Caring for Kids Pediatrics, PA

"That's What We Do"

PATIENT INTAKE FORM

Patient Name: _____ DOB: _____

SS# _____ Hm: _____ Cell: _____

Address: _____ Zip _____ Gender: M / F

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined Race: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Mail

Preferred Reminder Method: ☐ Phone ☐ Text

Preferred Language: _____

Parent/ Guardian Name: _____ DOB: _____

SS# _____ Relationship to Patient: _____

Parent/ Guardian Name: _____ DOB: _____

SS# _____ Phone#: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ (please furnish insurance card)

Policy Holder Name: _____ DOB: _____

Address (if different from above) _____

Relationship to Patient: _____

Secondary Insurance Name: _____ (please furnish insurance card)

Policy Holder Name: _____ DOB: _____

Address (if different from above) _____

Relationship to Patient: _____

Emergency Contact Name: _____ Phone#: _____

Relationship to Patient: _____

Financial Policy

Welcome to Caring for Kids Pediatrics, PA, specializing in the care of your children. Please take time to read the following financial policies. We ask that you read and sign this financial acknowledgement prior to any treatment. Please keep a copy of this document for future reference.

Insurance:

Prior to your child's visit we will attempt to verify eligibility and benefits with your insurance carrier. Please bring your child's insurance card to each appointment. Failure to do so may result in cancellation of the appointment. You are responsible for any co-payment required by your insurance carrier prior to services being rendered. You are also responsible for any deductibles or non-covered services, as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement.

Credit Card/Check Policy:

MasterCard, Visa, Discover, American Express and Personal checks are accepted for services rendered. Your credit card/bank account will be charged at the time of service. A $25.00 charge will be added to your account for any check returned by your bank for any reason.

No Insurance:

Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our office.

Medical Records:

We will provide a copy of your medical records upon request. You will need to sign a letter of release prior to pick-up. Please allow 7-10 business days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record.

Disability/Insurance, FMLA, Copy of Immunization Record, and Sports Physical Forms:

There will be a charge of $10.00-$35.00 for the completion of medical forms. You will be informed of the exact cost prior to completion of each form. Payment is due at the time of pick up. Please allow 7-10 business days for the completion of these forms. If you would like these forms mailed to you or your insurance company, payment will be due prior to mailing. Certain forms cannot be faxed.

Please review the following statements regarding Assignment of Benefits:

- Co-pays and non-covered service amounts are due at time of service.
- The Office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts.
- I authorize the release of any medical information necessary to process the applicable claim(s).
- I authorize payment of medical and surgical benefits to Caring for Kids Pediatrics, PA.
- A copy of this document shall be valid as the original.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

_____ _____

Parent or Legal Guardian Signature **Date**

_____ _____

Printed Name of Parent/Guardian **Patient Name and Date of Birth**

Caring For Kids Pediatrics, P. A.

10407 State Hwy 151, San Antonio, TX 78251

12510 Bandera Road, Suite 103, Helotes, TX 78023

(210) 877-5600 Office/ (210) 877-5601 Fax

Patient's Name:_____

Payment Policy

MEDICAID: We are participating providers of the Medicaid Program. We will accept assignment on all claims. Patients are responsible for maintaining their Medicaid benefits to receive care. However, in the event Medicaid eligibility has lapsed, patients will be responsible for the balance billed.

HMO/PPO OR OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered procedures or immunizations.

NOTE: We do file with secondary/supplemental carriers.

****Responsible Party Signature****:_____Date:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled, including Private Insurance, Medicaid and any other health plan to Caring for Kids Pediatrics, P. A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless limited by contract. I hereby authorize said assignee to release all information necessary to secure the payment for services rendered. And should a credit balance for said patient, due to payment from the above mentioned insurance(s) health plan(s) result; this amount may be applied to any other outstanding balance(s) owed the family by the insured or their family members.

All contractual co-payments are due at the time of service. Please let us know in advance if this is a problem, so that we may set up timely payment arrangements. Please note your company's procedures, particularly those regarding deductibles/referrals/co-payments.

I, the undersigned, certify that I have read the foregoing information and am duly authorizing as patient/parent or legal guardian that all services deemed necessary may be executed.

_____ _____

Printed Name of Parent/Legal Guardian | Parent or Legal Guardian Signature | Date

Clinic Information

Welcome to Caring for Kids Pediatrics, PA, specializing in the care of your children. Please take time to read the following information so that you can become familiar with your new clinic. Please keep this document for future reference.

Making Appointments:
We are eagerly scheduling appointments Monday through Friday from 8:00am to 5:00pm. For your convenience we also open on Saturdays from 8:30am to 12:00pm. Please call 877-5600 to schedule your appointment today.

Same Day Visits:
We will try to schedule same day visits for your child. We ask that you call our office prior to coming in. You may be given an appointment time or placed on a waiting list pending cancellations. We will make every effort to take care of your child as soon as possible. Unfortunately, walk-in visits are not allowed.

Your Appointment:
Please arrive before your scheduled appointment to allow time to complete any required registration forms. Bring your insurance card to every appointment. We will verify your insurance and personal information at each visit. You will be allowed a ten (10) minute grace period for being late after which you will be given the opportunity to reschedule or wait for cancellations.

Preventative Well Child Exam:
Includes a general exam, vital signs as well as a vision and hearing screening. Additionally, depending on age, hemoglobin/lead may be tested along with a developmental screening known as MCHAT. **Any other additional findings, complaints and or issues addressed during a Preventative Well Child Exam will be subject to an office visit. Co-payments and/or deductible as required by insurance coding and billing guidelines will apply.**

Canceled Appointments:
If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule. Doing so enables us to use your appointment slot for another patient. This policy benefits you and others. Unfortunately, if you fail to make an appointment, without calling to cancel, you will be considered a "No Show". Repeated "No Show" appointments will result in dismissal from the clinic.

Medications:
Your prescriptions will be written at the time of your office visit. Refill request may be made through your pharmacy. Please be aware that for certain illnesses your refill may require an appointment. We will not prescribe any medications based on telephone consults. If this is an emergency medication please follow our Emergency Care instructions.

Emergency Care:
If your child has a life-threatening emergency, call 911. For minor emergencies and common illnesses call our office during regular business hours. After hours, feel free to call Methodist Children's Call-A-Nurse at 226-8773. For urgent (after hours) medical advice you may also call the clinic at 877-5600. If you must go to an emergency room we advise using a Children's Emergency Center such as Christus Santa Rosa or Methodist Children's.

Waiting Room:
Please do not bring food our drinks into the clinic. We are attempting to maintain a sanitary office. Eating or drinking in the clinic may put you or your child at risk for acquiring infection. Our staff is instructed to inform you of this policy. Baby bottles are permitted.

Printed Name of Parent/Legal Guardian _____ Parent or Legal Guardian Signature _____ Date _____

Notice of Privacy Practices

I, the undersigned, do hereby confirm that I have been given access to and have received a copy of Caring for Kids Pediatrics, PA HIPAA Notice of Privacy Practices. I understand that I am entitled to receive a copy of this document.

Printed Name of Parent/Legal Guardian | Parent or Legal Guardian Signature | Date

Consent for Treatment

I, the undersigned, state that I am the legal custodial parent or legal guardian of the child named below and do hereby agree and give my consent for Caring for Kids Pediatrics, PA to furnish medical care, to treat the child, and to have his digital image recorded.

Child's Name | DOB

In addition, I give permission for the persons designated below to bring my child to Caring for Kids Pediatrics for treatment, and acknowledge that this designation will remain in effect until I give written notice of any change in designee.

Name of Other Responsible Guardian | Relationship to Patient

Name of Other Responsible Guardian | Relationship to Patient

Consent for Release of Information

In addition, I give permission to Caring for Kids Pediatrics, PA to disclose medical and appointment information – in verbal electronic, and document form – from my child's medical record to the persons designated below:

Childs Name | DOB

Name of Other Responsible Guardian | Relationship to Patient

Name of Other Responsible Guardian | Relationship to Patient

Printed Name of Parent/Legal Guardian | Parent or Legal Guardian Signature | Date

Medical Records Release Form

In accordance with state law and regulatory aagency requirements, the health record is the property of Caring for Kids Pediatrics, PA. By signing this form, I authorize you to release confidential health information about me, in the form of a copy of my medical records, or a summary or narrative of my protected health information, to the person or entity listed below.

I hereby authorize the release of information from:

Physician Name:_____

Office name: _____

Address:_____

City/State/Zip:_____

Phone#:_____

Fax#:_____

To: Caring For Kids Pediatrics, PA
10407 State Highway 151
San Antonio, TX 78251

Caring For Kids Pediatrics, PA
12510 Bandera Road, Suite 103
Helotes, TX 78023

Office # (210) 877-5600, Fax # (210) 877-5601

Patient Information:

Patient Name: _____ Date of Birth: _____

Address/City/State/Zip: _____ Phone #:_____

Information to be released: Please provide items checked below.

___Complete Medical Record	___Problem List	___Consultations
___Progress Note	___X-ray Reports	___Immunizations
___Lab Reports	___History and Physical	___Mental Health Record
___Medication List	Other:_____	

_____ _____

****Signature of Parent, Guardian, or Patient's Legal Representative**** Date

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.