



As of 01/01/2021, we are mandated by your insurance company to collect social determinants of health, which include race and ethnicity data. In addition, we would like to update our database with your preferred mode to contact you.

DEMOGRAPHICS/DATOS DEMOGRÁFICOS

Patient's first and last name/Nombre y apellidos del paciente:

Day of birth/Fecha de nacimiento: ___/___/___

Address/Dirección: _____

Primary phone/Teléfono fijo: (____) - ____ - ____ Cell phone/Celular: (____) - ____ - ____

Email address/Correo electrónico: _____

Sex/Sexo: ___M ___F

- Ethnicity/Etnia: ___ hispanic or latino/hispano o latino
- ___ not hispanic or latino/hispano o latino
- ___ declined to specify/prefiere no especificar.
- ___ unknown/desconocido

- Race/Raza: ___ asian/asiático
- ___ black or african american/negra o afroamericano
- ___ native hawaiian or other pacific islander/nativo de Hawai u otra isla del pacífico
- ___ white/blanca
- ___ declined to specify/prefiere no especificar
- ___ other race/otra raza

Parent 1/Mamá o papá1:

First and last name/Nombre y apellidos:

Address/Dirección: _____

Primary phone/Teléfono fijo: (____) - ____ - ____ Cell phone/Celular: (____) - ____ - ____

Email address/ Correo electrónico: _____

Parent 2/Mamá o papá 2:

First and last name/Nombre y apellidos:

Address/Dirección: _____

Primary phone/Teléfono fijo: (____) - ____ - ____ Cell phone/Celular: (____) - ____ - ____

Email address/ Correo electrónico: _____

Patient preferred contact methods/Método de contacto de preferencia:

- _____ mail address/correo electrónico
- _____ home phone/teléfono fijo
- _____ cell phone/celular
- _____ text to cell/texto al celular
- _____ no contact/no contactar

Health Insurance/Seguro médico

Name of health insurance/Nombre del seguro médico: _____

Subscriber's name/Nombre de persona suscrita: _____

Day of birth/Fecha de nacimiento: ___/___/___

Subscriber's ID#/Número de ID del suscriptor: _____

Patient relationship to subscriber/Relación del paciente con el suscriptor: _____

Per all Insurance Contracts all Co-payments are due at the time of service. It is your responsibility to be familiar with the specific rules of your plan. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know at each appointment exactly what those guidelines are.

I, the undersigned, acknowledge the child(ren) have insurance coverage with: (Insurance name)

and assign directly to the physician of Pediatric Dream Care, PA, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the physicians at Pediatric Dream Care, PA to release all information necessary to secure the proper payment of benefits. I authorize the use of this signature on all insurance claims.

Signature _____ Relationship to Child(ren) _____ Date ___ / ___ / _____

Pharmacy of your choice/Farmacia de su elección:

Name/Nombre: _____

Address/Dirección: _____

Phone number/Teléfono: (____) - ____ - ____

Fax number/número de fax: (____) - ____ - ____

How did you know about us? ¿Cómo supo de nosotros?

Google Our website Other doctor's office Family or friend Insurance/Agent
 Advertisement Social media: (Facebook Instagram) Other: _____

Family contacts/Contactos familiares

Contact 1/Contacto 1:

Full name/Nombre completo: _____

Relationship with the patient/Relación con el paciente: _____

Address/Dirección: _____

Day of birth/Fecha de nacimiento: ___/___/___

Cell phone/Celular: (____) - ____ - ____

Email address/Correo electrónico: _____

Family contacts/Contactos familiares

Contact 2/Contacto 2:

Full name/Nombre completo: _____

Relationship with the patient/Relación con el paciente: _____

Address/Dirección: _____

Day of birth/Fecha de nacimiento: ___/___/___

Cell phone/Celular: (____) - ____ - ____

Email address/Correo electrónico: _____

I agree that all telephone numbers and email addresses I have provided above may be used by Pediatric Dream Care and those acting on its behalf to communicate with me by telephone, text, or any automated or prerecorded messages.

Parent /Legal Guardian's name (print) Signature /____/____
Date



Pediatric Dream Care

3199 Lake Worth Road B-2

Palm Springs, FL 33461

☎ 561-621-1801

☎ 561-331-4603

pediatricdreamcare@gmail.com

Practice Policy.

