2115 S.E Lennard Rd, Port St. Lucie, FL -34952 Phone: 772-335-1812 Fax: 772-335-1825

New Patient Information

Patients Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Primary Language: _____Lives with Parent or Guardian (specify): _____
*Ethnicity (Circle): Hispanic or Non-Hispanic
*Race (Circle): White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: _____

Patients Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Primary Language: _____Lives with Parent or Guardian (specify): _____
*Ethnicity (Circle): Hispanic or Non-Hispanic
*Race (Circle): White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: _____

Patients Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Primary Language: _____Lives with Parent or Guardian (specify): _____
*Ethnicity (Circle): Hispanic or Non-Hispanic
*Race (Circle): White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: _____

Patients Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Primary Language: _____Lives with Parent or Guardian (specify): _____
*Ethnicity (Circle): Hispanic or Non-Hispanic
*Race (Circle): White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: _____

(*) Indicates optional information requested under the Affordable Care Act
(**) Guarantor is the contact with financial responsibility for medical care

Primary Insurance:

Policy Holder's Name: _____Policy Holder's D.O.B.: _____Policy Holder's Sex: _____
Insurance Carrier: _____ ID# _____Group # _____
Insurance Address: _____

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Please complete all items for each **biological** parent or **legal** guardian.

Parent Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____Work Phone: _____
E-Mail Address: _____ _____ Lives with Patient: _____
Employer: _____ Occupation: _____

Parent Name: First _____ M.I. ____ Last: _____
D.O.B.: _____ Sex: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____Work Phone: _____
E-Mail Address: _____ _____ Lives with Patient: _____
Employer: _____ Occupation: _____

Preferred Method of Contact: Phone E-Mail Text

Preferred Phone Number: Home Cell Work

_____

Name of Parent Completing Form (Please Print) **Signature** **Date**

Emergency Contacts (NOT Parents/Guardians) – Required

Patient Name: _____ **D.O.B.:** _____

Name: _____ Telephone Number: _____
Relationship to Patient: _____

Name: _____ Telephone Number: _____
Relationship to Patient: _____

*These contacts are for in the event our office cannot get in contact with either parent or legal guardian.
**If you would like to elect a person to bring your child to appointments, please complete the Authorization to Treat a Minor form.

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Past Medical History: _____

_____

_____

_____

Family History: (check the following medical history which has occurred in the child's family)

Disease	Mother	Father	Blood Relative	None	Disease	Mother	Father	Blood Relative	None
Asthma	☐	☐	☐	☐	**Heart Disease**	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	**Hypertension**	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	**Seizures**	☐	☐	☐	☐
Early Death	☐	☐	☐	☐					

Additional Comments: _____
Chronic Illnesses in any siblings: _____
Known allergies: _____ Known Chronic Illnesses: _____
Hospitalizations (if any): _____ Reasons: _____
Previous Surgeries: _____ When: _____
Vaccinations: Up to date _____ (please furnish records at front desk) Not Known _____

Parent Signature: _____ Date: _____

TENDER CARE PEDIATRICS

CONSENT FOR TREATMENT & INSURANCE AUTHORIZATION & ASSIGNMENT

(Please Read and Sign)

1. The patient or his/her representative recognizing the need for care, consents to **TENDER CARE PEDIATRICS** services as ordered by the physician, including laboratory procedures, medical treatment, vaccine administration, minor or emergency surgical treatment, examination, or other services rendered under the general and specific instructions of the physician.

2. I hereby authorize **TENDER CARE PEDIATRICS** to furnish information to insurance carries concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Parent/Legal Guardian's Signature Date

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Authorization to Treat a Minor (Alternate Caregiver)

Patient Name: _____ D.O.B.: _____

I authorize the person(s) listed below to accompany my child and authorize treatment for my child in accordance with the office policy of Tender Care Pediatrics. This includes bringing the child to the office, providing an accurate medical history, disclosing protected health information, consenting to vaccinations and any procedures, and witnessing any physical examination by the provider. This adult has the responsibility to relay diagnoses and treatment plans to the parent or legal guardian. This adult also can make, change, or cancel appointments, manage health forms, and pick up prescriptions for the child. I agree to continue to comply with the financial policy.

