LONE STAR PEDIATRICS PATIENT/FAMILY DEMOGRAPHICS

Child #1 Legal Name: _____ Date of Birth: _____
Preferred Name: _____ Assigned Gender at Birth: [ ] Male [ ] Female
Preferred Pronouns: [ ] He/Him [ ] She/Her [ ] They/Them

Child #2 Legal Name: _____ Date of Birth: _____
Preferred Name: _____ Assigned Gender at Birth: [ ] Male [ ] Female
Preferred Pronouns: [ ] He/Him [ ] She/Her [ ] They/Them

Child #3 Legal Name: _____ Date of Birth: _____
Preferred Name: _____ Assigned Gender at Birth: [ ] Male [ ] Female
Preferred Pronouns: [ ] He/Him [ ] She/Her [ ] They/Them

Child #4 Legal Name: _____ Date of Birth: _____
Preferred Name: _____ Assigned Gender at Birth: [ ] Male [ ] Female
Preferred Pronouns: [ ] He/Him [ ] She/Her [ ] They/Them

Child #5 Legal Name: _____ Date of Birth: _____
Preferred Name: _____ Assigned Gender at Birth: [ ] Male [ ] Female
Preferred Pronouns: [ ] He/Him [ ] She/Her [ ] They/Them

Parent/Guardian 1: _____ Date of Birth: _____

Home Address: _____ City/State/Zip: _____

Cell Phone: _____ Preferred Phone 2: _____

Email Address: _____

Parent/Guardian 2: _____ Date of Birth: _____

Home Address: _____ City/State/Zip: _____

Cell Phone: _____ Preferred Phone 2: _____

Email Address: _____

Please circle who is financially responsible for medical bills: Parent/Guardian 1 Parent/Guardian 2

Emergency Contact

Name: _____ Relationship: _____

Cell phone: _____ Alt. Phone: _____

Messages (unless requested otherwise, we only leave our name/phone and general message regarding appointments)
OK to leave a message (*please circle choices*): **Phone** **Work** **Email**

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LONE STAR PEDIATRICS DESIGNATED CONTACTS

Individuals allowed to bring your child to our office for evaluation and treatment.

Name: _____ Relationship: _____

Cell phone: _____ Alt. Phone: _____

Name: _____ Relationship: _____

Cell phone: _____ Alt. Phone: _____

Name: _____ Relationship: _____

Cell phone: _____ Alt. Phone: _____

Name: _____ Relationship: _____

Cell phone: _____ Alt. Phone: _____

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Lone Star Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent. By signing below, I certify that I have read and understand the HIPAA Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

We will not release your child's information to any other party unless requested by you in writing.

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child to the authorized individual(s) listed above. I understand that I can add or remove any individual from the Designated Contacts list.

_____ _____

Parent/Guardian Signature Date

LONE STAR PEDIATRICS INSURANCE & BILLING POLICY

We will need your assistance in providing us with necessary information and this information will be kept confidential and protected by federal law. Please understand that your information will be shared with insurance companies for the purpose of reimbursement and obtaining referrals/authorizations. If your child has any lab work done, this same information will be provided to the lab company as part of coordination of care.

Please note that the amount you pay for your office visit depends on several factors including: the type of visit that is scheduled (consultation/sick/well, etc.), whether you are a new patient or an established patient, the complexity of your visit, whether you had any testing or diagnostic/therapeutic procedures performed, and the doctor's examination (which will not always be known at checkout until the physician completes and signs-off on your child's medical chart). We will file claims with your insurance carrier if we are a participating provider with your policy. Any out-of-pocket expenses, copays, deductibles and coinsurance is the responsibility of the patient and is due at the time of service. If we are an out-of-network provider with your insurance carrier, then full payment will be due at the time services are rendered. A billing summary will be provided to you to submit a reimbursement claim. Often, the doctor will recommend that a diagnostic or therapeutic procedure be performed during a visit. The costs of these procedures are **separate and not included** in your office visit and may not always be covered by insurance. You can request an estimate of any service *prior to* a procedure being performed, however, once the procedure is completed, you are responsible for full payment.

We see patients for a variety of reasons, including behavioral, mental health, and attention/focus concerns. Please keep in mind that while you are being seen in a pediatrician's office, these benefits fall under "mental health" coverage, and your insurance company may not provide these benefits under your medical plan. We are happy to bill your insurance company for a visit to discuss the above issues, however, should they deny our claim because your policy does not include mental health coverage, you will become fully responsible for all bills, including any lab bills for bloodwork performed during the office visit.

