ORLANDO OFFICE
716 S. Goldenrod Rd.
Orlando, FL. 32822
(407) 658-1719
Fax: (407) 658-2536

KISSIMMEE OFFICE
3315 S. Young Parkway (OBT)
Kissimmee, FL. 34746
(407) 343-1919
Fax: (407) 343-1907

Tax ID: 593543941

CHILD PATIENT'S INFORMATION

Chief Complaint: _____
(Razón de la visita)

Patient's Name: _____ _____ _____
(Nombre del Paciente) **Last Name (Apellido)** **First Name (Nombre)** **Middle Name (Inicial)**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(Dirreción) **(Ciudad)** **(Estado)** **(Código Postal)**

Phone #: _____ **Parent's Cell Phone #:** _____
(Numero De Teléfono) **(Numero De Celular)**

Date of Birth: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **Social Security:** _____
(Fecha de Nacimiento) **(Edad)** **(Hombre)** **(Mujer)** **(Número de Seguro Social)**

Parent or Legal Guardian's Name: _____ _____ _____
(Nombre del Pariente ó Guardián Legal) **Last Name (Apellido)** **First Name (Nombre)** **Middle Initial (Inicial)**

Parent's Social Security #: _____ **Parent's Driver's License #:** _____
(Numero de Seguro Social del Pariente) **(Numero de la Licencia del Pariente)**

Parent's Place of Employment: _____ **Employer's Phone #:** _____
(Nombre de la compañia de Trabajo del Pariente) **(Teléfono del Trabajo)**

Employer's Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(Dirección de Trabajo) **(Ciudad)** **(Estado)** **(Código Postal)**

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED

Please mark all that applies to today's visit: ☐ Health Insurance ☐ Auto Insurance ☐ Medicaid ☐ Medicare ☐ Self – Pay

Primary Insurance: _____ **Claim Address:** _____
(Seguro Primario) **(Dirección del Seguro para mandar las facturas)**

City: _____ **State:** _____ **Zip Code:** _____ **Phone #:** _____
(Ciudad) **(Estado)** **(Código Postal)** **(Numero de Teléfono)**

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card/ Debit Card**
(Método de Pago)

Authorization of Treatment

I authorize Urgent Med to release any information regarding the patient's examination or treatment for the purpose of obtaining insurance compensation, pre-certification, or medical records. I authorize payment of medical benefits to Urgent Med when claim forms are filed upon patient's behalf for treatment. Also, I give authorization for medical treatment to the patient. All invoices must be paid within terms quoted. I understand that I am responsible for the bill if my insurance does not pay within 30 days.

_____ _____
Parent Or Legal Guardian's Signature **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date	Initial	Reason: