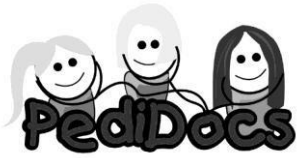



Date:_____
Patient Name:_____ Relationship to Guarantor:_____
Date of Birth:_____ Sex: M_____F_____ Social Security Number:_____
Home Address:_____
City:_____State:_____Zip Code:_____
Pharmacy of Choice:_____
Email address (to be used for patient portal): _____
Do you give consent to receive text messages from our clinic? (circle one) Y N

Siblings: Name Sex DOB Health Condition

_____
_____
_____

Father's Name:_____ Date of Birth:_____
Home Address:(if different)_____
City:_____State:_____Zip Code:_____
Work Telephone:(____)_____Cell Phone:(____)_____
Employer:_____ Employer Address:_____
Social Security Number:_____ Marital Status:_____

Mother's Name:_____ Date of Birth:_____
Home Address:(if different)_____
City:_____State:_____Zip Code:_____
Work Telephone:(____)_____Cell Phone:(____)_____
Employer:_____ Employer Address:_____
Social Security Number:_____ Marital Status:_____

## INSURANCE INFORMATION

Insurance Company Name:_____ Primary Insured Name:_____
Does the patient have secondary insurance? _____Y _____N
**Does the patient have Medicaid or chip (even as secondary)? (circle on) Y N**
***Please note our clinic panel is closed to new Medicaid/Chip patients and we are unable to provide care to new patients under these plans, even as secondary***
Previous Physician:_____

## NOTIFY IN CASE OF EMERGENCY!!

Name: _____Relationship:_____ Phone:(_____)_____
Name: _____Relationship:_____ Phone:(_____)_____

I hereby grant permission to PediDocs to give and/or leave information regarding appointment times, test results or other information over the telephone and/or answering machine.

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to PediDocs to release any pertinent information to my insurance company upon request, and I also authorize payment directly to PediDocs. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature:_____ Date:_____ Witness:_____

Dear Patient:
Please take a few minutes to complete this form. This will help assure you of the best possible care and will be held in confidence as part of your medical record.

NAME OF PATIENT:_____ _____ _____ Today's Date:_____
Last First M.I.
Age:_____Date of Birth:_____/_____/_____Reason for visit:_____

| PAST MEDICAL HISTORY | | | | | | | |
|---|---|---|---|---|---|---|---|
| Has your child ever had problems with the following? (Circle Y=Yes N=No. If Yes, give year.) | | | | | | | |
| | YES | NO | YEAR | | YES | NO | YEAR |
| Immunizations up to date | Y | N | | Bleeding problems | Y | N | |
| Major illnesses | Y | N | | AIDS/HIV | Y | N | |
| Has your child ever been hospitalized? | Y | N | | Constipation | Y | N | |
| Pregnancy problems including prematurity? | Y | N | | Urine or bladder infections | Y | N | |
| Abnormal prenatal ultrasound | Y | N | | Bedwetting | Y | N | |
| Heart disease | Y | N | | Daytime wetting | Y | N | |
| Lung Disease | Y | N | | Please use this space for additional comments: | | | |
| Nervous system | Y | N | | | | | |
| Coordination difficulties | Y | N | | | | | |
| Developmental milestones | Y | N | | | | | |

| Hospitalizations: |
|---|
| |
| |

| BIRTH HISTORY | |
|---|---|
| Birth Weight: | Length: |
| Complications: | _____Vaginal _____C-Section and why?_____ |
| Hospital of birth: | |

| Please list surgical procedures your child has had and the approximate year: | Please list all medications your child is taking(include non-prescription drugs.) |
|---|---|
| 1._____<br>Year:_____<br>2._____<br>Year:_____ | _____<br>_____ |
| Please indicate allergies your child has to any medications:<br>Medication:_____ Reaction_____<br>Medication:_____ Reaction_____ | |

| Family History | | | | | |
|---|---|---|---|---|---|
| | Still Alive & Healthy | | Age Now | Medical Problems | If yes, what? |
| | YES | NO | | | |
| Mother | □ | □ | | | |
| Father | □ | □ | | | |
| Sibling | □ | □ | | | |
| Sibling | □ | □ | | | |
| Sibling | □ | □ | | | |
| Sibling | □ | □ | | | |

| Social History | |
|---|---|
| Who lives in home with patient: | Pets?_____Type:_____ |
| Daycare/school (name):_____ | |
| Exposure to Tobacco?_____<br>Alcohol?_____<br>Drugs?_____ | |

# Responsibility Agreement(s)

## **Self-Pay Agreement (No Insurance)

_____I understand that PediDocs Pediatric Clinic is accepting my child as a self pay patient from today's date of service until I present insurance information that can be verified by a PediDocs employee. I understand that this means I will be responsible for paying for any services my child receives. Payment for these services are due at the time of service. The provider will not file a claim to Medicaid/any other insurance for the services that are provided to my child.