Your insurance policy is an agreement between you and your insurance company. We will file your claims as a courtesy, but ultimately all medical charges are the responsibility of the guarantor. We cannot always be aware of the details of each insurance policy; therefore, please be sure you are aware of any exclusions/provisions with your plan. Any service not covered by your insurance company will be the responsibility of the guarantor. **Cost-share plans will be treated as cash pay, and you will be provided with a receipt to submit for reimbursement.**

As is the nature of medicine, not all charges can be known up front, and there may be occasions when you will receive an additional statement for services that were provided but not paid for at the time of service. Please be aware that two (2) statements will be sent from our office; after the second statement your account will be transferred to a soft-collections agency for further follow-up. You must bring all payments with you on the date of your appointment, or you will be asked to reschedule. If you have not visited our office in the last three (3) years you will be considered a new patient. You are expected to pay your bill in full when you receive it. If this is not possible, you may consider a payment plan. To do this, you must speak with the billing manager and sign a *Payment Plan Agreement* form in our office. This form must be signed prior to services being rendered. It will become a part of your child's permanent record.

Children's names: _____ _____

_____ _____

Parent Signature: _____ Date: _____

LONE STAR PEDIATRICS COORDINATION OF BENEFITS (COB)

This applies to patients with more than one insurance.

Coordination of benefits is the process insurance companies use to determine how to cover your medical expenses when you're covered by more than one health insurance plan. It clarifies who pays what by determining which plan is the primary payer and which is secondary. It also ensures proper claim processing and helps avoid overpayment or duplicate payments.

How does coordination of benefits work?

When a person has multiple insurance plans, COB rules determine the order in which the insurance plans will pay for covered services. The primary plan is responsible for processing the claim first and paying its share of the coverage amount. The secondary/tertiary plan would then review the claim and potentially pay the remaining balance within its coverage limits.

COB is determined by the insurance plans, not the policy holder, and as such all insurance policies need to be made aware of the others.

You, the parent or guardian, are responsible for calling all insurance policies to initiate the COB process.

Our office will not bill insurance on your behalf until we can confirm that COB has been completed, and the order in which to bill. For that reason, we are asking you to provide the call reference number from the person you spoke with at your insurance companies below:

1. Primary insurance: _____ Call-Ref#: _____
2. Secondary insurance: _____ Call-Ref#: _____
3. Tertiary insurance: _____ Call-Ref#: _____

All balances will be patient responsibility until the above call reference numbers are provided. All claims denied, either immediately or after an insurance review, will become patient responsibility. Our office will not become involved in coordination of benefits issues.

☐ **I, ONLY, have a primary insurance policy, and COB is not needed.**

Children's names: _____ _____

_____ _____

Parent Signature: _____ Date: _____

WELLNESS CARE ACCORDING TO THE AFFORDABLE CARE ACT

We would like to explain how we expect your insurance company to cover your wellness appointment. A well child exam is defined as an annual, routine physical exam and immunizations (if performed) to patients at no additional copay, deductible or coinsurance. These services are exceedingly limited and apply only to:

1. Evaluation of growth/milestones
2. Immunizations
3. Developmental screening
4. Dietary & lifestyle counselling

Depending on your age, gender, family history and other circumstances, we may suggest more extensive diagnostic or preventative testing and we want you to be mindful that some of these services may not be covered, or paid fully, by your insurance provider.

We find that many patients who come in for their wellness care visit also have additional medical conditions that they would like to address at the same time, some of these conditions are:

1. Fever
2. Stomach pain
3. Headache
4. Asthma
5. Sore throat/Reflux
6. Ear pain
7. Cough/congestion
8. Digestive issues
9. Allergies
10. Behavioral
11. Skin conditions
12. Specialist referrals

Assessing and treating new or existing medical concerns during a well child visit falls under "medical management" and is not part of a wellness exam as defined by the Affordable Care Act. We understand, however, that your time is valuable, and we strive, when time permits, to address your medical concerns along with your wellness exam. Please note, you will be billed for two visits on the same day and consequently, any additional concerns addressed (that do not fall within the parameters of a well child check) will require a copay, deductible or coinsurance payment.

PLEASE NOTE: Since the nature of behavioral evaluations tend to be lengthy, these issues will likely need to be discussed at an additional appointment. Your provider may require you to schedule a behavioral specific appointment at check-out and complete additional forms prior to your child's appointment.

Children's names: _____ _____

_____ _____

_____ _____

Parent/Guardian Signature Date