Thank you for choosing our practice for your child's medical needs. We are committed to providing you with exceptional medical care, as well as making our medical billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasing the patient's portion of the payment. This is driving many physician practices to adopt new financial policies to enable more efficient operational processes. Please take a moment to familiarize yourself with our practice's Credit Card on File Policy.

To streamline our payment system and provide a convenient way for parents to pay their bills, we will require all patients to keep an active credit card on file with us. The credit card information will be stored in a secure vault by our payment processor. We will bill your insurance company first and upon their determination of benefits we will charge your credit card for the patient portion of the payment. Circumstances when your card would be charged include but are not limited to missed co-payments, deductible and co-insurance, non-covered services and/or denial of services, and past due balances.

Fee For Service: We encourage all patients who have questions or concerns about the cost of care to inquire about those costs in advance of service. Pediatric Dream Care follows the American Academy of Pediatrics, (AAP) guidelines for care provided to our patients. If deemed medically necessary, we will administer care according to those guidelines and patients will incur associated fees.

Insurance: We bill participating insurance companies as a courtesy. If you do not have participating insurance, full payment is expected at the time of service.

-Newborn: The initial newborn visit and the second visit within the first month of birth will be \$100 each, payable at the time of the visit if the patient does not have active insurance. Then, during the first month, when insurance is active, we bill the insurance, and if the insurance covers the visit, the \$100 paid for each visit will be reimbursed. If insurance does not cover the cost of the visits, or any of them, the \$100 for the visit not covered by insurance will be considered payment for the visit.

Any other visit without insurance will be considered self-pay, and the fee will be based on the type of visit. You have certain responsibilities, such as presenting your insurance card for EACH VISIT and paying deductibles and copayments at the time of service. Patients with insurance with a deductible must pay at the time of the visit. Once the insurance has paid for that visit, we will make the necessary adjustments to your account. If the difference is greater than what you paid for the visit, you will be notified of the amount due for payment. If the difference is less than what you paid for the visit, your account will be credited, and if you desire a refund, you must request it to our office. It is your responsibility to inform us of any changes in your address, phone number, or insurance information so we can ensure the correct billing, eligibility, and copayment requirements are accurate. If new insurance information was not provided at the time of service, the patient is responsible for the cost of the visit. Any claim older than 60 days is your responsibility and must be paid directly to us. You are expected to know what benefits are covered under your policy, including copayments and deductibles. Our office cannot always tell you in advance if your charges will be covered by your insurance plan. Because we have no way of knowing all individual insurance policies, it is your responsibility to contact your insurance company if you are concerned about whether a charge is covered.

Payments: Your insurance policy is a contract between you and your insurance company. We will not get involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered charges, and "customary" charges. We will notify your insurance company of information about your diagnosis and treatment. If your insurance company does not provide payment within 60 days of treatment, you

will be responsible for payment. Once we determine your personal financial obligation or after your insurance company reimburses Pediatric Dream Care, PA, for a portion of your care, we will mail you a statement explaining what is owed. Payments expected at the time of the visit, such as co-payments and deductibles, will incur a \$20.00 penalty if not paid on the day of the visit.

No-Show Fee: Missing an appointment without prior notice to the office deprives other patients of the opportunity to take a space that opens up. We require at least 24 business hours' notice for all appointment cancellations or rescheduling. Failure to notify the office in a timely manner will result in a \$35 same-day cancellation/no-show fee for regular and telemedicine visits and a \$50 same-day cancellation/no-show fee for well-child visits. A \$50 same-day cancellation/no-show fee will apply to Saturdays regardless of appointment type. Two same-day cancellations/no-shows on Saturdays, we will not give you any other Saturday appt. If cancellations, rescheduling, and no-shows occur repeatedly, the family will be advised to transfer care outside the practice.

Financial Hardship: We are not in the business of extending credit to our families. However, we understand that there may be occasions when a family faces financial hardship. Please contact our Office Manager to make special arrangements.

Outstanding Balances: Any charges remaining unpaid 60 days after the date of services are considered past due. Past due accounts must make arrangements with the office manager prior to scheduling well child appointments. All accounts that have not made arrangements and are not being paid off will be sent to our collection agency.

