August Pediatrics, P.A. - Registration Form

Patient Information

(Last) _____ (First) _____ (M) _____
Date of Birth: ___/___/___ SS#___-___-_____ Age: _____Sex: M ☐ F ☐
Street Address: _____ City/State/Zip:_____
Home phone: _____ Cell phone: _____

LEGAL CUSTODY PAPERS:** ***If parents are separated, divorced, or if guardian is other than biological parents, Legal Custody Papers, signed by a judge with the docket #, indicating the domiciliary parent is necessary.***

Parent/Guardian's Information and Primary Insured's Information

Primary Insured Name:
(Last) _____ (First) _____ (M)_____
Date of birth: ___/___/___ SS#: _____ DL# _____
Address (if different): _____ ***Relation to child*** _____
Home phone (if different): _____ Cell phone:_____
Employer Name/Phone Number:_____
Insurance Company: _____ Policy #: _____
Group #: _____Insurance Phone number:_____

Guarantor *(Please Choose)*: ☐ **Biological Parent** ☐ **Step-Parent** ☐ **Other** _____
(Last) _____ (First) _____ (mid) _____
Date of birth: ___/___/___ SS#: _____ DL# _____
Address (if different):_____ Relation to child _____
Home phone (if different): _____ Cell phone:_____
Employer Name/Phone Number:_____
Is child also on your insurance? _____ Ins. Company:_____
Policy #: _____ Group #: _____ Ins Phone #:_____

Other Parent/Guardian *(Please Choose)*: ☐ **Biological Parent** ☐ **Step-Parent** ☐ **Other** _____
(Last) _____ (First) _____ (mid)_____
Date of birth: ___/___/___ SS#: _____ DL# _____
Address (if different): _____ Relation to child _____
Home phone (if different): _____ Cell phone:_____
Employer Name/Phone Number:_____
Is child also on your insurance? _____ Insurance Company:_____
Policy #: _____Group #: _____Insurance Phone number:_____

Sibling's Names/Birthdays: _____
_____

How did you hear about us? __ Phonebook __ Friend __ Doctor __ Internet/Website __ Other AD

Assignment of medical benefits are to be paid to Anissa G. August, M.D., P.A. if filed by said office. I understand that I am financially responsible for all charges not paid within 60 days.

_____ _____
Signature of Financially Responsible Party Date

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard and Discover.

ATTENTION!!!

YOUR INSURANCE – Please understand that our office may submit a claim to your insurance company as a courtesy to you. We do not have to file a claim – we can ask that you pay the full amount of your rendered services at the time of your appointment and then you may file your own medical claim.

PARENTS OF NEWBORNS – Please understand that if you child is going to be added to an insurance policy but not covered until added, then we will honor that plan for 31 days (including the date of birth). However; also note that it is your responsibility to make sure that this claim does get billed out to the insurance carrier. If the child must be added to the policy before they are covered, then your file will stay " Self Pay" until the child is added. Our office is not responsible for unpaid claims!...the parent or guardian will be billed for services that are not covered by your plan or if the claim is past timely filing! *Please call our office once you know that the child has been added to the policy and is showing "Active".* If you receive a bill for services that should have been billed to an insurance carrier, then it is your responsibility to call our office and inform us of the situation!

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment or deductible at the time of service. This office's policy is to collect this payment when you arrive for your appointment.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient _____ Date of Birth _____

Patient's parent or guardian _____ Date _____

Patient and Parent Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, (patient name)_____, understand that as part of my health care, August Pediatrics, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that August Pediatrics, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that August Pediatrics, P.A. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should this office change its notice, it will provide a copy of the Notice to me at a subsequent visit.

I wish to add the following restrictions to the use or disclosure of my health information:

_____
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent. I have been notified of my privacy rights.

_____

Patient or Caregiver's Signature **If caregiver, relationship to patient**

Date_____ **Patient's Date of Birth** _____

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

August Pediatrics, P.A. – Patient Portal Registration

Patient Information:

Last _____ First _____ M _____

Date of Birth ____/____/____ Primary Phone # (_____) _____ - _____

Address _____

Responsible Party: ___ **Biological Mother** ___ **Biological Father** ___ **Other (Explain)** ___

Patient Portal Access ____ Email _____

Last _____ First _____ Phone _____

Address _____

Other Parent/Guardian: ___ **Biological Mother** ___ **Biological Father** ___ **Other (Explain)** ___

Patient Portal Access ____ Email _____

Last _____ First _____ Phone _____

Address _____

Primary Insured: ___ **Biological Mother** ___ **Biological Father** ___ **Other (Explain)** _____

Patient Portal Access ____ Email _____

Last _____ First _____ Phone _____

Address _____

*****List any other Contacts and if they will need Patient Portal Access*****

1) Name _____ Relation to the child _____

Patient Portal Access ____ Email _____

2) Name _____ Relation to the child _____

Patient Portal Access ____ Email _____

3) Name _____ Relation to the child _____

Patient Portal Access ____ Email _____

4) Name _____ Relation to the child _____

Patient Portal Access ____ Email _____

_____ _____

Signature/Relation to the Child Date

PLEASE ANSWER THESE IMPORTANT QUESTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of private health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home address.

I prefer to be reached:

- ❑ Home
- ❑ Work
- ❑ Cell
- ❑ E-mail and/or via our Patient Portal

If we are unable to reach you to answer a question you have asked:

- ❑ The nurse/doctor can leave a detailed message on your home answering machine
- ❑ The nurse/doctor can leave a detailed message on your work voice mail.
- ❑ The nurse/doctor can leave a detailed message on your cell phone voice mail.
- ❑ Please only leave your name and number at my:
  - ❑ Home ❑ Work ❑ Cell
- ❑ Do not leave a message of any kind at the above places.
- ❑ The nurse/doctor can send a secure email or send a secure message through our Patient Portal.