Name: _____ D.O.B:_____
Phone: _____Relationship to patient: _____

Name:_____D.O.B:_____
Phone: _____Relationship to patient: _____

Name:_____D.O.B:_____
Phone: _____Relationship to patient: _____

I attest that I am the parent or legal guardian of the following above children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of the individuals at any time.

Parent name: _____ Phone Number: _____

Signature: _____Date: _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Tender Care Pediatrics' Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Print): _____ Date: _____

Parent or Guardian Name (Print): _____

Signature: _____

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Tender Care Pediatrics Immunization Policy

At Tender Care Pediatrics, we are dedicated to providing the highest quality of evidence-based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious diseases, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyzes reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect children. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At Tender Care Pediatrics we strive to provide the highest quality care while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Tender Care Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others.

Please be advised that if you desire an “alternate” vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Tender Care Pediatrics, the AAP, and the ACIP. We believe that this alternate decision puts your child and others at risk, Tender Care Pediatrics respectfully reserves the right to decline to be your child’s pediatrician.

I have read and understand the immunization policy.

_____	_____	_____
Parent’s Name (Print)	Parent’s Signature	Date

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Authorization For Release of Medical Records
HIPPA Form-B

Patient's Name: _____ DOB: _____

Name of Parent / Guardian: _____

This authorization permits: (previous doctor's name and/or Practice name**)**

_____
Previous Doctor's name and/or Practice name

_____
Street Address

_____
City, State, Zip

_____- _____-_____ _____- _____-_____
Phone # Fax #

To use or disclose to:

Tender Care Pediatrics
New Provider, Specialist, or person receiving copy

2115 SE Lennard Road
Street Address

Port St. Lucie, Florida 34952
City, State, Zip

772-335- 1812 772-335-1825
Phone # Fax #

To release any and all information to Dr. Anitha Jagadish, M.D. / Dr. Arturo Gamez, M.D., pertaining to the aforementioned patient, including diagnosis' and medical records of any/and all treatment(s) and/or examination(s) rendered to the patient named above, to include but not limited to any federal and state protected documents under Florida Statute 394.459(9) Psychiatric Records; Florida Statute 381.609(2) Human Immunodeficiency Virus test results (aids and related conditions). I am aware that the information released pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by the HIPPA rule.

Information to be Released/Copied

( ) All pertinent Medical records including Immunizations and Lab Tests

( ) Immunization Records, Last Physical Exam, Medication List*

( ) Other: _____

I understand that this authorization will expire in six months. I further understand that I may revoke this authorization at any time during this period by notifying the providing organization in writing.

For Patient or Guardian Inspection / Copy Requests: ( ) Check here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges including the cost of supplies and labor and postage related to the production of my information. I understand that the charges for this service are $1.00 per page for the first 25 pages, then $.25 per page thereafter.

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____

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CREDIT CARD ON FILE CONSENT FORM

We now use a service, Instamed, that gives us the ability to swipe your credit card, debit card or health savings account card and accept a payment in the office at the time of service or at a later date. The credit card number is securely stored on a remote server with Instamed and is not visible to us.

We will notify you of your balance due after receiving the explanation of benefits from your insurance company. You will have 48 hours to discuss any questions or concerns, and if we do not hear from you within that time, we will charge your credit card, debit card, or health savings account (HSA) card. Our billing department will send you a receipt of any charges that are made to your card.

Please indicate below how you would like to be notified:

Phone #:_____

OR

Email#:_____

By signing below, you are agreeing to keep a credit card on file for future payments.

