Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

CHILDREN/PATIENT INFORMATION

1. Patient name:____

First *Middle* *Last*

Patient Date of Birth:________________________________ Preferred name:____________________

Child lives with ______ Mother ______ Father ______ Step-Mother ______ Step-Father ______ Other ______________________.

---

2. Patient name:____

First *Middle* *Last*

Patient Date of Birth:________________________________ Preferred name:____________________

Child lives with ______ Mother ______ Father ______ Step-Mother ______ Step-Father ______ Other ______________________.

---

3. Patient name:____

First *Middle* *Last*

Patient Date of Birth:________________________________ Preferred name:____________________

Child lives with ______ Mother ______ Father ______ Step-Mother ______ Step-Father ______ Other ______________________.

---

4. Patient name:____

First *Middle* *Last*

Patient Date of Birth:________________________________ Preferred name:____________________

Child lives with ______ Mother ______ Father ______ Step-Mother ______ Step-Father ______ Other ______________________.

PARENT/GUARDIAN INFORMATION

Custodial Parent/Guardian (where the child(ren) live(s))

Name:____

First *Middle* *Last*

Parent Date of Birth:________________________________ Preferred name:____________________

Spouse (Parent/Step-Parent) Name: ____

Mailing address:____

____

City *State* *zip*

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

Primary phone:____ Type:____________________

Secondary phone:____ Type:____________________

Email address:____

Employer: _____________________________ Occupation: ______________________ Phone:_______________

Other Parent/Guardian name:____

First *Middle* *Last*

Parent Date of Birth:________________________________ Preferred name:__________________

Spouse (Parent/Step-Parent) Name: ____

Mailing address (if different):____

____

City *State* *zip*

Primary phone:____ Type:____________________

Secondary phone:____ Type:____________________

Email address:____

Employer: _____________________________ Occupation: ______________________ Phone:_______________

EMERGENCY CONTACT INFORMATION

Emergency name:____

First *Middle* *Last*

Relationship to patient:____

Mailing address:____

____

City *State* *zip*

Primary phone:____ Type:____________________

Secondary phone:____ Type:____________________

Stonebridge Pediatrics

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

INSURANCE INFORMATION

Insurance subscriber name:____

First *Middle* *Last*

Insurance subscriber date of birth:____

Insurance subscriber social security number:____

****** please provide copy of insurance card to front desk receptionist at each visit******

AUTHORIZATION & CONSENT FOR MEDICAL TREATMENT

- I authorize the physicians of Stonebridge Pediatrics and their medical personnel, who are under their direct supervision, to provide all necessary medical treatments for my Child/Children

ASSIGNMENT OF FINANCIAL BENEFITS & PAYMENTS

- I have read and understand the Financial & Office Policies of Stonebridge Pediatrics, and I agree to abide by its guidelines which includes payments to be made to the physicians/healthcare providers of Stonebridge Pediatrics for any and all medical or surgical services rendered.
- I also understand that I am responsible for any balance payments for services provided by Stonebridge Pediatrics.
- I understand that if I am unable to resolve any financial balance that I may be reported to a collection agency and thus reported to all credit bureaus.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- I have reviewed Stonebridge Pediatrics Notice of Privacy Policies, which explains how my child/children's medical information will be used and disclosed.
- I understand that I can request a copy of this notice at any time. (may be viewed/printed on our website at any time)
- I understand that I have the right to review the notice prior to signing this consent.
- I have had the opportunity to receive and review the Notice of Privacy Policies of Stonebridge Pediatrics.

APPROVED HIPAA CONTACTS

Name:____ Relationship to patient:_________________________

Name:____ Relationship to patient:_________________________

Name:____ Relationship to patient:_________________________

Name:____ Relationship to patient:_________________________

CONSENT AND AGREEMENT

- I have carefully reviewed this document and fully agree to comply with the guidelines defined within the Authorization & Consent for Medical Treatment, Assignment of Financials Benefits & Payments, HIPAA Policy, and Approved HIPAA Contacts.
- The duration of this authorization is indefinite unless it is revoked in writing.
- I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

PARENT/GUARDIAN (GUARANTOR) NAME:____

SIGNATURE:____ **DATE:**_________________________________

OFFICE POLICIES

FIREARMS POLICY

- The physicians of Stonebridge Pediatrics respectfully ask that no guns be brought into our office.
- We have posted signs in compliance with the Texas State Codes 30.06 and 30.07.

