



844 N Thornton Ave
Orlando, Fl 32803
407.398.6470

11325 Lake Underhill Rd.
Orlando, Fl 32825
407.398.6702

13750 W Colonial Dr
Winter Garden, Fl 34787
407.905.4717

3801 W Lake Mary Blvd
Lake Mary, Fl 32746
407.585.0568

1267 W. Osceola Pkwy
Kissimmee, Fl 34741
407.569.0220

1500 Alafaya Trail
Oviedo, Fl 32765
407.385.1790

Welcome to Night Lite Pediatrics

Every effort will be made to ensure that your wait time is kept to a minimum. However, since we are an urgent care center, it is necessary for us to sometimes see patients according to severity level. Since emergencies may take longer than anticipated, your patience is greatly appreciated.

Date: _____ Time: _____ Phone #: _____

Patient Name: _____ DOB: _____

Pediatrician Name: _____

Why are we seeing your child today? _____

Does your child have a history of **Seizures**? yes no

Is your child **allergic** to any medications? yes no Name: _____

If yes what happens when they take this medication: _____

Is your child in respiratory distress? yes no

Does your child have a **fever**? yes no Temperature: _____ °

Circle last medication given **if** any: **Tylenol/Motrin** given @ _____ am/pm

Has your child **vomited** today? yes no

DO NOT WRITE BELOW THIS LINE

OFFICE USE ONLY

Follow-Up Call:

Date: _____

Parent's Words _____

Person Calling: _____



Central Florida Pediatric Intensive Care Specialists

**&
Night Lite Pediatrics**



Welcome to our practice. Night Lite Pediatrics shares a common goal of providing you with our very best care. We encourage you to ask questions about your care, your treatment and our policies. We make every effort to make your visit here as pleasant as possible. At Night Lite Pediatrics, we are committed to delivering quality care in the most effective manner **365 days a year**.

NEW PATIENT INFORMATION			
<u>Patient Last Name, First Name</u>		<u>Birth Date</u>	<u>Male</u> <input type="checkbox"/> <u>Female</u> <input type="checkbox"/>
			<u>Social Security #</u>
<u>Street Address</u>			<u>Apt #</u>
			<u>Home Phone</u>
<u>City</u>	<u>State</u>	<u>Zip Code</u>	<u>Physician Who Referred You</u>
PARENT/GUARDIAN INFORMATION			
<u>Mother's Name</u>		<u>Birth Date</u>	<u>Social Security#</u>
<u>Cell Phone</u>	<u>Work Phone</u>		<u>Place of Employment/Occupation</u>
<u>Father's Name</u>		<u>Birth Date</u>	<u>Social Security#</u>
<u>Cell Phone</u>	<u>Work Phone</u>		<u>Place of Employment/Occupation</u>
EMERGENCY CONTACT INFORMATION			
<u>Name</u>	<u>Home Phone</u>	<u>Cell Phone</u>	
INSURANCE INFORMATION			
<u>Insurance Name</u>		<u>Insurance Phone</u>	
<u>PolicyHolder Name (If Medicaid write Self)</u>		<u>PolicyHolder Relationship to Patient (Please Circle)</u> Parent / Self / Other: _____	
<u>ID#/Policy #</u>		<u>Group#</u>	
<u>Insurance Address</u>		<u>City and State</u>	
Who <i>if</i> anyone other than parents or legal guardian has permission to access your child's medical records (PHI) and obtain results for labs tests including bringing your child in to Night Lite Pediatrics without your presence and making medical decisions for his or her treatment.			<input type="checkbox"/> N/A
			<input type="checkbox"/> Yes the following individuals:
<u>Name</u>		<u>Relationship to Patient</u>	
<u>Name</u>		<u>Relationship to Patient</u>	
<u>Name</u>		<u>Relationship to Patient</u>	

I certify that the above information is correct to the best of my knowledge. I release CFPICS/NLP, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records.

