AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

CEDAR PARK
1301 Medical Parkway, Suite 310
Cedar Park, TX 78613

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guarantee has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education. **Test results will not be discussed over the phone.**

I have the legal right to consent to medical treatment because I am the patient, or I am the parent/guardian of the patient.
All references to "patient," "me," and "my" in this document means: *_____(name of patient).

Electronic Medical Records

Your child's records are shared with their primary care provider to allow and promote continuity of care. Your child's records will not be released to anyone else without your express consent.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows heath care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/ patient relationship exists.

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting.

I acknowledge that I have received a HIPAA Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact us at 512-472-6134.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Name of Patient: * _____

Patient's Date of Birth (MM/DD/YYYY): * _____

Signature of Patient (or responsible party if a minor): *_____

Date: * _____

This page intentionally left blank

AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

CEDAR PARK
1301 Medical Pkwy., Suite 310
Cedar Park, Texas 78613

Phone: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

Past Medical History

Patient Name: * _____

Date of Birth: * _____

Medications

Current medications: * _____

Allergies

List all known allergies (medications, foods, or environmental): * _____

Previous Hospitalization(s): *Symptom & Date*

* _____

Previous Surgeries: *Procedure & Date*

* _____

Has your child had any blood transfusions? **No** ____ **Yes** ____

Has your child been circumcised? **No** ____ **Yes** ____ When? _____

Medical Conditions/Problems

*Please list any other known medical issues:

_____

Reason for today's visit: * _____

Has your child had any lab test or x-rays for this problem? **No** ____ **Yes** ____

If YES which test, when and where were they performed? _____

_____

Does your child follow any specialist(s)? If yes, please list them:_____

_____

Pharmacy Name: * _____ Pharmacy Address:* _____

Questions for Prenatal Only

When is your Due Date? _____ Who will be the Baby's PCP? _____

Who is your Obstetrician? _____Which Hospital will you deliver?_____

AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, Texas 78723
CEDAR PARK
1301 Medical Pkwy., Suite 310
Cedar Park, Texas 78613
Phone: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

Past Medical History

Social History

Parent 1 occupation: * _____

Parent 2 occupation: _____

Please list names and ages of siblings:

_____

_____

_____

Who lives in the Household? _____

Child's daytime activities

Home	**No** ____	**Yes** ____
Daycare	**No** ____	**Yes** ____
Recreation/Sports	**No** ____	**Yes** ____

List sports: _____

Birth History

Illness during the pregnancy of this child:

No ____ **Yes** ___ Explain: _____

Medications taken during pregnancy:

No ____ **Yes** ___ Explain: _____

Delivery: **Full Term** _____

Pre-Term _____ # of weeks _____

Late: _____

Problems during delivery:

No ____ **Yes** ____ Explain: _____

_____

Family history

Please list any family members (parent, sibling, grandparent, or other relatives) who have had any of the following medical conditions:

Bleeding Disorder	No ____	Yes ____	If yes, relation: _____
Anesthesia Complication	No ____	Yes ____	If yes, relation: _____
Kidney Failure	No ____	Yes ____	If yes, relation: _____
Kidney Stones	No ____	Yes ____	If yes, relation: _____
UTI	No ____	Yes ____	If yes, relation: _____
Hydronephrosis "extra urine in kidney"	No ____	Yes ____	If yes, relation: _____
Hypospadias "urine opening too low"	No ____	Yes ____	If yes, relation: _____
Diabetes	No ____	Yes ____	If yes, relation: _____
Hypertension	No ____	Yes ____	If yes, relation: _____
Vesicoureteral Reflux	No ____	Yes ____	If yes, relation: _____
Other	No ____	Yes ____	If yes, relation: _____