Initial here:_________

VACCINATION POLICY

- The physicians of Stonebridge Pediatrics believe in the benefits of vaccinations as outlined by the CDC.
- We strongly suggest that vaccinations be given at the scheduled visits.
- We understand that parents may feel apprehensive about vaccinations, but please ask our physicians about each vaccine prior to a decision to delay or not give vaccinations.
- Our office policy of delaying vaccinations is **ALL REQUIRED VACCINATIONS MUST BE COMPLETED** by the 4 year checkup.

Initial here:_________

FINANCIAL AGREEMENT/INSURANCE

- It is the Parents/Guardians responsibility to notify the office of any address, phone, or insurance changes. The Parents/Guardians will be responsible for any service rendered where they have failed to provide current and correct Insurance information prior to being seen. Please be prepared to present your insurance cards at every visit.
- Parents are responsible to make sure we are in- network with your insurance carrier.
- Parents are responsible to check for coverage on procedures.
- Stonebridge Pediatrics files primary insurance only for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services, and deductibles are the responsibility of the patient and payable at the time of service. Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under an insurance plan that is "Out of Network", are financially responsible for all charges at the time of service or thereafter. In the event that payment for a service performed is erroneously denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the two. It is also the responsibility of the patient to be aware of plan benefits and your right to appeal claims. Insurance contracts are subject to change. Online provider directories produced by Managed Care Plans may not provide the most current information regarding plan participation and therefore are not a guarantee of coverage.

Initial here:_________

COPAYMENTS/DEDUCTIBLES/BALANCES

- Payment is required at the time services are rendered. Insurance co-payments are due at each and every visit. Please note that we are required by the insurance company to collect co-payments. If your insurance plan has a deductible and it has not been met for the year, you may be required to pay for the visit in full. If your insurance does not pay for services provided, payment will be required for those services.
- For families in which parents are either separated and/or divorced, the parent bringing the child to the office is authorizing treatment and is, therefore , the parent responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request.
- Any past balances will require payment prior to being seen for your current appointment. We understand that sometimes those balances can be larger than expected. We can make payment agreements with you at your request.
- There is a $30.00 fee for any returned checks.

Initial here:__________

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

APPOINTMENTS/NO SHOW FEES

- We see patients by appointment only. If you are more than 15 minutes late for your appointment, you will be asked to reschedule. As a courtesy, we will attempt to contact you to remind you of your appointment; however, it is your responsibility to arrive for the appointment on time. If you cannot keep an appointment, please call at least 24 hours in advance.
- If you have scheduled a well appointment for your child and they are sick at the time of the appointment, some Doctors will require your child to be seen for a sick visit and the well visit will be rescheduled or combined. This applies to any conditions (I.e. ADHD/Behavioral visits) that requires more than a reasonable amount of time for the physician to effectively manage the condition, those appointments are separate. This is a requirement of your insurance company.
- If you miss a scheduled well visit or cancel less than 24 hours, there will be a no show charge of $25.00.
- If you miss a scheduled ADHD/Behavioral visit or cancel less than 24 hours, there will be a no show charge of $100.00. This fee must be paid before refills will be given.

Initial here:__________

MEDICAL RECORDS/FORMS

- There will be a charge of $25.00 per child for copies of medical records, and/or FMLA paperwork. Please allow 15 business days for copies to be prepared.
- There is no charge for physician completion of appropriate forms. Please allow 5-7 business days for forms to be completed.
- In order for sports physical forms to be completed, we require that you have a current well visit from our office. If your well visit is not current, we cannot fill out sports physical forms even if you have been seen in our office for sick visits.

Initial here:___________

PRESCRIPTION REQUESTS

- Antibiotics will not be prescribed over the phone, If you feel your child might need an antibiotics, they will need to be seen by a physician.
- If your child is an established patient and has a chronic but stable medical condition requiring ongoing medication, you may request refills over the phone if they have been seen for the condition in the last 6 months. This does not uniformly apply to ADHD refills. The physician will advise you when the next visit will be required. If you fail to scheduled or be seen during the follow up time frame, a refill may not be filled.
- All refill requests will be processed within 48 business hours, at the discretion of the prescribing physician. For Controlled substances, you will be notified via phone when your prescription is ready.

Initial here:____________

REFERRAL REQUESTS

- If we refer you to a specialist and your insurance requires a referral, we must have 7-10 days advance notice of the appointment date to secure your referral. We follow insurance company rules to refer to specialists. It is the Parents/Guardians responsibility to make sure we have all the necessary information to make the referral.
- If you call requesting a referral for a specialist we may require you to come in for a visit before that referral is made.