Patient/Legal Guardian Signature: _____

Date: _____

Signature of Person Responsible for Bill: _____

Staff Initial: _____ Date: _____

Monday-Friday 4pm-Midnight



Saturday-Sunday Noon-Midnight

<p><u>Referrals</u></p> <p>Your Primary Care Physician must review and approve referrals based on medical necessity. Night Lite Pediatrics participates with many different plans and each plan has specific regulations in how a referral is issued. Please contact your physician on the next business day, and inform them of your recent visit at Night Lite Pediatrics. MOST INSURANCE COMPANIES WILL NOT BACKDATE A REFERRAL: PLEASE NOTE IF YOU FAIL TO OBTAIN ONE YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.</p>	<p><u>Please Initial</u></p> <hr/>
<p><u>Lab Work and X-Ray Results</u></p> <p>You will be notified by phone of abnormal results. We ask that you allow sufficient time to receive your notification. In most cases, your Primary Care Physician will have received a fax from our facility about the results. Lab work performed at Night Lite Pediatrics is normally submitted to Florida Pathology. Florida Pathology has accommodated our late evening hours in obtaining STAT results therefore, we prefer to utilize them. However, your insurance company normally has strict guidelines to use “<i>their contracted</i>” labs. Please inform us if your insurance company has such a guideline. We will not be held accountable if lab work is sent to a non contracted facility. You will receive a separate bill from the laboratory company.</p> <p>Please mark your preference below: Quest <input type="checkbox"/> Lab Corp <input type="checkbox"/> Florida Pathology <input type="checkbox"/> Cognoscenti Lab <input type="checkbox"/> Any lab <input type="checkbox"/></p>	<p><u>Please Initial</u></p> <hr/>
<p><u>Financial Policy</u></p> <p>For insured patients, should your insurance company require a co-pay for your visit or a deductible, it will be due at the time of service. Please be aware that you are responsible for all co-payments, non-covered services, and deductible amounts. Your insurance company coverage is an agreement between you, the patient, and your insurance company, the insurer. It is your responsibility to know your insurance benefits when you are receiving services from an urgent care center or labs. Please note “Urgent Care Centers” have higher co-pays and deductibles. Our charges will be higher than your normal pediatrician, but significantly less than the emergency room.</p> <p>For uninsured patients, payment is due at time of service. A substantial discount will be offered to Self Pay Patients. We will charge a minimum of \$120.00 with a maximum of \$360.00 depending on the severity of the case.</p>	<p><u>Please Initial</u></p> <hr/>
<p><u>Insurance Lifetime Authorization</u></p> <p>I hereby request payment of authorized insurance (Medicaid, Managed Care, Commercial) benefits to be made either to me or on my behalf to CFPICS & NLP for any services furnished to me by CFPICS & NLP. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid HMO carrier as the full charge, and the patient is responsible only for the coinsurance, and co-pay services. Coinsurance and the deductibles are based upon the charge determination of the Managed Care carrier.</p> <p>I hereby authorize payment of Insurance Benefits Directly to CFPICS & NLP for Services Rendered, and release of any Medical Information necessary to process claims. I am responsible for all Co-Payments, Non covered Services and for Deductible Amounts.</p>	<p><u>Please Initial</u></p> <hr/>

Patient/Legal Guardian Signature

Date

Staff Initial: _____

Date: _____

Monday-Friday 4pm-Midnight



Saturday-Sunday Noon-Midnight

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical record information by **Central Florida Pediatric Intensive Care Specialists & Night Lite Pediatrics** in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree that the Practice may also disclose the following types of information contained in my medical record:	<u>Please Initial</u>
HIV/AIDS Information	
Mental Health Information	
Substance Abuse Information	
Sexually Transmitted Disease Information	
If Patient is under the age of eighteen (18), Pregnancy Information	
I do not agree to any of the above types of information being disclosed by the Practice	

I agree and consent to Night Lite Pediatrics/CFPICS releasing information to me in the following manners:	<u>Please Initial</u>
Via Mail	
Via Telephone	
Via Fax to my designated fax number which is: _____	

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) does not sign this Consent Form. If you (or authorized representative) sign this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. By signing this consent form, you consent to our use and release of PHI about you for the treatment, payment and health care operations as described in our notice. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Patient/Legal Guardian Signature

Date

Thank you for choosing Night Lite Pediatrics for your child's urgent care needs.

Staff Initial: _____

Date: _____

Parent refused to sign