2022 Patient Demographic Form

Patient/Child Information

Child's Legal Name: __________________________________ Date of Birth__________________

Assigned Gender at Birth:_ □ Male □ Female Preferred Pronouns: __He/Him She/Her They/Them___________

Parent 1: ____ Date of Birth: __________________________

Home Address: ____ City, State, Zip_____________________________

Cell Phone: _________________________________ Preferred Phone 2:__________________________________

Email Address: ____

Parent 2: ____ Date of Birth: ____________________________

Home Address: ____ City, State, Zip____________________________

Cell Phone 1: _________________________________ Preferred Phone 2: __________________________________

Email Address: ____

Which parent is financially responsible for medical bills? ______________________________________

Primary Insurance Information

Primary Insurance: ___________________________________

Member ID: __________________________Group:_________

Subscriber Name: ____________________________________

Relationship to patient: ________________________________

Subscriber DOB: _____________________________________

Secondary Insurance Information

Secondary Insurance: _________________________________

Member ID: _______________________ Group: __________

Subscriber Name: ____________________________________

Relationship to patient: ________________________________

Subscriber DOB: _____________________________________

Pharmacy Information

Name: ______________________________________

Phone: ______________________________________

Address: ____________________________________

Fax: ____

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 detailed message at home/cell? □ YES □ NO Work? □ YES □ NO Email messages? □ YES □ NO

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.

____ ______________________________________

Parent/Guardian Signature Date

Child Health History Form

Child's Name:____ DOB: ___________
First Middle Last

Preferred Name

MEDICAL HISTORY

1. Has your child had any medical issues and/or hospitalizations (asthma, diabetes, etc.)? ☐ None

SURGICAL HISTORY

2. Has your child had any surgery (tubes, tonsils, appendicitis, etc.)? ☐ None

MEDICATION HISTORY

3. Is your child currently taking any **prescribed** medications? ☐ None

ALLERGIC TO MEDICATION HISTORY

4. Is your child allergic to any medications? ☐ None

FAMILY HISTORY

5. Are there any family medical concerns?

Family Member	Medical Problems
Mother:	☐ Anxiety ☐ Depression ☐ ADD/ADHD ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ IBS/Crohn's/Ulcerative Colitis ☐ Thyroid Issues Other: ______________________________
Father:	☐ Anxiety ☐ Depression ☐ ADD/ADHD ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ IBS/Crohn's/Ulcerative Colitis ☐ Thyroid Issues Other:______________________________
Sisters:	☐ Anxiety ☐ Depression ☐ ADD/ADHD ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ IBS/Crohn's/Ulcerative Colitis ☐ Thyroid Issues Other:______________________________
Brothers:	☐ Anxiety ☐ Depression ☐ ADD/ADHD ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ IBS/Crohn's/Ulcerative Colitis ☐ Thyroid Issues Other:______________________________

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: ______________________________________ (facility) Phone: ______________________
______________________________________ (address) Fax: ________________________
______________________________________ (city, state, zip)

To release to: **LONE STAR PEDIATRICS** **Phone: 469-591-1900**
177 N. RIDGE ROAD **Fax: 866-695-1347**
MCKINNEY, TX 75071

Patient information:
Name: ____ Date of birth: ________________________
Patient address: ____
Patient phone: ____________________________________ Social Security Number: ______________________

Information to be released:

☐ Complete chart	☐ History & physical	☐ Operative records	☐ Pathology reports
☐ Lab reports	☐ Consultation reports	☐ Radiology/xray report	☐ ER reports
☐ Progress notes	☐ Vaccination record	☐ Discharge summaries	☐ Billing Records ONLY
☐ Other (specify):			

Reason for release:

☐ Transfer of care	☐ Treatment/consult	☐ Patient request	☐ Attorney
☐ Billing of claims	☐ Other (specify):		

Substance use/abuse treatment, psychiatric, genetic testing and/or HIV/AIDS records release:
Federal and State law requires specific & separate authorization from patients to release sensitive information. I understand that if my medical or billing record contains information in reference to any of the above categories, I must specifically agree to its release by checking the appropriate box (TX HB 300).

