Ismaela Gomez DNP, APRN, CPNP, PMHS; Amy Long DNP, CPNP; Molly Cator, MSN, CPNP; Shaylon Rettig, MD

Patient Information

Full Name: _____ DOB: _____ Age: _____ Sex: M ☐ F ☐

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

Mother/Guardian: _____DOB: _____

Home Tele. #: _____Cell #: _____ Email: _____

Father/Guardian: _____DOB: _____

Home Tele. #: _____ Cell #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Tele. # _____

Insurance:

Insurance: _____ Name of Insured: _____ DOB: _____

Employer: _____

Policy #:_____Group #: _____ Social Security #: _____

Secondary Insurance: _____ Name of Insured: _____ DOB: _____

Employer: _____

Policy #: _____Group #: _____ Social Security #: _____

Medicaid: _____ Medicaid #: _____Self Pay: ☐

Assignment and Release:

I, the undersigned certify that (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to Premier Plus Pediatrics. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the providers to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Parents/Guardian Signature Date

Premier Pediatrics

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HIPAA Consent form

Due to any circumstances in the absence of the parent(s) I, (parent name) _____

_____give my permission for the following person(s) to authorize medical,

attention/decisions for my child/children (child name) _____.

1. Name_____Relationship_____Phone#_____
2. Name _____Relationship_____Phone#_____
3. Name _____Relationship_____Phone#_____
4. Name _____Relationship_____Phone#_____

Patient/Guardian Signature: _____ Date: _____

My signature below signifies that Premier Plus Pediatrics Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of the Premier Plus Pediatrics. The Notice of Privacy Practices for Premier Plus Pediatrics is also provided at the front desk. This Notice of Privacy Practices also describes my rights and Premier Plus Pediatrics duties with respect to my protected health information.

I consent to use Telehealth when appropriate ☐ yes ☐ No

Patient/Guardian Signature: _____ Date: _____

Premier Plus Pediatrics, PLLC | 1414 E. Walnut, Seguin, TX 78155
Tel: 830-491-5019 | **Fax:** 830-491-5109 | **Email:** Info@PremierPlusPediatrics.com
Web: PremierPlusPediatrics.com | **Facebook:** @PremierPlusPediatrics

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Patient Orientation and Financial Policy

Patient Name: _____ **DOB: _____**

Appointments:

- If you are **late** for your appointment, you may be asked to see another provider or reschedule.
- If you are unable to keep your appointment, we ask that you kindly call the office 24 hours in advance to cancel.
- Any scheduled appointment that results in a **missed appointment will result in a $25.00** missed appointment fee. A missed appointment is any appointment that is missed or not cancelled within 24 hours.
- We cannot see a minor patient without a parent or other responsible adult present.
- When your child turns 18 years of age, they are considered an adult and we cannot release any information without their written consent.
- **NEED TO ADD SOMETHING ABOUT APPOINTMENTS WITH BALANCE**

Insurance/Fees:

- **Co-pays are due at the time of visit**, deductible amounts can be set up as payment plans, and any balances from previous visits are due at the time of service.
- Please verify preventive care benefits with your insurance company including limitation, exclusions, and vaccine coverage.
- During your wellness visit if another problem or diagnosis is discovered, discussed, and treated there may be an additional charge.
- **Uninsured patients please see the Self-Pay section below.**
- You must present your insurance card at each visit and update your personal information (address, phone number, etc.) as soon as there is a change.

E-Prescribing:

- I authorize Premier Plus Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as this child is a patient at this office.

Referrals:

- Please allow 7-10 business days for a routine referral to be processed.
- If your insurance requires a referral to see a specialist, Premier Plus Pediatrics must be listed as your PCP and **you must be up to date on your well child appointments**.

After-Hours:

- We have a provider on call, 24 hours a day, to provide **emergency and urgent medical needs**. Please call the office at **830-491-5019** and follow instructions given.
- In South Texas region, **non-urgent medical questions** can be answered by calling **210-22-NURSE.**

Divorced/Separated Parents and Custodial Arrangements

- Premier Plus Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

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Self-pay Patients

- Estimated charges for your visit with one of our providers will be determined at the time of checkout. If there are any additional charges based on your type of visit you will be sent a statement for additional payment. If you have any questions, please call our office.

Patient/Guardian Conduct

- We have a **zero tolerance policy on disrespectful/dishonest or dangerous behavior**. If this policy is not followed, we have the right to refuse to continue patient/provider relationship and you will be asked to find another provider.

Well Child Visits

- The American Academy of Pediatrics recommends the following intervals for well child visits:
  - 3-5 days, 2 weeks, and then the following 2, 4, 6, 9, 12, 15, 18, 24, 30 months
  - Yearly starting at age 3 until age 18

ADHD or Mental Health Visits

- These **visits must be at least every 3 months once the patient is stable on medication**.
- While starting and changing medication, you must follow the providers requested follow up instructions.
- When requesting refills for controlled substances (ADHD medications), please **request at least one week prior to running out of medication** as these medications may require a prior authorization from the insurer.

Parent/Guardian Signature: _____ **Date:** _____

CONSENT FOR ELECTRONIC, VOICEMAIL COMMUNICATION

We use text services to inform of appointment reminders, important clinic updates and closures, etc. Voicemails may be used as above and to relay various lab or radiology results. Urgent medical information will not be relayed by voicemail. There are always risk of unintentional disclosure of information when using electronic communication and we ask that you password protect your phone and computer as we make every attempt to keep personal health information confidential.

Please initial one of the following:

_____ **I DO** consent to electronic communication. _____ **I DO NOT** consent to electronic communication.

Preferred Text Cell Number: _____

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Authorization for Release of Records

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

I authorize the release of medical information as indicated below:

FROM:	**TO:**
Name_____	Name Premier Plus Pediatrics
Address_____	Address 1414 E. Walnut
_____	Seguin, TX 78155
Phone_____	Phone 830-491-5019/ Fax: 830-491-5109

☐ I would like to pick up my records ☐ I would like my records mailed to address above

What to release: Please choose the records you would like to release-

☐ All Medical Records ☐ Immunization Records ☐ Laboratory Reports

☐ Other-Specify_____

The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDs, including HIV test ☐ Yes ☐ No/NA

The diagnosis or treatment of drug and/or alcohol abuse ☐ Yes ☐ No/NA

The treatment and/or consultation for mental health ☐ Yes ☐ No/NA

Purpose of release: Please check the reason for this release

☐ Continue patient care ☐ Moving ☐ Switching doctor's ☐ Personal use

☐ Use in law suit ☐ Follow-up related to an injury ☐ Other-specify _____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for _____ days

I understand this authorization can be revoked at any time to Premier Plus Pediatrics privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of the release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Premier Plus Pediatric and may potentially be re-disclosed by the party who received these records. Premier Plus Pediatrics, its employees and officers, and attending physicians are released for legal responsibility or liability for the above information to extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use of the protected health information under the above stated terms.

Signature of parent/legal guardian_____**Date**_____