list \_\_\_\_\_

FAMILY HISTORY (age and health status) Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

### REVIEW OF SYSTEMS (Please indicate if your child has a health problem in any of the following areas)

| No                       | Yes                      | System                  | Circle Conditions (if present)               | or | Fill in for Other Conditions |
|--------------------------|--------------------------|-------------------------|--|----|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes                    | (Glaucoma, Glasses)                          |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ears/Nose/Throat        | (Deafness, Otitis, Sinusitis)                |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart                   | (Murmur, Valve Defect)                       |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs                   | (Asthma, Bronchitis, Tuberculosis)           |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen                 | (Hepatitis, Colitis)                         |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidneys/Bladder         | (Reflux, Incontinence, Infections)           |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscles/Bones           | (Fractures, Joint Problems)                  |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin                    | (Rashes, Eczema, Unusual Birth Marks)        |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurologic              | (Seizures, Headaches, Delay, Cerebral Palsy) |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychologic             | (ADHD, Depression, Anxiety)                  |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine               | (Diabetes, Thyroid Disease, Obesity)         |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Hematologic             | (Anemia, Sickle Cell, Leukemia, Lymphoma)    |    | _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Infectious/Inflammatory | (HIV, Recurrent Infections)                  |    | _____                        |

### BIRTH HISTORY

Born On Time? Yes No...if so, at how many weeks gestation was patient born? \_\_\_\_\_ weeks

What was the birth weight? \_\_\_\_\_ Pounds \_\_\_\_\_ Ounces

Was patient born via C-Section? No Yes...if so, why? \_\_\_\_\_

Did baby present in the Breech position? No Yes

Were there any complications with the pregnancy/delivery? No Yes...if so, why? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Age when first: Sat independently \_\_\_\_\_  
Crawled \_\_\_\_\_  
Walked \_\_\_\_\_  
Talked \_\_\_\_\_

[Girls: Age at first menstruation? \_\_\_\_\_

What grade is your child in? \_\_\_\_\_

Hand your child writes with? Right Left

Involved in sports? No Yes...if so, please list: \_\_\_\_\_

Most recent Height [\_\_\_\_\_ feet \_\_\_\_\_ inches] and Weight [\_\_\_\_\_ pounds] of your child.

Does your child smoke? \_\_\_ No \_\_\_ Yes

Additional Comments:

The past medical history and review of systems was reviewed by: \_\_\_\_\_

# Pediatric Orthopedics of Southwest Florida

## Financial Policy

Thank you for choosing **Pediatric Orthopedics of Southwest Florida** as your healthcare provider. We are committed to providing the best pediatric orthopedic treatment possible. The following is a statement of our **Financial Policy**, which we require you to read and sign prior to treatment.

### Participating Insurance Plans

We participate in many insurance plans, however if your insurance plan is not accepted by this office, payment is expected in full at the time of service. It is your responsibility to confirm with your insurance company whether our physicians are in-network providers. Please remember that an insurance policy is a contract between you and your insurance company. We are not a party in that contract.

The following information is required:

INSURANCE CARD(s) and a VALID DRIVER'S LICENSE or other form of government-issued photo identification.

We reserve the right to refuse to file claims to out of state insurances. Upon request, we can provide you with a copy of a detailed receipt, so you may file your own claim.

If your insurance plan changes, it is your responsibility to update that information with our office, failure to do so, will result in balance of the claim becoming your responsibility. It is also your responsibility to update change of address and phone number.

### Non-participating Insurance Plans

Patients, who are insured by a carrier that our practice is not contracted with, are considered self-pay. And Payment is expected in full, at the time of service. Upon request, we can provide you with a detailed history of your child's visit(s) so that you can submit it to your carrier. As a courtesy, the insurance company will be billed, by us, as a non-assigned claim. If the carrier chooses to pay our practice for a non-assigned claim, the patient will receive a refund. Our practice issues refund checks once a month. If you are due a refund, it will be mailed at that time.

There is a \$5.00 fee to complete all accident claim forms – including, but not limited to, Aflac and Colonial Penn.

### Referrals and Authorizations

If your insurance has designated a Primary Care Physician (PCP), you are required to have prior authorization from your PCP prior to your office visit.