Emergency Contact:
If in the event we are unable to contact the parent/legal guardian, whom may we speak:

1) Name: _____ **Relationship:** _____

Phone Number: _____

2) Name: _____ **Relationship:** _____

Phone Number: _____

NOTE: If picking up any documents, you must bring a driver's license for proof of identification and/or a consent form if you are not the biological parent/guardian.

Please understand that your phone calls are returned by the nurse from 8:00 a.m. to 5:00 p.m. Non-emergent calls placed after 4:00 p.m. may not be returned until the next business day. Please leave us a number that we can reach you during those hours.

Dr. August sometimes makes calls after 5:00 p.m. Please leave a number with the nurse so that she can reach you from 5:00 p.m. to 9:00 p.m.

Please always leave us a pharmacy name/number when you need a medication refill.

Any of the above information can be changed while you are in the office or by written request.

_____ _____
Parent/Guardian Signature/Printed Name Date

_____ _____
Patient Name DOB

(Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.)

Anissa G. August, M.D., F.A.A.P.
2401 S FM 51 Suite 100 – Decatur, Texas 76234
Phone: (940)627-8044 – Fax: (940)627-8055

Date: _____

I _____ give my permission to the office of Anissa August, M.D., to release my child or children's personal Immunization Record, Return to School Note or any records for any reason during the school year of: _____ - _____ to either myself or the school.

Personal Email _____

Sincerely,

_____ _____
Parent/Guardian Signature (Please print your name)

Date: _____

My child's school is (Please print)

My child (children)s names and DOB (Please print)

_____ _____DOB___/___/___

_____ _____DOB___/___/___

_____ _____DOB___/___/___

_____ _____DOB___/___/___

Anissa August, M.D.
General Pediatrics

CONSENT TO MEDICAL TREATMENT OF A MINOR

Date: _____

To Whom It May Concern:

I hereby give my permission for following individuals to seek medical services and treatment from Dr. Anissa August for _____ until further notice.

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**

_____

Parent or Guardian

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Name of Patient

_____

Date of Birth of Patient

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship to Patient

August Pediatrics, P. A.

Welcome to our office. We strive to create a warm and loving environment for your child. We promise to get you in and out of our office as quickly as possible. We know your time is valuable. We thank you for entrusting us with your child's health.

Please read these office policies carefully.

New patients are required to have a parent or legal guardian present at the first visit. We will ask that you fill out appropriate paperwork if you would like to give your unaccompanied teenager permission to seek medical care. Please let us know if other relatives like Grandma or the sitter have permission to bring your child in for you.

We request that all new patients arrive a few minutes early to fill out paperwork.

All patients are requested to arrive on time. If you are running late, please call the office. **Beginning January 1, 2019:** Patients that are more than 10 minutes late for an appointment will be offered a work-in appointment (this may involve a wait) or rescheduled for another day. Please be aware that if you "No Show" to your appointment there may be a $25 fee charged to your account. Appointments must be cancelled 2 hours prior to the scheduled appointment and Behavioral Consults must be cancelled 24 hours prior. This is in an effort to get our patients in and out in a timely manner.

Patient Portal: Forms and pertinent information regarding your child's medical history are now available through our patient portal. Upon account activation you will be able to view and/or print a vaccine record and office visit summaries, request refills, send non-urgent messages to the nurse and/or front office and request appointments. Please talk with us about getting your portal activated!

Guardianship

- **Please be advised that as a pediatric office, the majority of our patients are minors. We must obtain consent from the patient's legal guardian or biological parent/s before treating the child.**
- **If the child is in foster care or has been adopted it is required that we obtain a copy of those signed court documents granting legal custody.**

- Please give us at least 48 hours to prepare a paperwork/forms and medical record requests.
- Please turn off all cell phones or put them on vibrate while in the exam rooms.
- Please bring immunization cards to all well child check ups.

The nurse or doctor will return any calls between 8 am to 5 pm as quickly as possible. Any non-emergent calls placed after 4 pm will be returned the following business day.

If your child is experiencing a life threatening emergency, please call 911. If your child has swallowed something that might be poisonous, call Poison Control. If you would like to speak to the doctor about a non-life threatening emergency after hours, please call the office and leave a message on our emergency line. Your call will be returned as quickly as possible. Please be kind to the doctor and nurses with after hours calls, they too need rest. Please be aware that a $25 after hours fee for a "non-emergent" issue may be charged to you account.

Please bring your insurance card to each visit. Let us know if there have been changes in your insurance since the last visit.

Payment in full is expected at the time services are rendered, unless other arrangements have been made. Please be aware as of January 1, 2009 we no longer accepts checks. We accept credit cards or cash.

Please recognize that any person who is rude, uses profanity or becomes physically or verbally abusive to any of our staff may be dismissed from August Pediatrics effective immediately.

I have read the above office policies and agree to comply by these guidelines and I understand that these policies may change at given time without notice.

Parent/Legal Guardian: _____ Date: ____/____/____

Patient Name: _____ DOB: ____/___/____

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I have read the above office policies and agree to comply by these guidelines and I understand that these policies may change at given time without notice.

Parent/Legal Guardian: _____ Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____

Information regarding person or entity who can receive and use this information:
Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)	**Reason for release of information:** *(Choose all that Apply)*
_____ Drug, Alcohol or Substance Abuse Records	□ Treatment/Continuing Medical Care
_____ Mental Health Records (Except Psychotherapy Notes)	□ Personal Use
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	□ Billing or Claims
_____ Genetic Information (Including Genetic Test Results)	□ Insurance
	□ Legal Purposes
	□ Disability Determination
	□ School
	□ Employment
	□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization**: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period**: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION,** except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION,** and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____