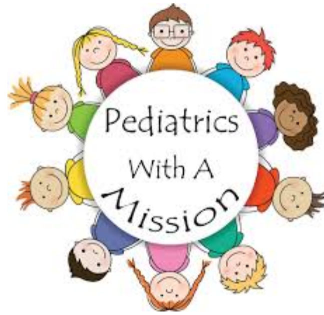

PATIENT DEMOGRAPHICS FORM

Patients Information:

Patients Name: __________________________________ DOB: __________________ Sex: M / F
Patients Name: __________________________________ DOB: __________________ Sex: M / F
Patients Name: __________________________________ DOB: __________________ Sex: M / F
Address: ____APT___________________
City____________________________State________________ZIP________________
Phone Number: _________________________________ Home / Cell / Work
Email Address: ____

Patients Emergency contact(s):

Name: ____
DOB: _______________________ Sex: Male / Female SSN: ___________________________
Relationship to patient: Parent 1 / Parent 2 / Other: _____________________________________

Phone Number: ___________________________________ Home / Cell / Work
Name: ____
DOB: _______________________ Sex: Male / Female SSN: ___________________________
Relationship to patient: Parent 1 / Parent 2 / Other: _____________________________________
Phone Number: ___________________________________ Home / Cell / Work

Insurance Information:

Coverage? Yes / No / Self-pay Insurance Name:_________________________________
Subscriber's Name (Person who holds the insurance):
____
Subscriber's Member ID#: ______________________________ Group#: _____________________________
Subscriber's DOB: __________________ Subscriber's SSN: __________________________
Do you have a secondary insurance? Yes / No
Insurance Name:_________________________________ Member ID#: ______________________________
Group#:_________________________________

Pharmacy:

What is the name of your Preferred Pharmacy & City? _________________________________
What is the address or Street/Cross Street and Number?
____

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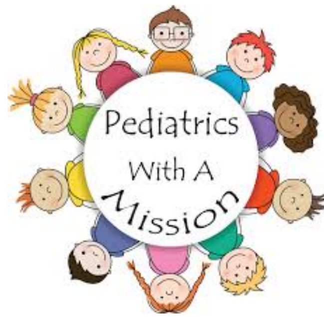

CONSENT TO TREAT

I, ____, being the parent / legal guardian, authorize Pediatrics with a Mission to provide medical care reasonable by today's standards for:

____

(Patient's full name)

Parent / Legal Guardian Printed Name: ____

Parent / Legal Guardian Signature: ____

Contact Telephone Number: ____

Today's Date: __________________________________

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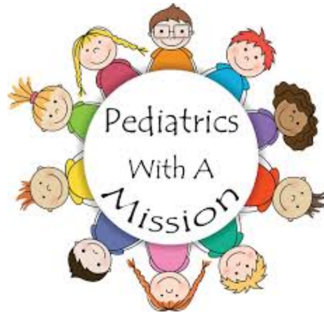

ACKNOWLEDGEMENT OF REVIEW OF NOTICE FOR PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ __________________________

Signature of Parent / Legal Guardian's **Today's Date**

Children's Name: **D.O.B**

____ ________________________

____ ________________________

____ ________________________

Please initial the following for approval of Protected Health Information (PHI) to be communicated to you.

_____Our practice may use of disclose you child's PHI to contact you by phone, voice mail message or by email for any appointment reminders to the designated phone number or address filled out by you.

_____Our practice <u>MAY NOT</u> use or disclose your child's PHI to contact you by phone

---

Sign below <u>ONLY</u> if you are declining your Notice of Privacy Practices

I acknowledge that I have declined to receive or review the Notice of Privacy Practices offered by Pediatrics with a Mission. I also understand that I do not have to sign this acknowledgement in order for my children to receive treatment by Pediatrics with a Mission.

___________________________________ _________________

Signature of Parent / Legal Guardian **Date**

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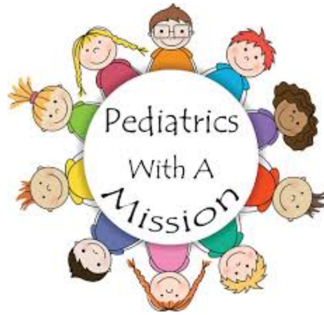

PAYMENT AGREEMENT

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of services. For you convenience we accept Visa and MasterCard.

We have made prior arrangement with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized amount at the time of service. This may include amounts deemed to copays, deductible amounts or co-insurance. Amounts paid in office are not a guarantee of payment by insurance's, claims will be submitted to insurance and any balance brought back will be parent or legal guardian's responsibility.