Patient Past Medical History

Ear/Eye Problems	No ___Yes ___	Nose/Sinus/Throat Problems	No ___Yes ___
Seizures	No____Yes ___	Headaches/Dizziness	No ___Yes ___
Heart Problems/Murmurs	No___Yes___	Asthma/Bronchitis	No ___Yes ___
Pneumonia	No ___Yes ___	Stomach Problems	No___ Yes___
Diarrhea/Constipation	No___Yes___	Bleeding/Clotting Problems	No____Yes ___
Frequent Nosebleeds/Bruising	No____Yes____	Sickle Cell diseaseTraitG6PD	No____Yes___
Anesthesia Problems	No ___Yes ___	Cancers	No ____Yes ___
Diabetes	No ___Yes ___	Behavioral/Emotional Problems	No ____Yes ___
Developmental Problems	No ___Yes ___	School Problems	No ___Yes ___
Psychiatric Problems	No ___Yes ___	Muscle/Bone Problems	No ___Yes ___

Name of Patient: * _____

Signature of Patient (or responsible party if a minor): * _____

Date: * _____

AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

CEDAR PARK
1301 Medical Pkwy, Suite 310
Cedar Park, TX 78613

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

Patient Information

Patient

Last Name: * _____ First Name: * _____ Nickname: _____

Date of Birth: * _____ Patient SSN: _____ Gender: * Male ____ Female ____ Non-binary ____

Race: American Indian or Alaskan Native ____ Asian ____ Black or African American ____ Native Hawaiian or other Pacific Islander ____ White ____

Other: _____ Decline: ____

Ethnicity: Hispanic/Latin ____ Not Hispanic/Latin ____ Other: _____ Decline: ____

Who referred you? (Please CHECK one) FAMILY ____ FRIEND ____ PHYSICIAN REFERRAL ____ WEBSITE ____

Person referring you: _____ Primary Care Doctor: * _____ Phone: * _____

In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient.

NAME: * _____ **RELATIONSHIP: *** _____

NAME: _____ **RELATIONSHIP:** _____

Parent 1

Last Name: * _____ First Name:* _____ DOB: * _____ Social Security #: * _____

Street Address:* _____ City: * _____ State: * ____ Zip: * _____

Cell Phone: * _____ Secondary Phone: * _____ Email: * _____

*Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

Parent 2

Last Name: _____ First Name: _____ DOB: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Secondary Phone: _____ Email: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

Emergency Contact

Last Name: * _____ First Name: * _____ Relation: * _____

Cell Phone: * _____ Secondary Phone: * _____

Primary Insurance

Policy Holder

Last Name: * _____ First Name: * _____ Policy Holder's Birth Date: * _____

Insurance Provider: * _____ Insurance ID Number: * _____ Group Number: * _____

Provider Phone Number (from insurance card): * _____ Policy Holder's SSN: * _____ Relation to Patient: * _____

Secondary Insurance

Policy Holder

Last Name: _____ First Name: _____ Policy Holder's Birth Date: _____

Insurance Provider: _____ Insurance ID Number: _____ Group Number: _____

Provider Phone Number (from insurance card): _____ Policy Holder's SSN: _____ Relation to Patient: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER(S) - (Check all that apply)

___**HOME TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**WORK TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**MOBILE TELEPHONE**
- ___OK to leave message with detailed information
- ___Leave message with call-back number only

___**WRITTEN COMMUNICATION**
- ___OK to mail to home address

___**PATIENT PORTAL**

Email: * _____

PLEASE INITIAL

*____ I acknowledge I have reviewed the HIPAA Notice of Privacy Practices policy at childrensurology.com. This can be found at: childrensurology.com/Patient Information/Forms & Information/HIPAA Notice of Privacy Practices.

I hereby give authorization for payment of insurance benefits to be made directly to Pediatrix Urology of Central Texas for services rendered.
I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

Name of Patient: * _____

Signature of Patient (or responsible party if a minor): * _____ Date: * _____

pediatrix
UROLOGY OF CENTRAL TEXAS

PaTIenT FINANCIAL POLICY

PATIENT NAME: * _____ **PATIENT DATE OF BIRTH:*** _____

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 staff. 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.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. For your convenience we accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

Insurance (PLEASE INITIAL)

* ____ Insurance plans subject to a deductible will be charged $150 at Check-In and the balance collected at Check-Out.

