



Need a baby Doctor?

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Child's Full Name _____

Address _____

City _____ State _____ Zip _____

Telephone # Where Child Lives _____ Other _____

Sex M F Date of Birth ____ / ____ / ____ SSN# ____ - ____ - ____

Who Referred Patient? _____

Have you arranged for your child's records to be transferred here from another pediatrician? YES NO

Brother or Sister's Name _____ Sex: M F DOB: ____ / ____ / ____

Brother or Sister's Name _____ Sex: M F DOB: ____ / ____ / ____

Brother or Sister's Name _____ Sex: M F DOB: ____ / ____ / ____

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Mother's Full Name _____ Date of Birth _____

Mother's Home Address (if different from above) _____

Mother's Home Telephone # _____ Work _____

Cell Phone # _____ SSN# ____ - ____ - ____

Driver's License # _____ State _____ Exp. Date _____

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Father's Full Name _____ Date of Birth _____

Father's Home Address (if different from above) _____

Father's Home Telephone # _____ Work _____

Cell Phone # _____ SSN# ____ - ____ - ____

Driver's License # _____ State _____ Exp. Date _____

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Name of Person NOT Living with Child _____

Home Address _____

Home Telephone # _____ Cell Phone # _____

Relationship to Child _____

There may be times when you have a friend, relative, or nanny bring your child to the doctor. Please designate those people who you authorize to bring your child to our office, call our office, and/or have access to his or her medical information.

Name Relationship to Patient

Name Relationship to Patient

We MUST have a copy of your insurance card

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number _____ Copay _____

Patient's Relationship to Subscriber: (Circle One) Self Child

Subscriber's Full Name _____

Address (If Different from Patient) _____

City _____ State _____ Zip _____

Phone # _____ Alternate Phone # _____

Date of Birth ____ / ____ / ____ SSN# ____ - ____ - ____

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Please sign to verify that all information above is correct and valid

Name of Child

Date

X _____
Signature of Parent or Guardian

Child's Name _____

Place of Birth _____ Birth Weight _____

Pregnancy and Birth Problems: _____

Prior Hospitalizations: _____

Prior Surgeries: _____

Chronic Medical Problems: _____

Food or Medication Allergies: _____

FAMILY HEALTH PROBLEMS: IDENTIFY PROBLEM AND RELATIONSHIP TO CHILD

Description	Problem	Relationship to Child
SKIN (Dermatitis, Birthmarks, Etc)		
EYE, EAR, NOSE, THROAT (Visual, Hearing, Infections, Allergies, Cleft Lip)		
LUNGS (Asthma, Tuberculosis, Reactive Airways Disease, Emphysema)		
IMMUNOLOGIC (Receiving Chemotherapy or Steroids, AIDS)		
HEART (Heart Disease, Stroke, High Blood Pressure, High Cholesterol)		
BLOOD DISORDERS (Anemia, Sickle Cell Disease, Hemophilia, Leukemia)		
STOMACH (Ulcers, Pyloric Stenosis, Liver Disease, Diarrhea, Constipation)		
KIDNEY (Urinary Tract Infections, Renal Failure)		
ENDOCRINE (Thyroid Disease, Diabetes)		
BONE/MUSCLE (Dislocated Hips, Arthritis, Scoliosis)		
NERVOUS (Headaches, Seizures, Learning Problems, Mental Illness, Mental Retardation)		
OTHER (Cancer, Obesity, Cystic Fibrosis, Birth Defects, Alcoholism)		



CONSENT TO TREAT

I give my consent for diagnosis and treatment to Collin County Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available in each exam room. Your child's digital photograph may be taken and incorporated into the electronic medical record.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request.

ASSIGNMENT OF BENEFITS

I hereby assign Collin County Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Collin County Pediatrics and I will be responsible for any charges accrued and not paid by the insurance company. I am responsible for all co-pays, deductibles, co-insurance and non-covered services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my child's medical information by Collin County Pediatrics to any consulting physician, hospital, and third-party payers such as insurance companies, government agencies, self insurance employer or utilization review organization.

This document remains in effect unless revoked in writing.

Child's Name

X

Signature of Parent/Guardian

Date



Payment Policy

1. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim. Please bring your insurance card to every visit and notify us of any new changes.
2. All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience, we accept MasterCard, Visa, Discover, and American Express. You may make credit card payments via the phone. Hot check writers will be charged a \$30 fee and may be referred to the Collin County District Attorney's office and/or sent to our collection agency.
3. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days, we will require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.
4. Please be aware that some of the services you receive may not be covered by your insurance company. You will be responsible for payment of all charges for services not covered by your insurance company.
5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment. If you do not give adequate notice, you may be charged \$25.00.
6. Self-pay families will receive a prompt pay discount, which is due at the time of service.
7. Families with higher balances or extreme circumstances may contact our office to discuss a payment plan.
8. Statements are sent monthly. To save on postage, we do not bill for balances less than \$5.00. Credits will be applied to your next visit.

Signature of Parent or Guardian

Date

Patient Name



Notice of Privacy Practices for Collin County Pediatrics

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. This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact Collin County Pediatrics.

Treatment, Payment, Health Care Operations

Treatment: We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Options: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation certificates, licenses and credentials we need to serve you.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask 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, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled. We may also disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by law enforcement official, we may disclose your medical information under limited circumstances provided that the information: a) is released pursuant to legal process, such as a warrant or subpoena; b) pertains to a victim of crime and you are incapacitated; c) pertains to a person who has died under circumstances that may be related to criminal conduct; d) is about a victim of crime and we are unable to obtain the person's agreement; e) is released because of a crime that has occurred on these premises; or f) is released to locate a fugitive, missing person or suspect. We may also release information if we believe that disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized government functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law: We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Notice of Privacy Practices for Collin County Pediatrics (Page 2)

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: a) The information to be restricted, b) What kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and c) To whom the limits apply. Please send the request to the address at the end of this document. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to Collin County Pediatrics. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designed record set, which is information that is used to make decisions about your care. Texas law requires that request for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to Collin County Pediatrics. We can refuse to provide some of the information you ask to inspect or ask to be copied if the information a) Includes psychotherapy notes; b) Includes the identity of a person who provided information if it was obtained under a promise of confidentiality; c) Is subject to the Clinical Laboratory Improvements Amendments of 1988; d) Has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in prior decision to deny access will make any such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charge permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designed record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment if the information, a) Wasn't created by this practice or the physicians here in this practice; b) Is not part of the Designated Record Set; c) Is not available for inspection because of an appropriate denial; d) If the information is accurate and complete. Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing. Allow the amendment to be made and tell others that we now have the correct information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed at the end of this document. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Service is:

U. S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise To You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request to the rights described above, please contact:

Collin County Pediatrics
4461 Coit Road, Suite 315
Frisco, TX 75035
Phone: 972-731-9900 Fax: 972-731-9907

This notice is effective on the following date: June 15, 2009

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.