Substance use/abuse	☐ Yes	☐ No
Psychiatric care	☐ Yes	☐ No
Genetic testing	☐ Yes	☐ No
HIV/AIDS testing/treatments	☐ Yes	☐ No

Time limit and right to revoke:
This consent is subject to revocation at any time except to the extent that the action has been taken thereon. This authorization & consent will expire one year from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization.

Authorization & re-disclosure:
Once your health care information is released, re-disclosure of your health care information by the recipient may no longer be protected by law. I understand that this authorization is voluntary, and I may refuse to sign it, however, an unsigned authorization cannot be completed by our office. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a fee may be charged for the reproduction of records. A copy or fax of this authorization is as valid as the original.

_________________________________ _________________________
Signature of Patient/Guardian Relationship to Patient

_________________________________ _________________________
Printed Name Date Signed

Medical Records Request Fee

The office of *Lone Star Pediatrics* will provide your medical records to the requesting party once we have received either a Medical Release Form (if the information is to be provided to another clinic) or a written request if you are requesting a personal copy of the records. You can find the Medical Release Form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.
Your medical records request will be processed and fulfilled within 15 working days as required by Texas state law. We will either mail or fax the records. The Texas Medical Board (TMB) rules (including §165.2. Medical Record Release and Charges) set the maximum allowable charge that providers may charge for copies under Texas law. As allowed by state law, the fee for personal copies of your medical records is as follows (records requested by other providers are not subject to the fees below):

- $25 for the first 20 pages
- 50 cents for each page thereafter.

This is to notify you that the office of *Lone Star Pediatrics* will apply the applicable fee for medical record copying to your patient account once we have received your request for medical records. A statement will be enclosed with your medical records and this fee is required to be paid within 30 days from the date on the statement. Failure to pay the medical records copying fee will result in your account being turned over to our collection agency, Transworld for further collections proceedings as allowed by Texas Government Code Sec. 2107.003.

PERMISSION TO TREAT A MINOR

I, ____ give permission to my minor child
(Name of guardian)
_____________________________________ to attend his/her illness appointment alone,
(Name of child age 16-18 years)
without my presence and authorize treatment for my child in accordance with the office policy of *Lone Star Pediatrics*. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective on: ________________ and expires _________________.
(today's date) (future date)

Guardian's Signature: _________________________________ Date:_________________

PRESCRIPTION REFILL, SIGNATURE FORMS, AND PHARMACY POLICIES

Prescription Refills

Lone Star Pediatrics is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our prescription request policy. To fill prescriptions in a timely manner, we need your assistance with the following:

1. Typically, a child must be seen before a medication can be prescribed for the first time. Exceptions are at the physician's discretion only.
2. Your child must be up to date on their annual physicals and any behavioral follow-ups as required by your child's doctor.
3. Please allow **7 DAYS** for a prescription to be filled after it is requested. Please allow enough time for the provider to complete your request **BEFORE** your child's prescription runs out.
4. Please call your pharmacy to request a prescription refill or you may request a refill through your child's individual patient portal. Our nursing staff, front office staff and office manager are unable to prescribe medication or send in requests for medications.

IMPORTANT: If your child is prescribed a medication and appears to be having a reaction to it, please call our office immediately. It is imperative that our providers are aware of any reactions that need to be documented and followed up on.

Pharmacy Consent

I give consent for any doctor with Lone Star Pediatrics to obtain information regarding prescriptions filled at any pharmacy. This would be used if you had a prescription filled by a hospital or urgent care and a doctor with Lone Star Pediatrics needs to see what had been prescribed by another physician. This is used in most cases when a parent cannot remember the name of the medication their child was prescribed. This is to be able to accurately prescribe medication to best suit your child's needs.