If authorization is not provided, you will be asked to either reschedule your appointment or pay for the visit, in full, at the time of service.

As a courtesy, we will assist you in obtaining authorization for subsequent visits.

It is imperative that you keep our office, as well as your primary care provider up to date with any changes in insurance information. This is your responsibility.

### Financial Responsibility

A parent or legal guardian with a valid photo ID must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for all payments of the account. If someone other than the parent or legal guardian will be bringing the patient to subsequent appointments, they must be listed on the patient's demographic form.

And they must be prepared to pay any co-pays or remaining balances from the guarantor.

### Divorced Parents of Patients

By signing this agreement, the adult who signs a minor child into our practice, accepts all financial responsibility. This office does not communicate, forward statements, medical records or give any treatment status to the other parent or legal guardian. That is your responsibility.

### Payments

Payment is expected at time of service. We accept Visa, MasterCard, Discover and Care Credit.

Payments and credits are applied to the oldest charge's first, except for insurance payment.

Bad Checks A fee of \$35.00 will be assessed for returned checks and must be paid by another form of payment.

Stop payment checks constitute a breach of contract and a \$30.00 fee will be issued and it will be turned over to the State Attorney Office.

We will also utilize our right to terminate the relationship from our office.

### Co-payments

Co-payments and Co-insurance charges are due at the time of service. Failure to pay these charges will result in a possible rescheduling of your appointment. Unpaid fees beyond 60 days, without prior arrangements may result in discharge from our practice. Effective September 1, 2005 there will be a \$7.00 processing fee applied to your account if the payment is not made at the time of service.

**Self-pay accounts**

Self-pay patients are expected to pay in full for their charges at the time of visit; exceptions require prior financial arrangements with our billing office. Statements for Guarantor Balances will be mailed monthly, and are due upon receipt.

**Durable Medical Equipment**

Durable Medical Equipment and supplies charges (cast cover, water-proof cast, sling, cast shoe, etc.) are due at the time of service. Insurance companies do not reimburse our practice for these products.

**Extended Payment Arrangements**

For charges exceeding \$300.00 we require a deposit of a minimum of 50% of the total charges at the time of service. The remaining balance is to be paid over the next 90 days, in equal monthly payments, due by the first of each month.

**Pediatric Orthopedics of Southwest Florida** reserves the right to add a service charge or an interest fee to any extended payments. Patients, who fail to make a monthly payment, will be sent to a collection agency which will include termination from the practice. All accounts that are turned over to collections carry a 30% fee that will be added to your balance to cover the service cost. Alternative payment schedules must be arranged, in advance, with the Billing Department prior to treatment.

**Patient Refunds**

Prerequisites for patient refunds: (1) No outstanding insurance claims on the account(s).  
(2) No outstanding balances on the account(s). The account(s) shows a 0.00 balance.

**Medical Records**

The charge for medical records is \$1.00 per page, for the first 25 pages and 0.25 cents thereafter, with a minimum charge of \$5.00. Please allow 2-3 days to obtain school forms, 1-2 days for prescription refills and 4-7 days for other requests.

**X-Rays**

There is a charge for X-Rays copies. CD's, containing films, are \$10.00 each.

**Missed Appointments**

A \$20.00 fee will be charged for missed appointments. This includes No-Show's

**Appointment Changes and Cancellations**

Appointment changes and cancellations must be made 24 hours in advance or a fee of 20.00 will be fined.

As with any orthopedic practice, our Doctors are on call with the hospitals on any given day. This requires us to see emergency appointments at any given time. This will also back up our office hours and wait times may be extensive. We will try to keep you updated of wait times at the time of check in.

**AUTHORIZATION FOR PAYMENT AGREEMENT**

I authorize the release of all medical information necessary to process insurance claims, as well as, the release of information back to my Primary Care Physician. I also authorize payment of medical benefits to **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services rendered.

In the event, my medical insurance does not pay for services rendered, I agree to pay **PEDIATRIC ORTHOPEDICS OF SOUTHWEST FLORIDA** for services provided, per the agreements as stated above.

\_\_\_\_\_  
Print your First and Last Name

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date