Lone Star Pediatrics

PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____

Date of Birth: ___/___/___ Social Security Number: _____-_____-_____ Home Phone: (____) ____-_____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information: _____

Name Relationship to patient Phone number

Guardian Information

Legal Guardian

☐ MOTHER ☐ FATHER ☐ OTHER (specify): _____

Name: _____

Date of Birth: ___/___/___ SSN#: _____/_____/_____

Email: _____

Home Phone: (____) ____-_____ Work: (____) ____-_____

Cell: (____) ____-_____ Other: (____) ____-_____

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: (If DIFFERENT from patient's):

Address: _____

City: _____ State: _____ Zip: _____

Legal Guardian

☐ MOTHER ☐ FATHER ☐ OTHER (specify): _____

Name: _____

Date of Birth: ___/___/___ SSN#: _____/_____/_____

Email: _____

Home Phone: (____) ____-_____ Work: (____) ____-_____

Cell: (____) ____-_____ Other: (____) ____-_____

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: (If DIFFERENT from patient's):

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Company: _____

Policyholder: _____ DOB: _____

Secondary Insurance

Company: _____

Policyholder: _____ DOB: _____

I have reviewed this office's Notice of Privacy Practices, explaining how (above patient's) medical information will be used and disclosed.
I understand that I am entitled to receive a copy of this document, upon request.
I understand that it is the policy of Sreebhavi dba Lone Star Pediatrics to respect patient's privacy and office policy prohibits video and audio recordings on any electronic device while in the office.
I understand that Sreebhavi dba Lone Star Pediatrics will only use/or disclose PHI (protected health information) for treatment, payment or healthcare operations. Pursuant to Section 30.06, Penal Code (trespass by holder of license to carry a concealed handgun), a person licensed under Subchapter H, Chapter 411, Government Code (concealed handgun law), may not enter this property with a concealed handgun.
Pursuant to Section 30.07, Penal Code (trespass by license holder with an openly carried handgun), a person licensed under Subchapter H, Chapter 411, Government Code (handgun licensing law), may not enter this property with a handgun that is carried openly.
Conforme a la Sección 30.06 del Código Penal (ingreso sin autorización de un portador de una licencia para llevar un arma corta oculta), una persona con licencia según el Subcapítulo H, Capitulo 411, del Código del Gobierno (ley para portar armas cortas ocultas), no pueden ingresar a esta propiedad con un arma corta oculta.
Conforme a la Sección 30.07 del Código Penal (ingreso ilegal de un portador de una licencia para llevar una arma corta de mano a vista), una persona con licencia según el Subcapítulo H, Capítulo 411, del Código de Gobierno (ley de licencias de armas de fuego), no puede ingresar a esta propiedad con una arma de fuego que se lleve libremente.

Name of Parent/Legal Guardian

Relationship to Patient

Signature

Date

Medical History Information Provided by:_____

Reason for visit:_____

Current Medications:_____

Allergies to medications?_____ Foods?_____ Other?_____

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF PATIENT HEALTH INFORMATION{HIPPA}

Patient information:

Patient's Name:		Address:	
SSN:		City/State/Zip:	
Date of Birth:		Telephone #:	

Release from: (Authorized person/agency to release information):

Physician/ Agency Name:		Address:	
Telephone #:		City/State/Zip:	

Released to: (Who will receive the information)

Physician/ Agency Name:		Address:	
Telephone #:		City/State/Zip:	

Type of Information to be released: (Please specify)

Initial and date the following consent:

I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. _____ Initial _____ Date _____

☐ Entire Medical Record Set (May include records for drug, alcohol abuse or psychiatric illness)
☐ Progress Notes ☐ History/Physicals ☐ Immunizations
☐ Lab / X-Ray Reports ☐ Growth Chart ☐ Other_____

Reason for Disclosure:

Lone Star Pediatrics

☐ Transfer of Care Reason: ○ Relocation ○ Insurance Change
☐ Insurance Eligibility/Benefits ☐ Legal Investigation ☐ Personal Use
☐ Other (specify)_____

PROHIBITION OF RE-DISCLOSURE: Federal confidentiality laws protect this information. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws. However, I understand that the information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

I have had an opportunity to review and understand the content of this Authorization. I understand that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the clinic. I understand that my revocation will not apply to information that has already been released in response to this authorization.

