Gold Pediatrics

PATIENT INFORMATION FORM

Please complete the entire form and following pages for ALL patients in the same family

PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME:	PATIENT FIRST NAME:	GENDER:	PATIENT DATE OF BIRTH:
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS:	ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Decline to Report
RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American □ White □ Native Hawaiian/Other Pacific Islander □ Decline to Report	

GUARANTOR INFORMATION

(Individual responsible for bills and payment)

PARENT LAST NAME:	PARENT FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO CHILD (*Check all that apply*): □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other (*Please specify*):
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:
E-MAIL ADDRESS: □ None	SOCIAL SECURITY #:	DATE OF BIRTH (*mm/dd/yyyy*):	
GENDER:	EMPLOYER NAME:	EMPLOYER PHONE #: ( )	

OTHER PARENT

PARENT LAST NAME:	PARENT FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO CHILD (*Check all that apply*): □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other (*Please specify*):
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	DATE OF BIRTH (*mm/dd/yyyy*):	

INSURANCE INFORMATION
(Please present all current insurance cards to the Front Desk)

PRIMARY INSURANCE:	SECONDARY INSURANCE:
MEMBER ID:	MEMBER ID:
POLICY HOLDER:	POLICY HOLDER:
POLICY HOLDER DATE OF BIRTH: GENDER:	POLICY HOLDER DATE OF BIRTH: GENDER:
POLICY HOLDER SOCIAL SECURITY NUMBER:	POLICY HOLDER SOCIAL SECURITY NUMBER:

Telephone, Email Contacts

I hereby consent and agree that: (1) anyone acting on behalf of Gold Pediatrics (herein known as "GP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of GP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) GP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with GP and that GP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying Gold Pediatrics in writing.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Authorization to Pay Benefits to Physician

I hereby authorize Gold Pediatrics to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of Gold Pediatrics for medical treatment provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Gold Pediatrics is not a provider on my insurance, full payment is due on the date of service. If Gold Pediatrics is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay additional fees up to 35% of the balance due, collection agency charges, attorney's fees, and any other costs.

By signing below, I am acknowledging that I have read and understand the above statements.

Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date Signed

CONSENT TO TREATMENT OF A MINOR

On the first scheduled visit, the parent/legal guardian of the child is required to attend the visit. Once your child is an established patient with our office, a written consent form is required for any other adult to bring your child to his/her appointment. Please note the appointment will be rescheduled if this policy if not followed.

I hereby give my permission for Gold Pediatrics, P.A. and it's physicians, nurse practitioners, and other associates to examine and treat my children whose names are listed below:

Child's Name:______________________ DOB:______________________
Child's Name:______________________ DOB:______________________
Child's Name:______________________ DOB:______________________
Child's Name:______________________ DOB:______________________
Child's Name:______________________ DOB:______________________
Child's Name:______________________ DOB:______________________

In addition, in the event that I cannot be contacted or am unable to attend the appointment, I hereby give my permission to the following individuals or institutions to consent to medical treatment of the above named children. I am aware that protected patient health information may be shared with these individuals to facilitate informed decision making.

Name of Individual:______________________ Relationship:__________
Name of Individual:______________________ Relationship:__________
Name of Individual:______________________ Relationship:__________
Name of Individual:______________________ Relationship:__________
Name of Individual:______________________ Relationship:__________
Name of Institution:______________________ Relationship:__________

In the event a family member or friend attends my child's office visit and is in the exam room at the time or his/her evaluation and /or treatment, I give Dr. Gold and her staff, my permission to discuss freely my child's condition, treatment, or diagnosis in the presence of that person.

Parent of Guardian Signature:_________________________ **Date:**__________

GOLD PEDIATRICS

OFFICE AND FINANCIAL POLICY

Appointments

WE DO NOT SEE PATIENTS FOR ANY TYPE OF MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INJURIES.

1. You are required to bring proper identification and a current insurance card to all appointments. NO EXCEPTIONS.
2. We require 24 hours advance notice if you are unable to keep your scheduled appointment. If you do not give notice or notify us less than 24 hours prior to your appointment then it will be listed as a no-show. A $30 no-show fee may be applied to your account for EACH missed appointment. After three no-shows in a twelve month period you will be dismissed from this practice. The total number of no-shows count for all of your children. We will request that you find another doctor.
3. If you are more than 15 minutes late for your appointment it may be necessary to reschedule.
4. All appointments must be scheduled. We do not accept walk-ins. If you do walk in without an appointment, you may be asked to schedule the appointment for a later time or may have to wait until the provider has seen her scheduled patients.

Payment

1. Payment is required in full at time of service. This includes co-payment, deductables and coinsurance for participating insurance companies, full payment for self-pay patients, outstanding balances, and full payment if we do not participate in your insurance plan.
2. Gold Pediatrics accepts cash, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Checks will not be accepted.

Insurance

1. It is your responsibility to provide us with current insurance information and to present an active insurance card at each visit. It is your responsibility to notify us if your insurance changes. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement. If you are unable to pay for the visit, you may be asked to reschedule. We do our best to obtain benefit information from your insurance, but we have limited access due to the multiple plans available to each insurance carrier. Additionally, they advise us that the information they give us is not a guarantee of benefits. **It is your responsibility to understand your coverage and benefits, including if we are in network with your plan.**
2. If your plan requires, you must designate Dr. Stephanie Gold as your primary care provider prior to your scheduled appointment. If Dr. Gold is not named as your primary care physician you will be asked to reschedule your appointment or you will be financially responsible for the visit.
3. We will gladly submit fees for your covered medical services to your insurance company. **It may become necessary for you to pay your account in full if your insurance company fails**

to pay for services within 30 days, or if they deny the claim. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We must emphasize that as medical providers, our relationship is with you, not your insurance company.

Referrals

1. Advanced notice is required for all non-emergent referrals. Please allow 5 business days to complete the referral.
2. It is your responsibility to know if a selected specialist participates in your insurance plan.

Prescription Refills

1. We require 48 hours advance notice for all prescription refills.
2. Dr. Gold is responsible for all controlled substance prescriptions written. If you have a prescription that has expired or is not going to be filled, then you must return it to Dr. Gold.
3. There is a $10 fee for providing a new prescription if a controlled substance prescription has been lost or damaged.

Medical Records

1. Gold Pediatrics will provide you with a copy of your child's medical record for a fee of $25.
2. Please allow us 5 business days to complete your request.
3. We will only provide records for visits rendered at Gold Pediatrics (including consultations from specialists received while a patient of Gold Pediatrics).
4. There is a fee of $15 for completion of FMLA forms and $10 for school/sports/camp physical forms that are not brought in at the time of the visit.

Conduct

1. It is our responsibility as adults to serve as good role models for our children. Gold Pediatrics will not tolerate inappropriate language, yelling, name-calling or temper tantrums from any adult. If you are unable to act in an appropriate manner you will be asked to leave the office immediately and may be dismissed from our practice.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

I have been offered the HIPPA Notice of Privacy Practices which outlines my privacy rights and how Gold Pediatrics may use and disclose Protected Health Information about my child.

By providing Gold Pediatrics my phone number I consent for Gold Pediatrics to contact me regarding my child(s) condition, course of treatment, lab results, and appointment reminders. I understand that this consent may be revoked at any time by notifying Gold Pediatrics in writing.

Patient Name (s): ______________________________ **Date:** ___________________________

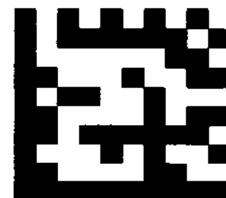
Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)

Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth ___/___/____ *Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**