
Date:_____
Patient Name:_____ Relationship to Guarantor:_____
Date of Birth:_____ Sex: M_____F_____ Social Security Number:_____
Home Address:_____
City:_____State:_____Zip Code:_____
Home Telephone:(_____)_____ Referred By:_____
Pharmacy of Choice:_____ Pharmacy Address:_____
Pharmacy Phone Number: _____

Siblings: Name Sex DOB Health Condition

_____
_____
_____
_____

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

## INSURANCE INFORMATION

Primary Insurance Name:_____ Effective Date:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Telephone Number:_____ ID Number:_____ Group Number:_____ Full Name of Insured:_____ Policy Type:_____ HMO _____ PPO _____ PPC__Other:_____
Previous Physician:_____
Do you have a secondary insurance? _____Yes _____No Do you have Chip or Medicaid? _____ Yes _____No

## 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:_____


_____ _____

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 may need to be rescheduled and will be considered a "no-show" appointment**
- 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 that are not cancelled at least 2 hours in advance will be considered a "no-show" apt.
- All "no-show" appointments will be charged a $25.00 "no-show" fee as allowed by your insurance. This fee must be paid before the patient can be seen in clinic again.
- Please note that all cancelations/reschedules should be made through our staff and not the answering service.
- There will be a fee of $5.00 for each copy of immunization records (a complimentary copy will first be provided to each patient.
- There will be a $10.00 fee for all sports/camp/daycare/school forms brought in outside of a visit.
- Personal copies of patient medical records start at $25.00.

**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, Visa, Master Card and Discover.

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

_____ 5. I have agreed to pay, in a current manner, any balance of said professional charges over and above this insurance payment.

_____ 6. 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.

_____ 7. Please note that patients with multiple no shows will be dismissed from clinic.

_____ 8. Please note that currently our clinic is not accepting new Medicaid patients. If your child changes from private insurance to a Medicaid plan, even as secondary insurance, within 6 months of establishing a patient/doctor relationship we will be unable to see your child until they are exclusively on private insurance again.

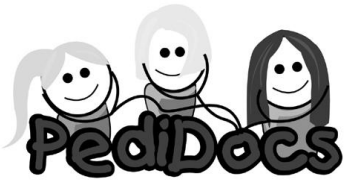
_____ 9. PediDocs will file claims to the insurance currently on file. It is your responsibility to update the insurance information as needed to ensure accurate filing. This includes adding a secondary insurance to your child's chart. Please note that PediDocs does not retro-file claims due to the presentation of incorrect insurance.

_____ 10. Patients with outstanding balances must have a payment arrangement on file to be seen in clinic.

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




# 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 expires 1yr from date signed.

1-Name: _____ Relationship to the child: _____ DOB: _____
Address: _____ Phone Number: _____

2-Name: _____ Relationship: _____ DOB: _____
Address: _____ Phone Number: _____

3-Name: _____ Relationship: _____ DOB: _____
Address: _____ Phone Number: _____

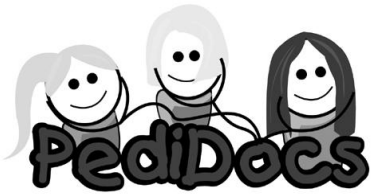
*Please note photo identification will be requested.

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




# 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.

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?_____ | |


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


# 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 Signature of Patient or Authorized Agent

_____ _____

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.

# PROVIDER NOTICE OF INFORMATION PRACTICES

Patient Name: _____ DOB: _____

***Uses and Disclosures of Health Information***
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use of disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new on the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

***Individual Rights***
In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $.05 (5 cents) for each page. You also have the right to receive a list of instance where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request but are not legally required to accept it.

***Complaints***
If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department and Human Services. The person listed below can provide you with the appropriate address upon request.

***Our Legal Duty***
We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are in this notice.

If you have any questions or complaints, please contact:
Amanda Higgins-Gollehon,
Administrative Assistant
9838 Westover Hills Blvd.
San Antonio, TX 78251
P: 210-733-4362 Ext. 120

I hereby acknowledge that I have received the provider notice of information practices from PediDocs Pediatric Clinic.

_____ _____

Parent Signature Date