_____

Your child's name (please print)

_____

Your name (please print) and signature Today's date

Please circle the type of card below:

MASTERCARD VISA DISCOVER

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Patient and Family Financial Responsibility Policy.

Thank you for choosing us as your child's health care provider. We strive to provide the very best care for you and your family. It is important for our patients to understand their financial responsibilities. Please make sure you bring your current insurance card to every appointment. We will ask you at each appointment about your current telephone number and address so that we have the correct contact information. For newborn babies, please make sure that you add them to your primary insurance plan in the first 30 days of their life. A newborn baby's initial visit to our office is typically considered a hospital follow up visit/well exam. If you have a secondary insurance, please inform us and your insurance company.

Claims and Payments

As a courtesy, Tender Care Pediatrics will submit claims to your insurance carrier for services provided. However, please note that you are financially responsible for:

- Any co-payment required by your insurance plan
- Any annual deductible that has not been met
- Any amount your insurance carrier deems your responsibility (Co-Ins)
- Any amount not covered by your insurance plan
- Any amount due following a termination of insurance coverage prior to your visit

Most insurance companies do not require a copay for a well visit exam. **However, if an acute or chronic medical problem is addressed during this visit, there will be an additional charge that may require a copay and it may be applied to your deductible.**

Payment Expectations

Payment is due at the time services are rendered unless prior arrangements have been made with our billing team. We accept Checks, VISA and MasterCard.
If you have no insurance, or if we are not able to verify your insurance eligibility, we ask that you pay for the visit at the time of service.

Missed Appointments and Cancellations.

A "No Show" fee of up to $25 may be applied if you miss an appointment without giving at least 24 hours' notice of cancellation. This fee is not billable to insurance and will be charged directly to you. **This fee is not applicable to members covered under a Medicaid Plan.** Any patient or family who miss too many appointments will be discharged from the practice.

Billing and Collections

Our billing staff will submit the bill for your appointment with your insurance company. For any patient balance due for more than 90 days, $5 per month will be charged to your account until the balance is paid off. This is to cover the cost of sending additional bills and statements. If a check is returned because of insufficient funds, you will be charged a $25 fee to cover the bank costs. If there are two returned checks, you will have to pay by cash or credit card.

If you do not currently have insurance coverage, we can offer a Self Pay discount on the appointment charge if it is paid at the time of appointment. Please inform us when you arrive for that appointment that you do not currently have insurance.

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If you are unable to pay your balance in full, please contact our billing department. We may be able to set up a payment plan to help you. Unfortunately, if an account balance is unpaid over a prolonged period of time you will be sent to a collection agency, and we will no longer be able to provide care to your child and family. If you are sent to collections, a charge of 30% of the balance will be added to your account to cover the costs of the collection agency.
If you declare bankruptcy and list our practice as a creditor, we will no longer be able to provide care to your child or family.

Medical Forms.
No charge for Health/Immunization Forms requested at time of well visit; Additional copies are available at no charge via your patient portal. $5 fee for additional printed copies of health/immunization forms requested at times other than at well visit appointment.

Medical Records.
To obtain a copy of your or your child's medical records, we will need a signed medical records release form. No charge for medical records sent via fax to another physician's office. Printed copies of medical records provided to patient are charged based on current Florida guidelines ($1 per page for the first 25 pages and $0.25 per page for each page in excess of 25 pages). The fee must be paid at time of receipt. If the patient is over the age of 18 we will only release the records to the patient unless there is a written permission to release to other individuals.

I hereby assign my insurance benefits to be paid directly to Tender Care Pediatrics. I authorize Tender Care Pediatrics to release medical information required to process my claims for services received. I also authorize Tender Care Pediatrics to pursue any unpaid or incorrectly adjudicated claims.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time *by the practice.*

Patient Name (Please print): _____

Signature of Parent/Guardian: _____

Date: _____

Effective 2/15/2022 Updated 2/16/2026