KIDS CHOICE PEDIATRICS

PATIENT DEMOGRAHIC INFORMATION

Date:_____

FORM MUST BE FILLED OUT COMPLETELY AND KEPT CURRENT

Patient's Name_____D.O.B._____ M F

Home Address_____

City_____ State_____ Zip Code_____

Primary Cell Phone#_____ Secondary Cell Phone#_____

Email Address : _____

Pharmacy _____ Location_____ Ph. _____

Sibling Information

Name_____ D.O.B._____ M F

Name_____ D.O.B._____ M F

Name_____ D.O.B._____ M F

Parent Information

Mother's Name_____ Father's Name_____

D.O.B. _____ D.O.B. _____

Employer_____ Employer_____

Occupation_____ Occupation_____

Please Circle Parents Status: Married Single Widowed Separated Divorced

Name of PRIMARY Insurance: _____

Name of SECONDARY Insurance:_____

It is the parent/ guardian's sole responsibility to provide and maintain current contact information to Kids Choice Pediatrics to ensure contact can be made regarding your child. This includes but is not limited to current phone numbers, mailing address, and physical address. If all information is true and accurate please sign below.

Parent/ guardian signature X_____

Consent to Treatment

Kids Choice Pediatrics **will not** provide health care to minors without a parent/legal guardian, parent's written consent or contact from the parent/legal guardian giving said consent. I also understand that written authorization is required before allowing anyone other than parent/legal guardian to bring child to the office for treatment.

***Legal guardians should bring all related documents to prove guardianship, before patient can be seen.**

***Exceptions:**

Child abuse, Patient seeking counseling/family planning services, Treatment for drug/alcohol abuse, Treatment for STDs, Suicidal ideation, Immunization to prevent STDs (Hep B) and/or HPV. For questions regarding this, contact:

Texas Department of Health, Adolescent Health Promo at 512-458-7111 Ext 2021.

In an emergency a Grandparent, Sibling, Aunt or Uncle can consent to treatment.

As the parent/legal guardian of the child designated as patient, I hereby authorize ***Kids Choice Pediatrics*** to provide medical treatment deemed necessary for the patient. I understand that no guarantees can be made as to the eventual outcome of medical treatment advised or performed.

I give consent to the following people to seek medical treatment for my child in my absence:
Ex: Grandparent, Sister, brother, aunt, uncle (if none please leave blank)

Name _____ Relation _____ Tel _____

Name _____ Relation _____ Tel _____

Name _____ Relation _____ Tel _____

- Hearing and vision tests are recommended for ages 4, 5, 6, 8, 10, 12, 15 and 18 years. We will perform these procedures for said ages and if insurance does not cover them, you will be responsible for payment. You will be sent a statement for the charges. If you wish to decline these services, please let us know in advance.
- I understand that when my provider of choice has a full schedule, it is possible to be assigned to any of the other available providers for same day sick appointments.
- I have read and agree to the Treatment Consent Policies stated herein.

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____

Date _____

Privacy Consent

I understand that as part of my healthcare, **Kid's Choice Pediatrics** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The **Physician's *Notice of Privacy*** provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand the **Kid's Choice Pediatrics** reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me upon request submitted to the front desk (provide my address below). I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information:

_____
_____
_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have reviewed the **PHYSICIAN'S *Notice of Privacy Practices.***

I request that any changes to the **PHYSICIAN'S *Notice of Privacy Practices*** be mailed to me at the following address:

_____
_____
_____

_____
Printed name of Parent/Legal Guardian

_____
Signature of Parent/Legal Guardian

_____
Date

Kids Choice Pediatrics – Payment Policy

Thank you for choosing Kids Choice Pediatrics as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We require **insurance information to be provided prior to your visit**. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All **co-payments and deductibles must be paid at the time of service**. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and deductible at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly, especially if you have Medicaid (e.g. **other insurance coverage for coordination of benefits**). It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Insurance changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

8. Missed appointments. Our policy is to charge $20 for **missed appointments not canceled at least 24 hours in advance**. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Returned Checks. Our policy for a Non-Sufficient Funds check is to charge a returned check fee of $30.00 plus the amount of the check and bank fees.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

- I assign insurance benefits to be paid directly to ***Kids Choice Pediatrics and/or Dr. Monika Bhatia***.
- I authorize the staff of ***Kids Choice Pediatrics*** to release any information necessary to process claims for payment or to obtain necessary medical care.

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____

Date _____

Authorization to Release Medical Records

Kids Choice Pediatrics
599 South Custer Rd. Allen TX, 75013
Phone (972) 359-7600 Fax: (972) 359-7601

Patient Name:_____**Date of Birth**: _____

Previous Doctor Information: Name of Provider/Doctor/Hospital request will be sent to :

_____**Phone:**_____

_____**Fax**:_____

By checking the spaces below, I specifically authorize for the following health information and/or medical records:

___The entire medical record
___Immunization Records
___Growth Charts
____Most Recent Physical
____Most Recent Lab Results
____Electronic copy
Other:_____

Send my medical information to: Kids Choice Pediatrics 599 S Custer Rd. Allen TX, 75013

Expiration Date: This Authorization is effective through_____unless revoked or terminated by the patient or patient's personal representative.

I understand that:

- *By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.*
- *I may refuse to sign this authorization, which will not affect my treatment or payment for health care*
- *I may revoke to sign this authorization at any time before the information I have requested is released by providing written notice of revocation as specific in the Notice of privacy practices*
- *If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Kids Choice Pediatrics shall not be healed liable for any consequences resulting from re-disclosure*
- *If the information to be released contains and information about HIV/AIDS an additional HIPAA release of medical information for will be requested*
- *Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released*
- *A copy of this form will be provided to me upon request*

_____ _____

Patient/ Representative signature **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name **Relationship to patient**