PEDIATRICZ NOW

Patient Intake Forms

Patient Demographics

Name:_____ _____ _____ _____
Last First M.I Suffix

Date of Birth:_____-_____-_____ Social Security Number:_____-_____-_____ Sex: _____

Email:_____

Street Address:_____ Apt #: _____

City:_____ State: _____ Zip Code:_____

Home Phone:_____-_____-_____ Cell Phone: _____-_____-_____

Preferred Language:_____ Race:_____

Ethnicity:_____

Emergency Contact

Emergency Contact Name:_____ _____
Last First

Emergency Contact Number: _____-_____-_____ Relation to the Patient:_____

Parents/ Guardians Information

Mother's or Guardian Name:_____ _____
Last First

Work Phone:_____-_____-_____ Cell Phone: _____-_____-_____

Date of Birth:_____-_____-_____ Social Security Number:_____-_____-_____

Street Address:_____ Apt #: _____

City:_____ State: _____ Zip Code:_____

Employer:_____

Father's or Guardian Name:_____ _____
Last First

Work Phone:_____-_____-_____ Cell Phone: _____-_____-_____

Date of Birth:_____-_____-_____ Social Security Number:_____-_____-_____

Street Address:_____ Apt #: _____

City:_____ State: _____ Zip Code:_____

Employer:_____

Please check on one of the following below in each category

Parents Relationship:

Married	Separated	Divorced	Living Together

Guardians Relationship:

Grandparent	Aunt	Uncle	Foster	N/A

PEDIATRICZ NOW

Insurance Subscriber

Policy Holder Name:_____ _____
Last First

Work Phone:_____-_____-_____ Cell Phone: _____-_____-_____

Date of Birth:_____-_____-_____ Social Security Number:_____-_____-_____

Sex:_____ Employer:_____

Street Address:_____ Apt #: _____

City:_____ State: _____ Zip Code:_____

Relationship to the patient:_____

I hereby authorize direct payment of medical benefits to Pediatricz Now, PLC for service rendered. I understand that I am fully financially responsible for any balance not covered by my insurance and I hereby authorize Pediatricz Now to release my medical or incidental information that may be necessary for either medical or in processing applications for financial benefit. The signed authorization is good for the life of treatment with Pediatricz Now or until the patient reaches 21yrs of age.

Patients Name:_____ Date: _____-_____-_____

Parents Name:_____

Signature:_____ Date: _____-_____-_____

PEDIATRICZ NOW

Patient Name:_____ DOB: _____-_____-_____

Patient Financial Responsibility **Policy Statement:**

_____
Initials

Pediatricz Now is pleased to provide your children, and our patients, with the highest level of care for your child's health and quality of life We strive to employ the most professional staff and deliver services to you with the latest technology and education available each day. You and Pediatricz Now, together, will combine our energies to bring positive results to your child's healthcare needs. Pediatricz Now, in its continuous efforts to deliver the best in care requires payment of all known patient responsible balances at the time of service. These balances may include but are not limited to co-pays, deductibles, or co-insurance (amounts as stated in the benefits coverage contract with your insurance carrier); any amounts due for patients who are self-pay; any amounts due from previous dates of service or amounts that may be incurred during your current visit. We understand that circumstances may preclude you from paying amounts due at the time of service. In this event, arrangements may be made to work out a payment plan with our billing office. We appreciate your understanding and cooperation to ensure that Pediatricz Now can continue its provision of the highest level of services to all in need of our staff and facilities.

Payment Policy:

_____
Initials

Payment is expected at the time of service for any applicable co-pay, co-insurance, and/or deductible. Pediatricz Now accepts cash, checks, Visa, MasterCard, or American Express as forms of payment for your convenience. If your check is returned for insufficient funds, a thirty-dollar ($30.00) returned check fee will be applied to your outstanding balance.

Insurance Policy:

_____
Initials

We will require a copy of your insurance card and driver's license at the time of your arrival. Pediatricz Now will bill your insurance company as a courtesy to you, but this billing service does not preclude your financial responsibility for the services received. Any deductible, co-insurance, or non-covered services, including ineligibility, are your responsibility. Please understand that your insurance policy is a contract between you, your employer, and your insurance company. Our office will not enter a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. If Pediatricz Now is not contracted with your insurance provider, as a courtesy, we will submit claims to your carrier; any deductible, co-insurance, or non-covered services, including ineligibility are your responsibility. Pediatricz Now will mail monthly statements and contact you to collect any open balances. Please inform our staff immediately of any insurance changes.