Self-Pay

Any self-pay patient will be subject to pay full amount due at time of services.

Self-pay Well Child Examination- $125.00

Self-pay Sick- $80.00

Any labs are a separate charge.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

______________________________________ ____________________________

Print name of patient **Today's Date**

______________________________________ _____________________________

Name of person completing form **Relationship to patient**

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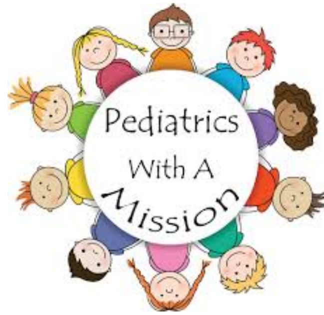

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby permit Pediatrics with a Mission to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purpose of treatment, payment, or healthcare operation to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies. HMO's and PPO's managed care organizations contracting with any of the above entities to perform such functions.

The Notice of Privacy practices provided by Pediatrics with a Mission provides specific information and complete description of how my personal health information may be used and disclosed. I have the right to review the notice prior to signing this consent. If this consent is revised in the future, you may obtain a revised copy from the office.

You have the right to request that this office restrict uses and disclosures of your health information; however, our office is not required to agree to requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional upon your signing this consent.

____ ____________________________

Patient, Parent or Legal Guardian's Name **Today's Date**

____

Signature

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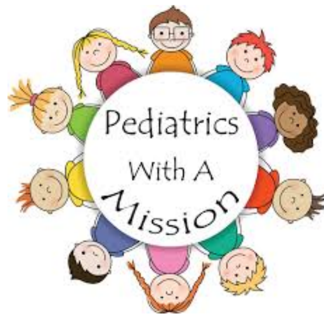

PATIENT BILL OF RIGHTS

Relationship to Policy

Policies of a physician and facility should facilitate the protection of and not contradict these rights.

The patient has the right to:

- **Considerate and respectful care.**
- **Obtain from physician complete and current information regarding his or her diagnosis, treatment and prognosis in terms than can be reasonably understood.**
- **Receive from physician information necessary to give informed consent prior to the start of any procedure or treatment.**
- **Refuse treatment to the extent permitted by law and to be informed of the medical consequences of his or her actions.**
- **Every consideration of privacy regarding his or her own medical care.**
- **Expect all communication and records pertaining to care be treated as confidential.**
- **Expect that within its capacity a physician must make reasonable response to the request of a patient to be treated; the right to be treated.**
- **Obtain information regarding the relationship of the physician to other health care and educational institutions insofar as his or her care is concerned.**
- **Be advised if the physician proposes to do human experimentation affecting his or her care.**
- **Expect reasonable continuity of care. Examine and receive an explanation of his or her bill, regardless of the source of payment.**
- **Know what physician rules and regulations apply to his or her conduct as a patient.**

____ ____________________________

Patient, Parent or Legal Guardian's Signature **Today's Date**

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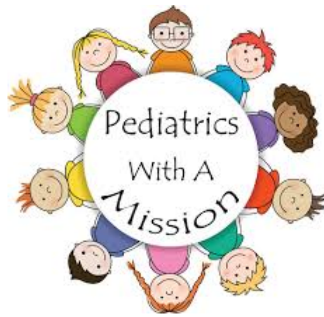

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Request Medical Information FROM:

____

Name of Physician / Facility

____

Street Address **City, State** **Zip Code**

____

Phone Number **Fax Number**

I hereby authorize the above stated person / facility to release medical record TO:

Pediatrics With A Mission
6300 Stonewood Drive, Ste 206
Plano, TX 75024-5281

Phone: (972) 769-8700
Fax: (972) 769-8728

Records to be released:

- **Immunization record**
- **Growth chart**
- **Other: ____**

I understand that my medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable disease. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for disclosure or use of m health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law.

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I will not hold Pediatrics With A Mission liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I have read the above forgoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I understand that I may revoke this authorization in writing at any time to the extent that Pediatrics With A Mission has already resided on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

I further understand that the information released is for the specific purpose sated above. Any other use of this information without the written consent of the patient is prohibited. This consent will expire 90 days after the date of signature.

Release Records Regarding:

______________________________	______________________________	______________
Signature of Parent / Legal Guardian	**Print Name**	**Date**
Patient Name	**D.O.B**	**Phone #**
Patient Name	**D.O.B**	
Patient Name	**D.O.B**	

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