The following is the Good Faith Estimate ranges for PediDocs office visit fees:

- Well Child Check office visit fees range from $105.00-$160.00 depending on the age of the patient.
- Acute office visits range from $100.00-$150.00 depending on the complexity of the visit.
  *For each acute visit, our office will collect $100.00 at the time of service. Based on the complexity of your visit, you may be left financially responsible for the remainder of the fee.

***Disclaimer**

This Good Faith Estimate shows the cost range of the visit only, which is the service that is reasonably expected to address your health care needs. The estimate is based on the information known to our office at the time the estimate is done. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You could be charged more if testing or other procedures are done.

Your signature below states that you have received this good faith estimate and have consented to receiving services.

_____ _____

Patient name Patient DOB

_____ _____

Parent/Guardian Signature Today's Date

## **Pending Insurance Agreement (For newborn coverage)

_____ I understand that PediDocs Pediatric Clinic is accepting me as a patient with the mutual understand that I will add my newborn on to my insurance within 30 days of birth. I understand that if my child is not added by the 30-day grace period, that this means I will be responsible for paying for any services I receive. I understand that the provider will not retro-file a claim for any services received at this clinic. I also understand this clinic's panels are closed to new Medicaid patients and if my child is added onto Medicaid or Chip, even as a secondary insurance, the providers of PediDocs will be unable to provide care to my child.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Parent/Guardian signature Today's Date

**Please note:

All charges are your responsibility whether your insurance pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies arbitrarily select certain services they will not cover, i.e. vision screening, audiology testing, circumcision, or certain vaccines. We will gladly file with your insurance on your behalf. Please be aware any unpaid balance will be your responsibility. Some insurances will not cover a wellness/annual exam if it has been less than 365 days since the previous exam. We will still submit the visit to your insurance, and if not covered, will send you a statement for any fee determined to be your responsibility. Please note that nurse visits will not be charged up front. Services provided will be billed to your insurance. We will send you a statement for any fee determined by the insurance company to be your responsibility.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Parent/Guardian signature Date signed


Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

## Consent for Medical Photography

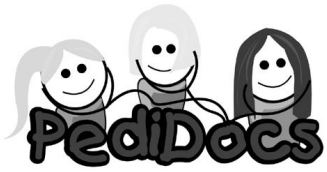
I consent for any photographs to be used in medical publications, including medical journals, textbooks and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize my child. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ _____
Parent Signature Date

## Consent for General Photography

I consent for any photographs taken of my child(ren) named above to be used by PediDocs for marketing purposes to include office art, paper mail-outs and brochures and web design. I understand that if my child's photo is used, no identifying information including, name, address, or phone number will be included. I agree that the photos taken for PediDocs will remain property of PediDocs.

_____ _____
Parent Signature Date




# Release of Medical Records

Date:_____

I hereby authorize _____
to release to_____
the following information from the medical records of:

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

Covering the period: (All) (From_____to_____)

Guardian's Name:_____ DOB:_____

PLEASE SEND US ONLY:
Immunization information, Problem List and Growth Charts
Copy of complete medical records
Lab & copy of X-Ray reports
Birth records and Infant Screen (PKU)

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that this authorization may be revoked in writing at any time, and that the disclosed information may be subject to disclosure by the recipient although discouraged. I also understand that this authorization gives permission to transmit the requested records electronically. This authorization includes the electronic submission of any and all requested information from your insurance company for billing purposes. If another party receives them in error, I absolve this clinic and the employees of this clinic of any and all liabilities relating to such submission of said records.

This authorization expires on _____ unless revoked in writing prior to date.

Signed:_____Relationship to Patient:_____

Print Name:_____Witness:_____

Prohibition on Re-disclosure: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42CPRPart2) prohibit recipients from making any further disclosure of the information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for that purpose.


# Assignment of Benefits
# &
# Authorization to Release Information

I hereby authorize payment to this clinic of all benefits specified and otherwise payable to me for any services rendered by the clinic on or after this date and for such other charges as may be made by this clinic.