Care Policy: Our Pediatric practice follows the American Academy of Pediatrics (AAP) recommendations for well-child visits, and will adhere to a schedule of regular checkups, developmental surveillance and screening, and follow-up of chronic conditions. These visits are crucial for monitoring growth and development, administering vaccinations, and identifying potential health issues early on. Keeping appointments is crucial for the health and well-being of children, as highlighted in the 2025 Recommendations for Preventive Pediatric Health Care.

Vaccine policy: As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We are more than willing to discuss any questions you may have about vaccines, but do require all new and established patients of our practice to adhere to the vaccination schedule endorsed by the American Academy of Pediatrics (AAP). If vaccinating your child on schedule is not part of your healthcare goal, then we will not be a good fit for you.

Terminating Patient Relationships: Despite the best efforts, it may become necessary to end patient relationships that are no longer therapeutic or appropriate. Prior to terminating a patient relationship, we will address the underlying reasons with the patient/guardian. If efforts to rehabilitate the relationship are not appropriate or are unsuccessful, the patient's physician and the Practice Manager will analyze the case and send a termination letter to the address the patient has on file. Circumstances for termination are:

-Treatment nonadherence: The patient does not follow the treatment plan or the terms of a pain management contract or discontinues medication or therapy regimens before completion.

-Follow-up noncompliance: The patient repeatedly cancels follow-up visits or fails to keep scheduled appointments with practitioners or consultants.

-Office policy noncompliance: The patient fails to observe office policies, such as those implemented for prescription refills or appointment cancellations or refuses to adhere to mandated infection-control precautions.

-Verbal abuse or violence: The patient, a family member, or a third-party caregiver is rude, uses disparaging or demeaning language, or sexually harasses office personnel or other patients, visitors, or vendors; exhibits violent or irrational behavior; makes threats of physical harm; or use anger to jeopardize the safety and well-being of

anyone present in the office. Office staff may need to contact law enforcement promptly for support to help ensure that the situation does not escalate.

-Display of firearms or other type of weapons: The patient, a family member, or a third-party caregiver threatens practice operations by wielding a firearm or weapon on the premises. Office staff may need to contact law enforcement promptly for support to help ensure that the situation does not escalate.

-Inappropriate or criminal conduct: The patient exhibits inappropriate sexual behavior toward practitioners or staff or participates in drug diversion, theft, or other criminal conduct involving the practice.

-Nonpayment: The patient owes a backlog of bills and has declined to work with the office to establish a payment plan or has discontinued making payments that had been agreed previously.

-Age limits: When the patient turns 18, we will advise them to find an adult primary care physician, which will facilitate their care. Upon reaching this age, they will be automatically deactivated from our office.

-Violation of our policy: Any patient or family member who in any way continues to fail to comply with the Pediatric Dream Care, PA Policy after a prior warning (verbal or written) has been made.

Artificial Intelligence: To dedicate as much time as possible to the patient, we may use Artificial Intelligence during the visit, and the audio of the doctor-patient interview may be recorded.

Cell Phone or Other Device: The use of a cell phone or other device during a medical visit interferes with the visit, so please keep it silent and answer calls after the visit. To ensure the safety of our patients, Pediatric Dream Care, PA maintains audio and video surveillance outside the office and inside the office in common areas. We also keep monitoring the security of our patient information, so audio/video recording inside the office by unauthorized persons is not permitted.

Food, Drinks, and Property Damage: During a visit to our office, the minor's guardian must constantly monitor their behavior to avoid accidents and property damage. Our office is 100% designed for the care of pediatric patients, so please keep all adult food and drinks out of the office to avoid accidents and property damage. All adult food and drinks are strictly prohibited inside the office.

Acceptance of Practice Policy: by signing this policy, the patient (guardians) certify that they have fully read, fully understand, and fully agreed to be bound by this policy. The content of this policy is subject to changes and updates at any time at the discretion of the Practice and any update is going to be posted on the Practice's Website. It is the client's responsibility to search the Practice's website at pediatricdreamcare.com for the most recent version of the Practice's policy. By executing this Policy and continuing receiving care and services provided by Pediatric Dream Care, PA to client, the client hereby agrees to continually check for any updates to such Policy and to be bound by such terms and conditions.

Parent /Legal Guardian's name (print) Signature Date



MEDICAL TREATMENT AUTHORIZATION AND CONSENT

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized. This is to authorize other individuals to bring your children to our office.

