Austin Pediatric Surgery

PATIENT INFORMATION FORM

PATIENT NAME _____ NICKNAME _____ SEX: M F
STREET ADDRESS _____ DATE OF BIRTH _____ AGE _____
CITY _____ STATE _____ ZIP _____ COUNTY _____ HOME PHONE (___) ___-_____
SCHOOL _____ SOCIAL SECURITY #: ___-___-_____
REFERRING PHYSICIAN _____ PHONE (___) ___-_____
PRIMARY CARE PHYSICIAN _____ PHONE (___) ___-_____

RESPONSIBLE PARTY

NAME OF PARENT/GUARDIAN ACCOMPANYING CHILD: _____
RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY #: ___-___-_____
STREET ADDRESS _____ DATE OF BIRTH _____ AGE _____
CITY _____ STATE _____ ZIP _____ COUNTY _____ SEX: M F
HOME PHONE (___) ___-_____ ALTERNATE PHONE (___) ___-_____
EMPLOYMENT STATUS _____ OCCUPATION _____
EMPLOYER _____ EMPLOYER TEL #: (___) ___-_____

OTHER PARENT/GUARDIAN OF CHILD: _____
RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY #: ___-___-_____
STREET ADDRESS _____ DATE OF BIRTH _____ AGE _____
CITY _____ STATE _____ ZIP _____ COUNTY _____ SEX: M F
HOME PHONE (___) ___-_____ ALTERNATE PHONE (___) ___-_____
EMPLOYMENT STATUS _____ OCCUPATION _____
EMPLOYER _____ EMPLOYER TEL #: (___) ___-_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ SUBSCRIBER NAME _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____
SUBSCRIBER ID# _____ GROUP # _____
GROUP/EMPLOYER NAME _____
SUBSCRIBERS ADDRESS _____ CITY/STATE/ZIP _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ SUBSCRIBER NAME _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____
SUBSCRIBER ID# _____ GROUP # _____
GROUP/EMPLOYER NAME _____
SUBSCRIBERS ADDRESS _____ CITY/STATE/ZIP _____
_____ INITIAL IF NOT APPLICABLE

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENTS)

NAME _____ PHONE (___) ___-_____
RELATIONSHIP TO PATIENT _____

PHARMACY NAME/LOCATION _____ PHONE (___) ___-_____

CONSENT TO TREAT

I, _____, HEREBY AUTHORIZE MY CHILD, _____ TO BE EVALUATED AND/OR TREATED BY THE PROVIDERS OF AUSTIN PEDIATRIC SURGERY.

PRINT PARENT/GUARDIAN NAME _____ DATE ___/___/_____

SIGNATURE PARENT/GUARDIAN _____ DATE ___/___/_____

Austin Pediatric Surgery
Austin Office - 1301 Barbara Jordan Blvd., Suite 400, Austin, TX 78723
North Austin MOB - 9010 North Lake Creek Pkwy, Bldg 2, Suite 303, Austin, TX 78717
Cedar Park Office – 1301 Medical Parkway, Suite 340, Cedar Park, TX 78613
Phone (512)708-1234 • Fax (512)708-4567

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed by my physician or his/her designee. I understand that **Austin Pediatric Surgery** includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care. This facility has mid level providers on staff to assist in the delivery of medical care. I understand there may be times when I am seen by a mid level provider instead of a physician.

I understand that this Consent to Treat will be valid for each visit I make to the **Austin Pediatric Surgery** until revoked by me in writing.

2. Consent to Release Information

I acknowledge that **Austin Pediatric Surgery** may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that **Austin Pediatric Surgery's** Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by **Austin Pediatric Surgery**.

I acknowledge and consent to allow **Austin Pediatric Surgery** to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to **Austin Pediatric Surgery** all rights, title and interest in payments from third-party payors, including but not limited to, health plans and health insurers. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that **Austin Pediatric Surgery** is unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

PATIENT: _____ DOB _____

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to **Austin Pediatric Surgery** on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by **Austin Pediatric Surgery** or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging **Please note: We do not take pictures at this time**

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the **Austin Pediatric Surgery** will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from **Austin Pediatric Surgery**.

_____	_____
Patient Printed Name	Patient Date of Birth
_____	_____
Patient/Responsible Party Signature	Date
_____	_____
Witness	Date

Austin Pediatric Surgery
Austin Office -1301 Barbara Jordan Blvd. Ste 400, Austin, TX 78723
North Austin MOB - 9010 North Lake Creek Pkwy, Bldg 2, Suite 303, Austin, TX 78717
Cedar Park Office – 1301 Medical Parkway, Suite 340, Cedar Park, TX 78613
Phone 512-708-1234 Fax 512-708-4567

FINANCIAL POLICY

As we enter this doctor-patient (parent) relationship, we agree to provide quality pediatric surgical care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, MasterCard, Visa, Discover and American Express. If you are not prepared to pay the required amount, we may be required to reschedule the appointment. The estimated financial responsibility for scheduled surgery will be due ***prior*** to the surgery date. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 60 days with no payment activity will be reported to the credit bureau(s).*
- **Your insurance policy is a contract between you and your insurance company. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. You are responsible for obtaining a properly dated referral if required by your insurance company and responsible for payment if your claim denies for lack of one. Failure to provide accurate insurance information within 15 days from the date of service will result in the balance becoming your responsibility. If after 60 days from the initial filing date, we do not obtain payment for services performed by your insurance company, the balance will be transferred to you for payment in full.