Non-Covered Service Policy:

_____
Initials

Certain services performed by our office, for your child's benefit, may NOT BE COVERED by your insurance plan(s). We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility.

Delinquent Accounts Policy

_____
Initials

Delinquent accounts will be reported to our collections department if a claim is unpaid after 90 days from the date of service following Pediatricz Now's normal collection procedures to resolve any outstanding balances. Please inform our billing staff if you know your payment will be late in arriving or if you require payment arrangements. In the event of an overpayment, we will reimburse you or your insurance company at the end of the following month that the overpayment occurred. Any balance over 120 days will be sent to a collection agency unless arrangements have been made prior to the due date.

Late Arrivals

_____
Initials

For our physicians to see their patients in a timely manner. your help in arriving promptly for your appointment is required. If you are more than 15 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you. We understand your time is valuable and will do our best to respect your time and see you as promptly as possible. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

Medical Records

_____
Initials

Should you request a copy of your medical records or financial statements please allow our office 7-10 business days for completion.
The charge for this service is five dollars ($5.00) pages 1-5, then one dollar ($1.00) for each additional page

PEDIATRICZ NOW

Forms Policy

_____ Initials

Should you request our office to complete forms on your child's behalf such as immunization records, disability forms, daycare, etc., there will be a charge of five dollars ($5.00) per form. Payment of this charge is expected at time of completion

Office hours/Afterhours Policy

_____ Initials

Our office hours are Monday-Friday 8.00a.m.- 5:00p.m. We have an answering service available after hours that will contact the physician on call for that evening. If you call during this time your number will be forwarded to that physician. Your call will be returned within 15 minutes. If your call is an emergency, dial 911

Prescription Refills

_____ Initials

If you need refills, please contact your pharmacy first to notify them of what you need. Most continuous medications are originally written with authorized refills. If your child's refills are no longer authorized, the pharmacy will then contact our offices for approval. Please notify your child's pharmacy at least 1-2 days before your child completes their medication. Prescription refills on controlled substances Ie. ADD, ADHD medications require 7days notice to our office staff. If you fail to pick up your prescription within the time allowed a five-dollar ($5.00) charge will apply for a replacement of the prescription.

Appointments/Cancellations/No Shows/Reschedules

_____ Initials

A parent or legal guardian must accompany all minor patients. We do not treat patients that are pregnant or become pregnant. Parents who cancel, reschedule or no show for an appointment frequently without giving 24 hours' notice may be dismissed from our practice. These appointment times could have been given to another patient who needs medical care. We understand unusual circumstances may arise, please contact our office as soon as possible.

Referrals & Authorizations

_____ Initials

If a referral is required by your child's insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits, and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment by your insurance carrier and remain your responsibility.

By signing below, I hereby declare I am the parent/guardian for the child listed above. I have read and understood all office policies and take full responsibility for all my child's medical and financial obligations,

The signed authorization is good for the life of treatment with Pediatricz Now or until the patient reaches 21 years of age.

_____	_____-_____-_____	_____-_____-_____
Patient Printed Name	Date of Birth	Date
_____	_____	_____-_____-_____
Parent/Guarantor Print Name	Parent/Guarantor Signature	Date

Reviewed By:_____ Date _____-_____-_____

Staff member's first initial and last name

PEDIATRICZ NOW

ACKNOWLEDGEMENT OF THE RECEIPT OF PEDIATRICZNOW'S NOTICE OF HEALTH INFORMATION PRACTICES, OFFICE, AND FINANCIAL POLICIES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your child's medical information can be used by our staff in providing and arranging your medical care.

Pediatricz Now is furnishing you with the attached notices, which provides information about how Pediatricz Now may use and/or disclose protected health information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law. You shall also be given a copy of the office and financial policies for Pediatricz Now. By signing this form, you acknowledge that you have received a copy of Pediatricz Now notice of Private Health Information, office, and financial practices and policies.

_____ _____-_____-_____

Patient Printed Name Date of Birth

_____ _____-_____-_____

Parent/Guarantor Signature Date of Birth

Patient Preference Regarding Communication of Health Information

I hereby give permission to Pediatricz Now to disclose and discuss any information related to my child's medical condition(s) to:

_____	_____	_____-_____-_____
Relationship	Name	Contact Number
_____	_____	_____-_____-_____
Relationship	Name	Contact Number
_____	_____	_____-_____-_____
Relationship	Name	Contact Number

Parent Consent for Minor Child

The following adult family members) and/or adult family friend may consent to healthcare treatment of my child when I am not available.