I hereby agree to pay the same and also agree that in the event that payment by a third party for any individual visit exceeds that necessary to cover charges incurred during that visit, any coverage may be applied to outstanding charges owed by the clinic for other services rendered to myself, my spouse, or legal dependents of myself or spouse at the time.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or any insurance carriers all information needed for the completion of all medical claims. I understand that the information to be released may include information pertaining to mental- or psychiatric-related conditions and/or drug or alcohol abuse. A copy of this authorization shall be as valid as the original.

I also understand that this authorization gives permission to transmit the requested records electronically, including the electronic submission of claims to your insurance company. If another party receives them in error, I absolve this clinic and the employees of this clinic of any and all liabilities relating to such submission of said records.

I certify that I have read the foregoing and am the patient or the patient's duly authorized agent to execute the above and accept its terms.

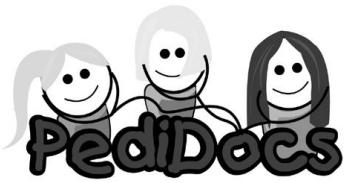
_____ _____

Patient Name Parent/Guardian Signature

_____ _____

Witness Date

Prohibition on Re-disclosure: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42CPRPart2) prohibit recipients from making any further disclosure of the information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for that purpose.




# Authorized Contacts

Date:_____

Patient Name:_____ Date of Birth:_____

Mother's Name: _____ Father's Name: _____

Married: _____ Separated: _____ Divorced: _____ Other: please specify_____

Please remember to protect the privacy of your child we must have your written consent to evaluate and treat your child during each visit. Please list the following information for each of the individuals you are authorizing to accompany your child to visits including but not limited to sick visits, well child checkups, nurse visits, etc. This authorization also gives us consent to release any information regarding your child's health and/or treatment to the below individuals including appointment times and diagnosis. In addition, we ask that you provide copies of any applicable legal custody paper, orders, medical authorizations, etc. to our office. Please note that we cannot prevent a biological parent or legal guardian from receiving information or accompanying his/her child to a visit without legal documentation.
**This form overrides all authorization or consents submitted previously.
**This authorization does not expire unless revoked in writing or a new form is completed.

1-Name: _____ Relationship to the child: _____ DOB: _____

Address: _____ Phone Number: _____

2- Name:_____ Relationship to the child: _____ DOB: _____

Address: _____ Phone Number: _____

3- Name:_____ Relationship to the child: _____ DOB: _____

Address: _____ Phone Number: _____

*Please note photo identification will be requested.

I understand that my child(ren)'s records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that this authorization may be revoked in writing at any time, and that the disclosed information may be subject to disclosure by the recipient although discouraged.

Prohibition on Re-disclosure: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42CPRPart2) prohibit recipients from making any further disclosure of the information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for that purpose.

Those listed above have my permission to accompany my child to PediDocs PLLC. In addition, the above named individuals have my permission to receive all pertinent health information regarding my child from PediDocs PLLC. This authorization shall remain valid until written notice to the contrary is received.

_____ _____ _____

Signature Relationship to child Date


_____ _____

Patient Name DOB

Office Policy

**Please note the following**:

- We ask that you be at the office at or before your appointment time. Late arrivals of more than 15min past the appointment time may be rescheduled and will be considered a "no-show".
- Please bring your photo ID and a valid, current Insurance card/Medicaid letter to each appointment.
- Please bring your child's vaccine record to each well visit.
- All appointments must be cancelled by the end of the business day the day before the appointment. (For ex. If the appointment is scheduled for Monday morning at 11:00a.m, the appointment would need to be cancelled by closing time on Friday). Same day appointments will still be a no show if rescheduled, cancelled, or not attended. Please remember that courtesy calls are not guaranteed, and you will still be responsible for attending your appointment if we are unable to confirm the appointments. Two separate appointment reminders are auto-sent through the patient portal for your convenience.
- All "no-show" appointments will be charged a $50.00 "no-show" fee as allowed by your insurance. This fee must be paid before the patient can be scheduled or seen in clinic again. Please note that all cancelations/reschedules should be made through the patient portal or through our staff and not the answering service/ PediDocs voicemail. Appointment cancellations left on voicemail or with the answering service will not be considered valid and the missed appointment will still be billed as a no-show.
- There will be a fee of $10.00 for each copy of immunization records provided by our office. Immunization records may be printed through the patient portal at no charge.
- There will be a $10-$30.00 fee for all sports/camp/daycare/FMLA forms brought in outside of a visit depending on the complexity of the form. This fee is due at the time of drop off and a 72 business hour turnaround is required for paperwork that requires signature or review from a provider. Any paperwork brought in during a scheduled appointment will be completed at no charge. Any paperwork for siblings will require a separate visit.
- Personal copies of patient medical records start at $25.00. This fee will cover the first 20pages. After those 20 pages, there will be a $0.50 charge per page.
- There will be a $5.00 charge for each controlled med prescription filled outside of a visit.
- PediDocs clinic uses CPL for all routine lab work and all billing is done through their office. It is your responsibility to notify us if you would like a different lab used.

