Patient Registration Form

Patient Information

First name: _____ Middle:_____ Last:_____

Date of Birth: ____/_____/_____ Gender: M / F

Marital status of parents (circle one): Married Single Separated Divorced Widowed

Who does the child primarily live with? Parents Mother Father Other: _____

How did you hear about us? _____

Mother/Guardian #1 information

Name:_____

Address: _____

City: _____ State: ____ Zip code: _____

Cell phone: _____ Gender: M / F

Work phone: _____

Date of Birth: _____/_____/_____

Email: _____

Relationship to patient: _____

Father/Guardian #2 information

Name: _____

Address: _____

City: _____ State: ____ Zip code: _____

Cell phone: _____ Gender: M / F

Work phone: _____

Date of Birth: _____/_____/_____

Email: _____

Relationship to patient: _____

My Pediatrician, PLLC
www.mypediatriciantx.com
412 Village Drive Suite 400
Murphy, Texas 75094
phone: 972-325-2188
fax: 972-535-4107

Patient Registration Form

Name of other person(s) who may bring my child to the clinic and consent to treatment (i.e. grandparent, step-parent):

Name: _____ Relationship to patient: _____

Phone #: _____

Name: _____ Relationship to patient: _____

Phone #: _____

I hereby authorize for payment directly to My Pediatrician, PLLC of all insurance benefits for the services provided for my child. Insurance will be billed as a courtesy for services provided for my child. However, I understand that ultimately I am financially responsible for all charges, whether or not paid by insurance, related to the services provided for my child. I authorize the doctors/providers of My Pediatrician, PLLC and ancillary staff involved in the care of my child to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Parent/Guardian name: _____ Date: _____-_____-_____

Parent/Guardian signature: _____

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My Pediatrician, PLLC

Consent for Use and Disclosure of Protected Health Information

My Pediatrician, PLLC may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations. This PHI may include but is not limited to name, address, contact information, date of birth, social security number and member ID number. I understand that any protected health information or other information released by My Pediatrician, PLLC to an organization or entity for healthcare operations may be subject to re-disclosure by such organization/entity and may no longer be protected by applicable federal and state privacy laws.

My Pediatrician, PLLC may call my home, cell phone or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

My Pediatrician, PLLC may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include but is not limited to appointment reminder cards and patient statements.

My Pediatrician, PLLC may email any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include but is not limited to appointment reminders, insurance items and laboratory results pertaining to my child's clinical care.

I have the right to restrict how my child's PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that My Pediatrician, PLLC reserves the right to refuse requested restrictions.

This agreement will remain in effect without expiration unless I revoke my consent. I may revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent My Pediatrician, PLLC will continue to provide treatment to my child. I understand that I have a right to have a copy of this authorization.

I hereby acknowledge that I have read the above Consent for Use and Disclosure of Protected Health Information.

Patient's name: _____ Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____ Relationship to patient: _____

Signature: _____ Date: _____/_____/_____

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My Pediatrician, PLLC

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE 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 My Pediatrician, privacy is one of our highest priorities.

Keeping your information

Keeping your medical information secure is one of our most important responsibilities. We value your trust, and we 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 information about you when considering a request from you or when exercising our rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures, and we continually assess 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, address, date of birth, social security number and claims information. We use this information to provide service to your child, to process your claims and to bring you health information that might be of interest to you/your child.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you or your child is incomplete, inaccurate or not current, please contact us as soon as possible so we can take appropriate action to correct any erroneous information as quickly as possible.

Information sharing

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

- *Sharing information within My Pediatrician, PLLC*. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as our billing/claims department, mailing companies and companies that 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 released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released 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 other parties, including government agencies. My Pediatrician, PLLC 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 you informed about how we protect 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.

My Pediatrician, PLLC

Acknowledgement of Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received and reviewed the Notice of Privacy Practices (HIPAA) of My Pediatrician, PLLC. I understand that I may request a copy of the Notice of Privacy Practices (HIPAA) at any time.