By signing this Authorization, I am confirming that it accurately reflects my wishes. A photocopy or facsimile of this Authorization is as valid as the original.

Patient/Legal Guardian Signature	Date	Relationship to Patient

INSURANCE AUTHORIZATION

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

INSURANCE INFORMATION

- As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.
- We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information.
- We will not be responsible for any denied claims due to filing deadlines if new insurance is not presented to us at the time of service.
- Prior to the appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.
- It is advised that all patients verify (if not already known) to see if we are in network provider for your insurance.
- Check which lab your insurance company is contracted with.
- Our clinic holds an additional stock of state mandated immunizations available for you child free of charge if you meet the criteria of being underinsured. A $5.00 charge per vaccine administration will apply.

AUTHORIZATION

As a courtesy, Sreebhavi dba Lone Star Pediatrics will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Sreebhavi dba Lone Star Pediatrics and/or the rendering providers to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Sreebhavi dba Lone Star Pediatrics . This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. Consent to release information acquired in the course of examination and/or treatment in regard to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

_____ _____ _____

Signature

_

Parent/Guardian (Please Print) / Relationship Date

Text Message/ Email Authorization:

CONDITIONS FOR THE USE OF E-MAIL AND TEXT MESSAGING:
The health care providers will use reasonable means to protect the security and confidentiality of e-mail/text message information sent and received. However, because of the risks outlined above, the health care providers cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information (PHI) that is the subject of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)). Thus, the patient/parent/legal guardian must consent to the use of e-mail for patient information. Consent to the use of e-mail/text messaging includes agreement with the following Conditions: a. E-mails to or from the patient/parent legal guardian concerning diagnosis or treatment will be printed out and/or made part of the patient's medical record. Because they are then a part of the medical record, other individuals who are authorized to view the medical record, such as staff and billing workforce members, will also have access to those emails/ Text. b. The health care providers may forward e-mails/text messages internally to other staff or agents of the health care providers/their practice as necessary for diagnosis, treatment, reimbursement, and other operations. The health care providers will not, however, forward e-mail or text messages to independent third parties outside of CHKDHS or CSG who are not involved with the patient's treatment, reimbursement, or otherwise involved in their care, without the patient/parent/legal guardian's prior written consent, except as authorized or required by law. The health care providers may possibly forward e-mail/text messages to other health care providers participating in the patient's care. c. Although the health care providers will try to read and respond quickly to an e-mail or text message from the patient/parent/legal guardian, the health care providers cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. The usual period of time is less than one (1) business day, but it may take up to a week or longer if the person to whom the e-mail is sent is away or if the e-mail system is not working. Thus, the patient/parent/legal guardian should not use e-mail for medical emergencies or other matters that have to be handled quickly. d. Text messages are used by health care providers for appointment reminders or to share more generic information. When text messages are sent by a patient/parent/legal guardian there should not be an expectation of a response from the health care provider. e. If the patient/parent legal guardian's e-mail requires or invites a response from the health care provider, and the patient/parent/legal guardian has not received a response within a reasonable time period, it is thepatient//parent/ CHKD Form 0848 MR Rev 10/20 FDB: IS PATIENT/HEALTH CARE PROVIDER E-MAIL/TEXTING CONSENT Page 2 of 2 Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service legal guardian's responsibility to call the practice in order to determine whether the intended recipient received the email and when the recipient will respond. As an alternative, the patient/parent/legal guardian can discuss the issue by telephone. f. The patient/parent/legal guardian should not use e-mail or text messages to discuss any subjects that the patient/parent/legal guardian feels should be kept confidential, such as sensitive medical information regarding sexually transmitted diseases, AIDS/HIV,
mental health, developmental disability, or substance abuse. g. Where applicable, there may be a provider charge for the time necessary to respond to the e-mail. h. The patient/parent/legal guardian is responsible for protecting his/her password or other means of access to e-mail or text messaging. The health care provider or his/her practice is not liable for information that is read by other people through errors caused by the patient/parent/legal guardian or any third party. i. The health care provider or his/her practice cannot engage in e-mail or text message communication that is unlawful, such as practicing medicine across state lines. j. If through e-mail or text message communication, the health care provider determines that an office or hospital visit is necessary to address the problem, or if the patient/parent/legal guardian wants to have such a visit, it is the patient/parent legal guardian's responsibility to schedule the appointment

2. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the health care provider and/or practice has provided me regarding the risks of using e-mail or text messaging. I understand the risks associated with the communication of e-mail or text messages between the health care provider and/or practice and me, and consent to the Conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that the health care provider and/or practice may impose regarding e-mail or text message communications. E-mail address:

Cell phone number for texting:

Name of the Patient: DOB:

Print Name: Relationship to Patient:

Signature: Date: Time:

FINANCIAL POLICY

Thank you for selecting Sreebhavi dba Lone Star Pediatrics for your healthcare needs. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, American Express, VISA, MasterCard, Discover. Please read and sign this financial policy prior to seeing the provider.

1. Your Insurance policy is a contract between you, (your employer), and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co- payments, covered charges, secondary insurances, and "usual and customary charges". We are however, contracted with most insurance plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decided what a covered benefit is and what it is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.
3. Co-payments not paid at the time of service are subject to a **$10 processing fee**. All balances more than 60 days past due are subject to a penalty of **$10 per month** to cover the cost of sending additional statements.
4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment**. If your insurance company does not pay within 60 days, you will be responsible for payment**.
5. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party. If we are forced to send your account to collections, a **40% fee will be added to your balance.**
6. Please note that all cancellations must be at least 24 hours in advance, which allows us to care for other patient in need of our services. If you fail to cancel your appointment, you may be charged a **$25 service fee** which will not be covered by your insurance plan.
7. There will be a **$35 NSF** charge on all returned checks.
8. Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for us at a future visit. You may request a refund of overpayment by notifying our office.
9. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our office, so that we can assist you in management of your account with a payment plan.

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GUARANTEE OF PAYMENT

I agree to be responsible for any amounts not paid by my insurance plan, excluding agreed-upon write-offs from any contracted insurance plans. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third -party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

AUTHORIZATION FOR CREDIT CARD ON FILE

I authorize Sreebhavi dba Lone Star Pediatrics to keep my credit card on file. See Credit Card on File agreement.

PATIENT PAYMENT WITH CREDIT CARD ON FILE

Signature of Parent / Legal Guardian: _____ **Date:** _____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Sreebhavi dba Lone Star Pediatrics may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $75, I will receive a courtesy call prior to my card being charged.

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

Parent / Legal Guardian Name: _____

Signature of Parent / Legal Guardian: _____ **Date:** _____

AUTHORIZATION FOR CREDIT CARD ON FILE PAYMENT

Patient Name: _____ DOB: _____

All card processing activities and related technologies utilized by Sreebhavi dba Lone Star Pediatrics will comply with the Payment Card Industry Data Security Standard
(PCI-DSS) in its entirety. No activity may be conducted nor any technology employed that might obstruct compliance with any portion of the PCI-DSS.

Credit card information is not kept on file in this office. It is kept securely off site and this office does not have access to the full credit card number once it is entered into the software system the first time.

AUTHORIZATION

Until further notice, I authorize Sreebhavi dba Lone Star Pediatrics to charge the patient- responsible balances on my account to the card on file.

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Sreebhavi dba Lone Star Pediatrics may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $75.00, I will receive a courtesy call prior to my card being charged.

Printed Name of Parent or Guardian_____

Signature of Parent or Guardian_____ **Date**_____