Initial here:_____________

AFTER HOUR CALLS

- If there is an emergency, call 911 or take your child to the nearest hospital emergency room.
- After-hours coverage is intended for urgent medical problems only. For questions about appointments, billing, referrals, or other issues of a non-urgent nature, please wait until the next business day.
- For after hours Nurse triage calls, there will be a charge of $20.00 per phone call.

Initial here:_____________

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

***By signing this document you are acknowledging that you have read, understand, and initialed each section of our office policies. ***

PARENT/GUARDIAN (GUARANTOR) NAME:____

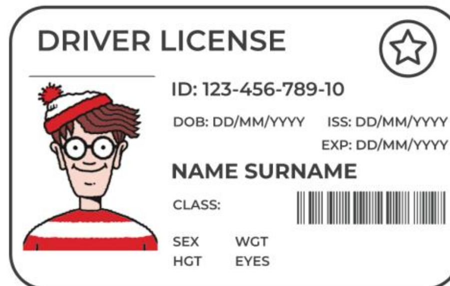
SIGNATURE:____ **DATE:**__________________________________

We would like to know how you heard about our office: ____

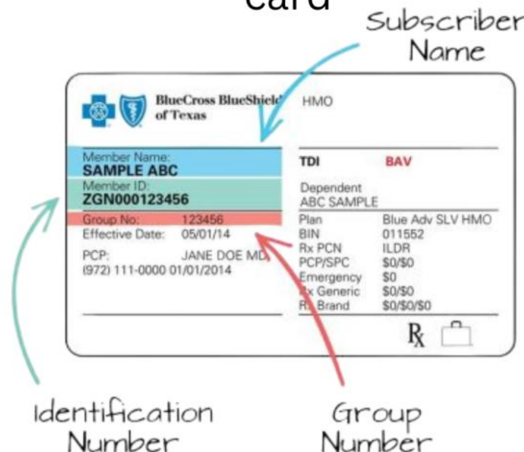
THANK YOU AND WELCOME TO STONEBRIDGE PEDIATRICS!!

PLEASE EMAIL AN IMAGE OF YOUR DRIVERS LICENSE & FRONT AND BACK OF YOUR INSURANCE CARD TO:

mailto:forms@stonebridgepediatrics.net



Please submit the FRONT & BACK of your insurance card



Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

Consent for Medical Care

(*This form is consent for someone other than a parent/legal guardian to bring your child for their appointment*)

I,_________________________________(parent/legal guardian), cannot accompany my child,___________________________(child's name), to Stonebridge Pediatrics. Therefore, I give permission to ____(person's name& relation -example: Step-parent, grandparent, relative, or someone over the age of 18.). ___________________________________(relationship to child) as follows (check one):

[ ] I give permission for this person to seek medical treatment (including any type of procedure, vaccinations/injections, or in office treatments) and provide consent for such treatment if attempts to contact me are unsuccessful.

[ ] I give permission for this person to seek medical treatment (including any type of procedure, vaccination/injections, or in office treatments) and provide consent for such treatment without having to contact me.

[ ] I give permission to speak with ____in regards to all medical diagnosis and treatments.

Please note this consent does NOT have an expiration date. If at any time you wish to revoke privileges for any individual, you must do so in writing to our office immediately. If you wish to have this person listed as short term, please include an expiration date in the space below. (Effective date must be completed.)

Effective Date:____________________________ / Expiration Date:___________________.

.____.
(Signature of parent or legal guardian) (Date)

Jeffrey J. Alvis, M.D., F.A.A.P.
Kathleen B. Dollins, M.D., F.A.A.P.
Yvette D. Cebrian, M.D. F.A.A.P.

Stonebridge Pediatrics
5561 Virginia Parkway Ste. 100
McKinney, TX 75071
214-544-2555 (P)
214-544-2550 (F)

I hereby request that my medical record to be released

Record request from:____

Address:_______________________________ City:___________________ State:______

Phone:___________________________ Fax:_______________________________

Patient{s} name:_______________________ DOB:_______________

_______________________ DOB:_______________

_______________________ DOB:_______________

Please check the following:

_____ Entire medical records _____ Growth Chart & Test results

_____ Immunization records _____ Other:_____________________

As guardian of the patient named above, I give permission to release all medical, mental, and social information to the facility listed. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Parent Printed Name:_________________________

Parent Signature:_____________________________ Date:___________