Patient's name: _____ Patient's Date of Birth:_____/_____/_____

Parent/Guardian's Name: _____ Relationship to patient: _____

Signature: _____ Date: _____/_____/_____

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My Pediatrician, PLLC

Office Policies

Welcome to My Pediatrician, PLLC! Here are a few of our rules & policies that we would like for you to be aware of to facilitate a good relationship among you, the physicians, and the staff:

- Office Hours: Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday and 9:00am to 12:00pm Saturday (seasonally).
- Appointments:
    - Scheduled appointments: We highly recommend and prefer for patients to schedule appointments ahead of time. This ensures that your child will have adequate time to see the doctor. Each child needing examination by the doctor should have a separate appointment. We limit each family to bring up to three (3) children at a time to be seen by the doctor. Exceptions can only be made on a case-by-case basis by the doctor who will be seeing your children that day. We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep your appointment.
    - Late-arrivals and No-shows: Rescheduling will likely be necessary if you are more than 15 minutes late for your appointment. We will try to work your child in if time allows. There will be a $25 fee for no-show (missed) appointments. We will send one warning letter after the first no-show (missed) appointment before charging you a fee. **If you no-show three (3) or more appointments, My Pediatrician, PLLC reserves the right to dismiss your family from the practice.**
    - Walk-ins: We will make our best effort to accommodate walk-ins on a case-by-case basis. This in no way guarantees that your child will be seen without a previously scheduled appointment. If you desire your sick child to be seen the same day, please call ahead to request any available same-day sick appointments.
- School Absences: Absences from school will only be excused by our office if your child has been seen in the office for the illness.
- Fees, Insurance and Health Plans: A Parent/Guardian must notify the office of changes in address, telephone number or insurance. You must bring your insurance card(s) to every visit. The person who brings the child to the office will be expected to pay at the time of service. You will be responsible for payment of charges from the services provided if we are unable to verify benefits with your insurance company. Insurance companies require collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not yet been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always ask your insurance company regarding your benefits first if you have any questions about covered services or bills. Balances are due at time of your child's appointment. Financial arrangements will be required for balances greater than 60 days outstanding and prior to appointment. We accept cash, checks, Visa, MasterCard, American Express and Discover. There is a $25 fee for returned checks.
- Medical Records: Medical records can be faxed to another physician's office free of charge upon release of the medical record. Patient copies of the medical record can be obtained for a fee (first 10 pages are free; 50

cents per page after the first 10 pages). Copies of the medical record will be provided within 2 business days with a prepayment.

- Medication Refills:
    - ADHD medications: Patients on medication for ADHD will be seen for ADHD visits at least every 3 months. Refills for ADHD medications will be provided only if these appointments are kept. Parents/Guardians may call the ancillary staff to request a refill of ADHD medications. These prescriptions will be available for pick-up within 2 business days after the request has been made during our regular business hours. Electronic prescriptions will also be available at your pharmacy within two days after the request. Controlled substance medications (ADHD medications) must be picked up by a parent/guardian and filled within **21 days** of the date the prescription was written to avoid expiration of the prescription. All prescriptions are given at the sole discretion of the physician based on her judgement.
    - Other medications: Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies, eczema), as long as the patient is established and has been seen for the condition within the past 6 months. Refills will not be provided after hours or on the weekends. Please allow 48 hours for these refills to be completed. All prescriptions are given at the sole discretion of the physician based on her judgement.
- Telephone Calls: Our physicians/staff are available during business hours to serve your needs. You can ask to leave a message with any questions that you may have. All messages will be returned as soon as possible based on urgency. Calls may be returned after business hours if deemed necessary by the physician. Please understand that we do our best to respond to all telephone calls as soon as possible, but we also have a responsibility to the patients who are physically in the clinic for scheduled appointments during that day. If you feel your child needs to be seen you should speak with someone in the front office to schedule an appointment. In general, antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen. In case of an emergency, call 911 or take your child to the nearest hospital emergency room.
- After Hours Services: After-hours contact with the nurse/physician is intended for urgent medical problems only. Questions about appointments, billing, referrals, refills, or other issues of a non-urgent nature should be placed during normal business hours. You always have the option to call the nurse advice line on the back of your insurance card.

Violation of office policies may result in family dismissal from the practice.

By signing below, you acknowledge that you have read and understand the office policies.

Patient's name: _____

Parent/Guardian's name: _____

Signature: _____

Relationship to patient: _____ Date: _____/_____/_____

My Pediatrician, PLLC

Consent to Treatment

I hereby authorize My Pediatrician, PLLC to administer such care, services and treatment for my child _____

_____ as is medically necessary and as is set forth in the treatment plan created by my child's doctor. I also authorize My Pediatrician, PLLC to release any necessary medical information pertaining to my child's examination, diagnosis or treatment, to any facility (including other physicians/clinics, laboratory, hospital or ancillary providers) to which my child may need to be referred. I further authorize My Pediatrician, PLLC to release any necessary medical information pertaining to my child's examination, diagnosis or treatment in order to process medical claims, to my insurance carrier.

Parent/Guardian's name: _____ Relationship to patient: _____

Signature: _____ Date: _____/_____/_____

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