_____	_____	_____-_____-_____
Relationship	Name	Contact Number
_____	_____	_____-_____-_____
Relationship	Name	Contact Number
_____	_____	_____-_____-_____
Relationship	Name	Contact Number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

_____ _____-_____-_____

Parent/Guarantor Signature Date

PEDIATRICZ NOW

Patient Consent for Use and Disclosure of Protected Health Information.

With my consent, Pediatricz Now, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TO). Please refer to Pediatricz Now, P.A. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Pediatricz Now reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practice may be obtained by forwarding a written request to Pediatricz Now, Privacy Officer at 1300 Post Oak Boulevard Suite 1180 Houston, TX 77095.

With my consent, Pediatricz Now, may CALL my home 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 TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatricz Now, may MAIL to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Pediatricz Now, may E-MAIL me appointment reminders and patient statements. I have the right to request that Pediatricz Now, restrict how it uses or discloses my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Pediatricz Now, use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____-_____-_____

Patient Printed Name Date

_____ _____ ____-____-____

Parent/Guarantor Print Name Parent/Guarantor Signature Date

PEDIATRICZ NOW

Authorization For Release of Medical Records

I authorize the following PHI (Protected Health Information) to be released from Pediatricz Now (or the facility listed below). Only parents or legal representatives may make a medical record request (attach other medical release consents). Some requests may be subject to a reasonable fee.

Date Requested: _____-_____-_____ Date:_____-_____-_____

Patient Name:_____ _____

Last First

Street Address:_____ Apt #: _____

City:_____ State: _____ Zip Code:_____

Home Phone:_____-_____-_____ Cell Phone: _____-_____-_____

Please check what information you are requesting:

	Dates of Service
	Office Visits & Labs
	Billing Records
	Entire Record

Please check how you want to receive your records:

	Mail My Records
	Call when Ready
	Fax

Please check the Purpose of Disclosure:

	Personal Use
	Billing or Claims
	Insurance
	Disability Determination
	School
	FMLA
	Other

I hereby authorize medical records release from:

Name of Facility: _____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Phone Number:_____-_____-_____ Fax Phone: _____-_____-_____

I hereby authorize medical record release to:

Pediatricz Now

Street Address:_____

City:_____ State: _____ Zip Code:_____

Phone Number:_____-_____-_____ Fax Phone: _____-_____-_____

I understand that this authorization is valid for 12 months unless I notify Pediatricz Now otherwise. I may revoke it by mailing or faxing a written notice to Pediatricz Now at the address/fax number above stating my intent to revoke this authorization. I understand my treatment will not be conditioned by my completion of this form. I will be responsible for any fees associated with the request before the records are delivered. The information will be provided to me within 30 days of my request.

_____ _____-_____-_____

Parent/ Guarantor Signature Date

_____ _____

Parent/Guarantor Printed Name Relationship to Patient

A minor's signature is required for release of medical records pertaining to sexually transmitted diseases, drug and alcohol or substance abuse and mental health treatment (See Texas Family Code 32.003)

_____ _____-_____-_____

Minors Signature Date

PEDIATRICZ NOW

Patient Name:_____ DOB: _____-_____-_____

To be completed ONLY for third-party disclosures. (If the disclosure if for personal use skip this section)
Medical records to be sent to the following third-party (school, employer, etc.) My completion of this from serves as authorization for Pediatricz Now to disclose these records to this person of facility. I understand that once my information is released Pediatricz Now is no longer able to protect the information and the recipients of my information may not be legally required to protect my information.

Name of Facility: _____

Phone Number:_____-_____-_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Fee schedule:

Medical Records	$50.00+ postage if mailed.
FMLA and other forms	$50.00
Attorney/Affidavit/insurance	$75.00

Please remit payment to:
Pediatricz Now
1300 Post Oak Boulevard
Suite 1180 Houston, TX 77095

_____ _____-_____-_____
Parent/ Guarantor Signature Date

Pediatricz Now staff use only.
I have verified the patient's account number and notified the legal representative of fee.

Released Date: _____-_____-_____ Released Time _____:_____ _____
AM/PM

Released By: _____ _____
Staff first initial and last name Title

Additional Notes:_____

Acknowledgment of Receipt of Notice of Privacy Practices
I have been presented with a copy of the Notice of Privacy Practices, detailing how my (child's) health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my (child's) health information.

_____ _____ _____-_____-_____
Parent/ Guarantor Signature Relationship to Patient Date

Internal Use Only:
If the patient or patients representative refuses to sign an acknowledgment, please document the date and time the notice was presented to the patient and sign below.

Presented on: _____-_____-_____ _____:_____ _____
Date Time. AM/PM

By: _____ _____
Staff first initial and last name Title