

# Hometown Pediatrics

## PATIENT INFORMATION

(Please Print Clearly)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: (circle) Male Female

Social Security #: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Cell Phone #: \_\_\_\_\_ Mother's Cell Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

## **Emergency Contact**

(Other Than Listed Above)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

## **Insurance Information**

Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults, lab work and other tests according to your managed care guidelines. However, our office deals with many different plans and **it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.** Please verify their participation **BEFORE** services are rendered to receive network benefits from your insurance company.

Primary Insurance	Secondary Insurance
Policy Holder: _____	Policy Holder: _____
DOB: _____ SS#: _____	DOB: _____ SS#: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insurance Company: _____	Insurance Company: _____
Address: _____	Address: _____
Phone #: _____ Effective Date: _____	Phone #: _____ Effective Date: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____

\*\*Whom may we thank for referring you to Hometown Pediatrics? \_\_\_\_\_

By signing below, I hereby authorize Hometown Pediatrics to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your child's care. I have read and understand the Hometown Pediatrics Financial Policy.

Parent/Guardian Printed Name: \_\_\_\_\_ Signature: **X** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_ rev 6/11

# Hometown Pediatrics

## FINANCIAL POLICY

Welcome and thank you for choosing Hometown Pediatrics for the medical needs of your child. We are dedicated to providing the best possible care for your child, and we want you to completely understand our financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible.

**Appointments:** Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

**Self-pay Accounts:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

**Co-pays:** The patient is expected to present an insurance card at each visit. All co-payments and past-due balances are due and payable at the time of service.

**Insurance:** If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is basically a contract between you and your insurance company. Not all insurance plans cover all services.

In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges.

Payment is due upon receipt of a statement from our office within 30 days.

**Referrals:** It is the responsibility of the patient to know their insurance plan's procedures for referrals. If your plan requires a referral, it will be necessary for you to inform us of that prior to you scheduling an appointment with a specialist. We kindly ask that you notify our office 5 (five) business days prior to non-urgent referral visits.

**Late Arrival:** As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are **more than 20 minutes late**, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

**No-Shows or Missed Appointments:** When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. **If an appointment is missed without 24-hours prior notice, you will be charged a \$25.00 fee.** This includes appointments made on the same day or on the day prior. This fee is not payable by your insurance company and will be your responsibility.

**Child Custody/Divorce Cases:** This office will not bill a divorced spouse for the patient's service. It will be the responsibility of the parent or guardian that brings the child in for all co-pays, deductibles or balances. It is the parents' obligation to work out agreement themselves or through the court system.

**Late Fee Charge:** The office reserves the right to charge a 1.5% late fee on all unpaid balances that are 60+ days overdue. This will accumulate on balances only until paid in full.

**I have read, understand and agree to the above Hometown Pediatrics Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.**

Parent/Guardian Printed Name: \_\_\_\_\_ Signature: X \_\_\_\_\_

Date: \_\_\_\_\_ Name of Patient: \_\_\_\_\_ Patient d.o.b.: \_\_\_\_\_

# Hometown Pediatrics

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

I, \_\_\_\_\_, understand that as part of my child's healthcare, Hometown Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Hometown Pediatrics' *Notice of Information Practices* which is available for review upon request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Hometown 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 taken 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 Hometown Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hometown Pediatrics change their notice, I will be notified of such.

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

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I understand that as part of this organization's treatment, payment or healthcare 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 disclosure via fax.

**I fully understand and accept the terms of this consent. Signature:** X \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Relationship to patient:** (circle one) **Father Mother Guardian**

**Date:** \_\_\_\_\_ **Name of Patient:** \_\_\_\_\_ **Patient d.o.b.:** \_\_\_\_\_

# Hometown Pediatrics

## PEDIATRIC HISTORY

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Allergies to Meds \_\_\_\_\_

Pregnancy Complications		
<i>(check Yes or No)</i>	<u>Yes</u>	<u>No</u>
Pregnancy less than 9 months	_____	_____
High blood pressure	_____	_____
Gestational diabetes	_____	_____
Medications <i>(if yes, list)</i>	_____	_____
_____		
_____		
<i>(check Yes or No)</i>	<u>Yes</u>	<u>No</u>
Bleeding <i>(if yes, which month)</i>	_____	_____
Serious illnesses	_____	_____
Serious infections	_____	_____
Previous miscarriages	_____	_____
C-section <i>(if yes, why?)</i>	_____	_____
_____		

Birth History	
Place of birth:	_____
Birth weight:	_____ Length _____
Length of labor:	_____
Adopted:	No ___ Yes ___
Birth Problems	
<i>(check Yes or No)</i>	<u>Yes</u> <u>No</u>
Jaundice	_____
Breathing problems	_____
Antibiotics	_____
Other problems <i>(explain)</i>	_____
_____	
Breastfed:	_____ Formula fed _____

Developmental History	
At what AGE did your child...	School Problems? <u>Yes</u> <u>No</u>
Smile: _____	Roll over: _____
Walk alone: _____	Sit alone: _____
Bladder trained: _____	1st word with meaning: _____
Bowel trained: _____	Use 3 word sentence: _____
Ride tricycle: _____	Tie shoes: _____

Medications Child Takes Routinely:	Hospitalizations & Operations:
_____	1 _____ Date _____
_____	2 _____ Date _____
_____	3 _____ Date _____

Childhood Illnesses			
<i>(check Yes or No)</i>	<u>Yes</u>	<u>No</u>	<u>Date</u>
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Bed wetting	_____	_____	_____
Chickenpox	_____	_____	_____
Convulsions/epilepsy	_____	_____	_____
Diabetes	_____	_____	_____
Kidney disease	_____	_____	_____
Measles	_____	_____	_____
Meningitis	_____	_____	_____
Mumps	_____	_____	_____
Pneumonia	_____	_____	_____
Rheumatic fever	_____	_____	_____
Scarlet fever	_____	_____	_____
Sickle cell trait or disease	_____	_____	_____
Whooping cough	_____	_____	_____

Other Serious Illnesses	<u>Date(s)</u>
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

# Hometown Pediatrics

## PEDIATRIC HISTORY (Continued)

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Child's Family	Family History																																																																																																														
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**Notes:**

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# Hometown Pediatrics

1595 Lake Front Circle  
The Woodlands, TX 77380

(281) 292-8980 (Office)

(281) 292-8070 (Fax)

Kristie R. Chandler, MD, FAAP

Tony John, MD, FAAP

Mona A. Smith, MD, FAAP

Michael T. Wright, MD, FAAP

## Newborns

It is your responsibility to notify the subscriber's employer and insurance company of the birth of your child. This must be done before the patient is 30 days old.

If an appointment is made after the 30 days and your insurance company states that your child has not been added to your coverage, you will be responsible for the total balance.

If your plan is a Health Maintenance Organization (HMO), you likely will also be required to assign a "primary care physician" (PCP) to your child.

\_\_\_\_\_  
Newborn's Name (please print)

\_\_\_\_\_  
Newborn's Date of Birth

\_\_\_\_\_  
Newborn's Place of Birth

\_\_\_\_\_  
Parent or Guardian Printed Name

\_\_\_\_\_  
Relationship to Newborn

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date