**Initials required**

_____ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurance regarding "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

_____ 2. All charges are your responsibility whether your insurance pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies arbitrarily select certain services they will not cover, i.e. vision screening, audiology testing, circumcision, or certain vaccines.

_____ 3. Fees for services, along with unpaid deductibles and co-payments are due at the time of service. We accept cash, checks, Visa, Master Card and Discover. Patients with outstanding balances must have a payment arrangement on file to be seen in clinic.

_____ 4. If your insurance company does not pay the claim within 45 days, it is your responsibility to contact your insurer to expedite payment.

_____ 5. All patients will be self-pay if insurance is unable to be verified or shows that patient is ineligible and must sign the self-pay agreement before being seen in clinic.

_____ 6. Please note that patients with multiple no shows will be dismissed from clinic.

_____ 7. Please note that if our clinic is not accepting new Medicaid patients, any patient who changes from private insurance to a Medicaid plan, even as secondary insurance, within 6 months of establishing a patient/doctor relationship will be unable to be seen as a patient until they are exclusively on private insurance again.

_____ 8.Your child's assigned PCP with your insurance plan must be one of the M.D.'s here at PediDocs before your child may be seen in clinic. Failure to update the PCP with your insurance before your child's appointment may result in having to reschedule the visit.

_____9. PediDocs will file claims to the insurance currently on file. It is your responsibility to update the insurance information as needed to ensure accurate filing. This includes adding a secondary insurance to your child's chart. Please note that PediDocs does not retro-file claims due to the presentation of incorrect insurance.

_____10. I acknowledge that I, or my health insurance, may be charged for the time spent communicating with a PediDocs provider for after hour phone calls.

--We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing. These policies have been implemented to better our care to you and your family and in effort to reduce wait times. Thank you for your cooperation and understanding.

_____ _____

Parent signature Date

# PROVIDER NOTICE OF INFORMATION PRACTICES

Patient Name: _____ DOB: _____

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

When you receive treatment from PediDocs Pediatric Clinic, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

## How We May Use and Disclose Your Health Information

- We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes or our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.
- We may use or share your health information without your authorization as authorized by law for our patient directory or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.
- We may use and disclose your health information without your authorization to contact you for the following activities: providing appointment reminders or describing/ recommending treatment alternatives
- We may also use and disclose your health information without your authorization for the following purposes:
    - For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
    - To comply with workers compensation laws and similar programs;
    - To alert appropriate authorities about victims of abuse, neglect, or domestic violence
    - For health oversight activities such as audits, investigations, and inspections of PediDocs Pediatric Clinic
    - To create or share de-identified or partially de-identified health information (limited data sets);
    - For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
    - For law enforcement purposes such as identifying or locating a suspect or missing person;
    - To coroners, medical examiners, or funeral directors as needed for their jobs;
    - To avert a serious threat to health or public safety;
    - For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
    - As otherwise required or permitted by local, state, or federal law.

## Your Privacy Rights

Although your health record is the property of PediDocs Pediatric Clinic, you have the right to:

- Inspect and copy your health information upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the PediDocs Pediatric Clinic privacy officer. You can reach PediDocs at 210-733-4362.

## Our Duties

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice. When changed, the revised notices will be posted in our waiting room areas. You may request a copy of the revised notice at any time.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint by contacting the Administrative Assistant at 210-733-4362 or by mail at 9838 Westover Hills Blvd. San Antonio, TX 78251

We will not retaliate against you for filing a complaint.

I acknowledge that I have received and have had a chance to review the Provider Notice of Information Practices.

_____ _____

Parent Signature Date


**Telemedicine Informed Consent**

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting PediDocs PLLC at 210-733-4362
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness Signature Date


**Referral Contact Consent**

Patient Name: _____ Patient DOB: _____

Please mark your preferred method of receiving referral information if your child's pediatrician determines your child needs to be referred to a specialist/specialty clinic.

*Text: _____

*E-mail: _____

*Call: _____

*Mail: _____

_____ _____

Parent Signature Date Signed