Pediatric Associates of Plano

Account#: _____ Pharmacy name: _____

Location: _____

Welcome to our office. We are happy to serve your healthcare needs. The information requested on this form will enable us to serve you more efficiently. It is important that the information be kept current. We require an update each year and with any changes. Thank you.

Please list ALL children under our care

Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F

Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F
Name: _____ DOB: _____ M / F

Marital status of parents: Married Single Widowed Separated Divorced

Primary residence with who above children live with: Parents Mother Father Other: _____

Parent contact information

Mom's name: _____
Address: _____
Apt#: _____
City: _____ State: _____ Zip: _____
County: _____
DOB: _____ DL#: _____
Occupation: _____
Employer: _____
Preferred contact: _____
Circle one: Home / Cell / Work
Other contact#: _____
Email: _____

Dad's name: _____
Address: _____
Apt#: _____
City: _____ State: _____ Zip: _____
County: _____
DOB: _____ DL#: _____
Occupation: _____
Employer: _____
Preferred contact: _____
Circle one: Home / Cell / Work
Other contact#: _____
Email: _____

Please list additional contact information for any step-parent(s), grandparent(s) or other guardian with whom the above patient may live with and/or may accompany the patient for office visits and consent to treatment.

Name	**Relationship to patient**	**Contact information**

For Office Use Only
Patient Allergies:

Insurance information

I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefit to Pediatric Associates of Plano, P.L.L.C. for services rendered.

Insured's name: _____ Relationship to patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Insurance Company: _____

ID#: _____ Group#: _____ Circle one: PPO / POS / HMO

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY ISNRANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE CMPLOETED THE ABOVE TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

Consent to Release Patient Health Information

I authorize Pediatric Associates of Plano to leave a detailed message on voice mail at homy home, cell and business telephone numbers with all appointment reminders and medical information including test results and billing issues that concern the patient(s) on this form.

In any case where we are unable to reach the parent(s), please list any step-parent(s), grandparent(s), other guardian or family member we may release information to by phone:

Name	**Relationship to patient**	**Contact information**

I have read, understand, and have fully completed all portions of this document to the best of my knowledge and confirm my consent to release information by phone to both parents and those family members/other listed above.

Parent signature: _____ Date: _____

Welcome to Pediatric Associates of Plano, P.L.L.C

Office Policies

We want your experience with our office to be a positive one. We are very happy that you have chosen our office to be part of your child's life. Below you will find our office policies. Please reach each carefully. We hop this information will be helpful to your when accessing our office and making decisions about your child's health.

Office hours

Our office offers appointments Monday – Friday between the hours of 8:30 a.m. and 4 p.m.

Appointments

Office visits are by appointment only. We work hard to see our patient as close to their appointment times as possible. As you know, emergencies can increase wait times. Patients who arrive late for appointment may be asked to reschedule.

Children cannot be seen without a legal guardian or parent present. Also, we are an English-only speaking office. If the guardian or parent present cannot communicate in English, it is required that an interpreter accompanies them to our office. An interprete r would also be required for any telephone communication with our office. If you are unable to be present with your child, "pow er of attorney" must be given to the adult accompanying your child for this appointment. Our office will provide you with the neces sary paperwork. This would allow for a sick visit in your absence. A parent or legal guardian is required to be present for routi ne well child exams.

Our physicians require routine well child examinations. These examination focus on your child's growth and development and early detection of illness. These are preformed frequently up to age 2, and yearly thereafter. Please allow 1 – 2 months to schedule this visit.

We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order for u s to be available to as many patients as needed, we ask that you provide or office with at least 24-hour notice of any necessary change. There will be a $25 charge for broken appointment without appropriate notice.

Telephone calls

We ask that you make all non-emergency calls during regular office hours when your child's chart is available. We will re turn your call as quickly as possible, generally within 2 hours. Our highly trained pediatric nurse staff returns all telephone calls. They work closely with the physicians. Typically, antibiotics are not prescribed over the phone. They physician will need to examine the child to secure an appropriate diagnosis and treatment. After office hours, the pediatric nurse staff at First Call received telephone calls. There is a fee for after hour phone calls. You will be given homecare guidelines and the physician on call will be paged if the matter is urgent. *If a life-threatening situation arises, call 911.*

Payment, insurance, and health plans

Payment is expected at the time services are rendered. We do accept Mastercard and Visa. If you have insurance coverage w ith a health plan that our office participates with, we will collect your co-insurance and file the claim with your plan. Our goal is to help you in every way to utilize the insurance benefits you have for your child. Please bee aware that **regardless of your insurance status**, you are ultimately responsible for the charges. We require that you present complete and accurate insurance information and that you complete a registration form on initial visit, on an annual basis, and if and when your insurance cove rage changes. We will keep a copy of your insurance card in your child's chart. Please be aware that most insurance plans do not cover 100% of services provided. If after your insurance company pays and you still owe a balance, even thought you paid your c o-pay at the time of visit, you will receive a statement. If after 2 statements are sent our and payment or arrangement have not been made, we will employ an outside agent to collect your account at which time you will be charged a collection fee. Please d o not hesitate to call on our billing staff at anytime to assist you with any insurance or account question you may have.

Physician selection

Once you have selected a physician in our group it is our policy to no allow you to change your primary physician. All of our physicians take call and cover for each other in their absence. You will probably see all of our physician at one time or another during the course of your child's care due to illness. Your primary physician will remain the same.

Medical records

All medical records request, including immunization records, require written release of information authorization with a signature of the legal guardian or parent. We can accommodate immunization records request the same day, but please allow up to 5 days for copies of other medical records. One free copy of your child's record, upon request, is provided to your if you move away or leave the practice for other reasons. After the initial copy, please be aware that a fee would apply for additional copies.

Telephone numbers

Please keep our office number and fax number handy for your records.

Office: 972-981-8380
Fax: 972-291-8463

I have read and understand the office policies related to care provided by Pediatric Associates of Plano, P.L.L.C.

Parent signature: _____ Date: _____

Patient consent and acknowledgement of receipt of privacy notice

I understand that as part of the provision of healthcare services, Pediatric Associates of Plano creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, and any plans for future care of treatment.

I have been provided with a Notice of Private Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosure have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reason outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that this use of my Protected Health Information (PHI), which is used or disclosed for the purposes of treatment, payment or healthcare operations are restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my PHI; and agree to terminate any restriction in writing on the use and disclosure of my PHI which have been previously agreed upon.

Patient's name printed	Date
Patient's signature (or guardian if a minor)	Social Security number (for identification purposes only)
Witness (optional)	Date

Pediatric Associates of Plano

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Pediatric Associates of Plano (**hereinafter referred to as "the Practice"**), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure I one of our most important responsibilities. We value yo ur trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access informa tion about you when considering a request from you or when exercising our right under the lay or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually access new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide services to you, to process your claims and to bring you health information that might be of interest to you.

How – and why- information is shared

We limit who receives information and what type of information is shared.

- *Sharing information with the Practice.* We share information within our company to deliver you the healthcare services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help offer you our services, we may share information with companies that work for us, such as claim process and mailing companies and companies th at deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other.* Patient-specific personally identifiable data is release only when required to provide a service for you and only to those with a need to know, or with your consent. Data is release with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so.) Except as required by law or as described above, we do not share information with o ther parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy.

You can count on us to keep your information about how we pr otect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the internet.

Pediatric Associates of Plano
6200 West Parker Road; Suite 410
Plano, Texas 75093
972-981-8380