- As a courtesy to you, we will file a participating insurance claim for you with proper assignment. Please bring your insurance card with you to <u>every</u> visit.
- We do not file third party insurance for motor vehicle accidents or liability claims. We do not carry balances for claims to be settled in or out of court.
- It is the responsibility of the parents to add your newborn to your policy within 30 days from birth.
- This office is not party to your divorce decree. The financial responsibility rests with the accompanying adult.
- A $25.00 fee will be assessed for all returned checks.
- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds will be provided within 30 days from the date all outstanding claims are satisfied.

ASSIGNMENT OF BENEFITS

I request payment of the medical and surgical benefits, otherwise payable to me, directly to Austin Pediatric Surgery for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____ _____
Patient Name Date of Birth

_____ _____
Responsible Party Printed Name (Must be 18 or over) Date

_____ _____
Responsible Party Signature (Must be 18 or over) Date

PATIENT HISTORY FORM

PAST HISTORY OF THE PATIENT **PATIENT:** _____ **DOB** _____

Please explain any YES answers in detailed description in the box provided.

Has the patient ever had any surgery or been hospitalized? **Has the patient had any problems with anesthesia? No ____ Yes _____ If yes, please list below:**	o No o Yes	Surgeries	Dates	Hospitalizations other than surgery	Dates

Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	o No o Yes	Medication	Dose	Times	Medication	Dose	Times
Does the patient have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	o No o Yes						

Past Medical History: Please mark any issues that your child has experienced

	NO	YES		NO	YES		NO	YES		NO	YES
HEENT			**Psychiatric**			**Musculoskeletal**			**Skin**		
Allergies			Anxiety disorder			Musculoskeletal disease			Prior abscess		
Hearing loss			Depression			Previous injuries			**Rheumatologic**		
Vision/eye issues			**Respiratory**			**Neurological**			Immune system disorder		
Retinopathy			Asthma			Head trauma			**Sleep**		
Cardiovascular			Lung disease			Headaches			Sleep apnea		
Heart arrhythmia			Pneumonia			Seizures			**Other**		
Heart disease			**Gastrointestional**			History of IVH			Anesthesia complications		
Heart murmur			Acid reflux/GERD			**Hematology/cancer**			Breast problems		
Genitourinary			Liver disease			Anemia			Organ transplant		
Kidney disease			**Endocrine**			Bleeding disorder			**Pediatric**		
Urinary tract infection			Diabetes			Cancer			ADD or ADHD		
			Thyroid disease			Sickle cell			Developmental delay		

FAMILY HISTORY: Please indicate if parents, brothers and/or sisters have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Diabetes No Yes		Kidney problems No Yes		Ulcerative colitis No Yes	
High blood pressure No ___ Yes __		Bleeding/clotting problems No ___ Yes ___		Crohn's disease No ___ Yes ___	
Issues with anesthesia No ___ Yes __		Cancer No ___ Yes ___	If yes, what type of cancer?		

Review of Systems: Please indicate if your child is experiencing any of the following problems

	NO	YES		NO	YES		NO	YES		NO	YES
Constitutional			**Cardiovascular**			**GI con't**			**Skin**		
Weight gain			Palpitations			Blood in stool			Skin lesions		
Weight loss			**Breasts**			Mucus in stool			Swelling		
Loss of appetite			Lumps			**Genitourinary**			Bruising		
Fever or chills			Tenderness			Discharge			**Neurological**		
Fussy			Discharge			Blood in urine			Muscle weakness		
Diminished activity			**Respiratory**			Pain with urination			Spasticity		
Fatigue			Cough			Increased frequency of urination			**Psychiatric**		
Sweats			Wheezing			Urgency			Depression		
EENMT			Noisy breathing			Testicular pain			**Endocrine**		
Wears glasses			**Gastrointestional**			Swelling			Increased thirst		
Drooling			Difficulty swallowing			Redness			Heat/cold intolerance		
Congestion			Abdominal pain			Itching			**Hematologic**		
Hoarseness			Nausea			Lumps/masses			Increased bleeding		
Mouth lesions			Vomiting			**Musculoskeletal**					
Runny nose			Diarrhea			Soft tissue swelling					
			Constipation			Limited motion					

parent signature _____ Date _____