I, _____ (Full Legal Name of Parent/Guardian), being the parent/legal guardian of:

1. Child's full name: _____ DOB: ____/____/____

Authorize,

1. Caregiver's full name: _____ Relationship to patient: _____

2. Caregiver's full name: _____ Relationship to patient: _____

3. Caregiver's full name: _____ Relationship to patient: _____

To seek, obtain and consent to routine medical care and treatment/emergency medical care and treatment, procedures, and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the period when my child is in the care of the person/people listed above and is effective _____ (date). I may revoke/edit this consent at any time.

____/____/____

Parent/guardian's name (print)

Signature

Date



3199 Lake Worth Road B-2
 Palm Springs, FL 33461
 ☎ 561-621-1801
 📠 561-331-4603
 pediatricdreamcare@gmail.com

FAMILY MEDICAL HISTORY

Family Name: _____ Children's Names: _____

Add a checkmark if positive.

Past Medical History (Please try to be specific with illness)	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Nasal Allergies/other allergies						
Asthma/lung disease						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Diabetes						
Other endocrine problems (thyroid)						
Cancer (type)						
Anemia						
Bleeding disorder						
Epilepsy or Convulsions						
Developmental Disorder						
Neurological Disorder including ADHD/ADD						
Liver Disease						
Gastrointestinal Disorder						
Kidney Disease						
Bedwetting						
Hearing impairment						

Vision impairment or eye disorder						
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Immune problems recurrent infections or HIV/AIDS						
Alcohol Abuse						
Drug Abuse						
Mental Illness						
Tuberculosis						
Additional Pert. Cond						



HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Pediatric Dream Care to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Pediatric Dream Care reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing at any time.

I further acknowledge receipt of the Pediatric Dream Care’s Policies and Procedures and Statement of Financial Policies.

Our Notice of Privacy Practice can be found on our website at pediatricdreamcare.com under the About Us tab or you may request a copy today by checking yes below.

- Yes, I would like a copy of the Notice of Privacy Practice.
- No, I would not like a copy of the Notice of Privacy Practice.

Patient Name (print): _____

Guardian Name (print): _____ Relationship: _____

Guardian’s Signature: _____

Date: ___/___/___



PATIENT PORTAL USER AGREEMENT AND INFORMED CONSENT

Parent Information

Name: _____ DOB _____

Address: _____ Telephone _____

Child's name: _____ DOB ____ / ____ / ____

Patient portal basics

Pediatric Dream Care understands the need for communication between health care professionals and patients. Pediatric Dream Care is committed to providing patients and other authorized personnel the ability to use a secure and confidential patient portal that provides the following functionality:

1. Access to medical records
2. Ability to contact the appointment desk.
3. Secure communication with health care professionals.

The Pediatric Dream Care Portal utilizes technology to deliver secure communication between patients and Pediatric Dream Care.

The term “patient portal” refers to Pediatric Dream Care’s information system that provides access to patients’ health information and allows for secure communication, including prescription, referral, and appointment requests.

“Electronic communication” means e-mail or text messaging with patients outside of a patient portal.

Patient portal policy

The following policies and limitations apply to the use of Pediatric Dream Care patient portal.

1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.
2. Correspondence via patient portal is supplemental to physician/patient encounters. Pediatric Dream Care will not provide patient portal-based diagnosis and treatment.
3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information cannot be discussed through the patient portal.
4. Other electronic communication with the health care professional, such as non-patient portal email or text messaging is prohibited.
5. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.



Pediatric Dream Care

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TRANSFER OF MEDICAL RECORDS RELEASE FORM

Patient Last Name: _____ First Name: _____

DOB: ___/___/___ Phone: _____

I, the undersigned, hereby authorize the below physician or medical facility:

(name) _____ Phone number: _____

To provide my medical record information to: Pediatric Dream Care located at 3199 Lake Worth Rd, Ste B-2,

Palm Springs, FL, 33461.

Phone: 561-621-1801

Fax: 561-331-4603

e-Fax: 561-288-4532

Date(s) of Service requested: _____

Document requested: _____

I understand that the **entire** medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should **not** be released: _____

I am requesting the transfer of my child's/ children/s medical records due to:

Relocation

Child's age

Dissatisfaction with physicians/ staff

Insurance change

Other: _____

Comments: _____

I understand that I have a right to receive a copy of this authorization upon request.

Patient/Parent/Legar Guardian's name: _____

Signature: _____

Date: ___/___/___