

# Ellis Pediatrics PLC

12086 Fort Caroline Road, Suite 401  
Jacksonville, FL 32225  
P: 904-456-9240 F: 904-456-9231

DATE: \_\_\_\_\_

**CHILD'S FULL NAME:**

FIRST

MIDDLE

LAST

\_\_\_\_\_ SEX: ☐ M ☐ F AGE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RACE: ☐ WHITE/CAUC ☐ BLACK/AFR-AMER ☐ HISPANIC/LAT ☐ OTHER

ADDRESS: \_\_\_\_\_  
NO. & STREET APT CITY COUNTY ZIP CODE

HOME PHONE #: \_\_\_\_\_

**PARENT INFORMATION:**

PARENT'S NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT'S DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PARENT'S DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY PLAN: \_\_\_\_\_ POLICY #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER D.O.B: \_\_\_\_\_

SECONDARY PLAN: \_\_\_\_\_ POLICY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY (OTHER THAN PARENTS):**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

*I hereby authorize Ellis Pediatrics to give my child total Pediatric Care, also to release medical information when and if requested by insurance company.*

SIGNED: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_



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## **Assignment of Benefits and Consent to Treat**

### **Consent to treat:**

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

### **Financial Responsibility:**

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

### **Assignment of Benefits:**

I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance, and any other health/medical plan, to issue payment directly to Ellis Pediatrics, PLLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

### **Authorization to Release Information:**

I hereby authorize Ellis Pediatrics, PLLC to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.

This order will remain in effect until revoked by me in writing.

I have requested medical services from Ellis Pediatrics, PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

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Patient/Responsible Party Signature

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Date



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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

NAME OF PATIENT: \_\_\_\_\_

NAME OF PARENT: \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_

I hereby acknowledge that I have the option to receive a copy or read the Notice of Privacy Practices from Ellis Pediatrics. A digital copy of the HIPAA Policy was also made available to me on Ellis Pediatrics's website at [www.ellispediatrics.com](http://www.ellispediatrics.com).

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE



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## Vaccine Policy

We want to ensure all of our patients and families are as healthy as possible and we strongly believe vaccinations play an integral role in your child's health. Scientific research has clearly shown that vaccines are safe and effective. To not vaccinate a child not only places the child at risk, but everyone with whom he or she comes into contact. This includes other children that are either too young to be immunized or unable to be vaccinated because of serious medical conditions.

Ellis Pediatrics follows the CDC and American Academy of Pediatrics (AAP) recommended vaccination schedule. We firmly believe in the effectiveness of vaccines and protection comes from mass immunity. As more people opt not to vaccinate, mass immunity will become decrease, helping the spread of infection.

We understand that the choice may be emotional for some parents. We will do everything we can to provide you with education and information on vaccines. Please be advised, delaying or splitting up the vaccines has not been shown to offer benefits and can put your child at risk for serious illness or death.

Ellis Pediatrics believes that vaccinating children on time and with the recommended schedule is of the utmost importance to keep our patients protected from vaccine preventable illnesses.

It is our policy that all patients receive the standard vaccines required by the state of Florida for school entry. **If you, as a parent, do not feel that vaccines are something you want for your child, we would kindly and regretfully ask you to search for a different pediatric practice which better fits with your philosophy.**

Thank you for reading this policy and for trusting us with the care of your children. Please feel free to ask any questions or concerns you may have regarding this policy or vaccines. Our providers are happy to discuss your concerns with you.

By signing below, you acknowledge receipt of this policy.

Patient Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_



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## Mutual Respect Policy

We vow to offer you the highest level of respect and professionalism in all situations. We ask that you do the same. Misconduct or the refusal to abide by office policies could result in dismissal from our practice.

## LATE ARRIVAL POLICY

Our doctors and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

**If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.** Patients must be on time or early to be seen. You may be given the option to wait for another appointment on the same day if one is available. We ask that you contact the office if you are running late for your appointment time so that we can reschedule the appointment, if needed.

If your family has multiple appointments scheduled on the same day, all patients with appointments must arrive at the FIRST appointment time.

New patients are encouraged to fill out new patient paperwork prior to their first visit. Otherwise, new patients need to arrive to our office 15 minutes prior to the scheduled appointment to complete the necessary paperwork..

Patient Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_



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## **Financial Policy**

Ellis Pediatrics, PLLC participates with most insurance plans. Each insurance policy is different, and it is therefore impossible for us to know what your particular benefits may be. Therefore, it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

### Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

### Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance.

#### After Hours Care

At Ellis Pediatrics, PLLC providing access to care is important to us. For this reason, you may contact the on-call provider for urgent needs after hours and on weekends by calling or texting the office. Many concerns can be addressed via text, phone, or a telemedicine visit. We hope you appreciate this service. Your insurance company will be billed according to their rules for this service.

#### No-Show Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of at least 24 hours for all cancellations. **Failure to notify the clinic in a timely manner may result in a no-show fee of \$50. Repeated no-shows will result dismissal from the practice.**

#### Divorced/Separated Parents and Custodial Arrangements

Ellis Pediatrics, PLLC does not get involved in disputes between divorced, separated, or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

I have read and understood the above policy and agree to it.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**WHO HAS PERMISSION TO BRING MY CHILD TO THE DOCTOR (Proxy Form)**  
*Photo ID from the individuals listed below must be provided at time of visit*

Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Name of Person #1: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Name of Person #2: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Name of Person #3: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Contact Number: \_\_\_\_\_

I give permission for the above listed individual(s) to transport my child to and from the doctor's office, to provide medical information about my child, to receive medical advice/instructions pertaining to my child, and to make medical decisions pertaining to my child at the time of the visit.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_