* ___ I acknowledge that I have disclosed all insurance coverages. My primary insurance will not pay the claim(s) if they suspect other insurance coverage.

* ____ We have contracted with many insurers and health plans to accept assignment of benefits. This means we will bill those plans and will only require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service.

* _____ It is the responsibility of the guarantor to know the benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **IF YOU DO NOT HAVE A CURRENT REFERRAL OR AUTHORIZATION ON FILE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.**

* _____ In the event 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.

* _____ Surgery deposits are due 10 business days prior to surgery. If for any reason surgery needs to be canceled it must be done 10 business days prior to the surgery date or a **$150 cancellation fee** may be charged to the parents.

seLF-PaY PaTIenTs

* _____ If you do not have insurance you will be considered a self-pay patient. Before seeing the doctor you need to make a deposit of **$150.** If the ENTIRE account is paid in FULL we will apply a 30% discount to your account. If you are unable to pay the entire account in full you will not receive the 30% discount. You will also need to make payment arrangements at CHECK-OUT with a credit card to pay the balance in full within **3 months.**

* _____ We use a billing service. For any billing questions call 512-600-0125 for assistance.

* _____ Telemedicine fees are $175 for new patients and $150 for established patients.

We accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

ESTIMATES

* _____ Upon request, our staff provides an estimate of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider.

FEES

* _____ I understand that in the opinion of our Providers, the services or items that I have requested to be provided to me at Pediatrix Urology of Central Texas may not be covered under my insurance as being reasonable and medically necessary for my care. I understand my health insurance plan determines the medical necessity of the services or items I request and receive. If my plan determines these services and/or items are not reasonable and medically necessary for my care, I am responsible for payment for the services or items I received.

* _____ I understand lab work is sent to a reference lab. Pediatrix Urology of Central Texas will provide the reference lab your insurance information necessary to submit a claim. Any charges incurred are my responsibility to pay.

* _____ **FEES FOR FORM COMPLETION:**
I understand I will be responsible for paying **$25** for forms completed by my physician or staff (Example: Disability forms, FMLA forms, etc.). There is a **$50** fee for Immigration forms/ letters.

* _____ **FEES FOR "NO SHOW":**
I understand that a **$60** "no show" fee may be assessed for appointments that I do not keep.

I understand that a **$150** "no show" fee may be assessed for in-office procedure appointments and surgical center procedures that I do not keep.

Medicaid Members: No shows will be reported to your health plan.

* ____ **FEE FOR MEDICAL RECORDS: $25**

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.

name of patient* _____

signature of patient
or responsible party if a minor * _____ date * _____

AUSTIN
1301 Barbara Jordan Blvd, Suite 302
Austin, TX 78723

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

CEDAR PARK
1301 Medical Parkway, Suite 310
Cedar Park, TX 78613

PHONE: (512) 472-6134
FAX: (512) 472-2928
childrensurology.com

Policy for Divorced or Separated Parents

Pediatrix Urology of Central Texas providers and staff are dedicated to our patients and to providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, and psychological health. We are not party to or involved in any legal issues involving divorce, separation or custody agreements. Please read and sign the following so that we may provide care to your child(ren).

1. The physicians, nurses, medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments and office procedures **PRIOR** to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Pediatrix Urology of Central Texas must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treatment" form that authorizes any named individuals (grandparents, nannies etc.) to bring your child to our practice, be present during the visit, and consent to treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. We reserve the right to charge an administrative fee for copying records should the requests become excessive.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless required by law, or tolerate appointment scheduling/canceling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collections process will be due at the next time of service.
8. Should the issues that come between parents become disruptive to our clinic or there is non-compliance with this policy, we may immediately terminate the patient/provider relationship. Your PCP will be notified.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Please List Children - Name and Date of Birth (DOB):

Child's Name	DOB	Child's Name	DOB
Child's Name	DOB	Child's Name	DOB

Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date
Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date