Signature Forms

If you need a form signed by your child's doctor, please fill out the form **COMPLETELY** prior to emailing the form or dropping it off. Forms that are not filled out by the parent/guardian will be returned to you to be completed and that will cause delays. Please allow 7 days for forms to be completed.

Patient's Name: ____

Parent/Legal Guardian Signature: ______________________________ Date: _________________

WELLNESS CARE ACCORDING TO THE AFFORDABLE CARE ACT

At *Lone Star Pediatrics,* we want to inform you about 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.

____
Patient's name

____ ________________________
Parent/Guardian Signature Date

APPOINTMENTS, CANCELLATIONS & RESCHEDULING POLICY

Patients who arrive more than 10 minutes late to a wellness appointment will be either asked to reschedule or given the option to be worked back into the schedule at the end of the morning. If you are 10 minutes late to a sick appointment, you have missed your entire appointment time and will also have to be worked back into the schedule, resulting in a much longer wait time in our office. The primary reason doctors run behind schedule is due to late arrivals. Please help us to serve you better by keeping your scheduled appointments and by arriving 15 minutes prior to your scheduled appointment to allow time to get checked in, complete any paperwork or update insurance.

We understand that unforeseen circumstances may arise, however, wellness appointments not cancelled 24 hours in advance, and sick visits not cancelled 3 hours in advance will be charged a $75 no-show fee. Multiple missed appointments may result in dismissal from the practice.

Lone Star Pediatrics always attempts to confirm appointments several days before the scheduled appointment occurs. If there is no response to our call, we will continue to call until the day of your appointment, however, failure to respond to our appointment confirmation calls and/or returning our voicemails could result in your appointment being offered to another patient. If you need to respond to us after hours to cancel or confirm an appointment, please leave a message on the general voicemail and we will check it the following morning.

Our telephones are answered Monday through Friday from 8:00 am–11:45 am and again from 1:15pm-4:45 pm and on Saturdays from 8:00 am-11:00 am. Our staff have been instructed to handle all incoming calls to allow the providers to attend to their scheduled patients with a minimum amount of interruption. If you feel you need to speak to a provider during office hours, you will be asked to leave a message with the front office and it will be relayed to the provider. It is possible that the provider will instruct the medical assistant/nurse to respond to your call with instructions as this may be the fastest way to assist you with your inquiry.

If you have a true medical emergency please contact emergency services at 9-1-1 or go to the nearest emergency room. DO NOT waste valuable time waiting for a provider to call you back.

This form must be signed prior to services being rendered. It will become part of your child's permanent record.

Patient's Name:

____ Date: ____________________________

____ Date: ____________________________

Parent/Guardian Signature

CONSENT TO TREAT AND
PICTURE POLICIES

I consent for my child to receive medical treatment at Lone Star Pediatrics. I consent for my child to receive discussed vaccines. I understand that I will be given handouts regarding vaccination safety and will have the opportunity to discuss vaccinations and have any questions I may have answered by my child's pediatrician.

Patient's Name: ________________________________

____ ________________________
Parent/Guardian Signature Date

I hereby give permission for the following people to obtain medical care for my child, and to have access to my child's medical records (this could be adult relatives/babysitters/a nanny etc.):

________________________________	________________________________
(Name)	(Relationship)
________________________________	________________________________
(Name)	(Relationship)
________________________________	________________________________
(Name)	(Relationship)
________________________________	________________________________
(Name)	(Relationship)

____ ________________________
Parent/Guardian Signature Date

By signing below, I give permission to any doctor with Lone Star Pediatrics to take a picture of my child for their official medical record. This small thumbprint picture is used for identifying purposes only and **will not be shared outside of Lone Star Pediatrics for any reason**.

____ ________________________
Parent/Guardian Signature Date

COVID 19 RESTRICTIONS AND MASK POLICY

Masks are required on anyone over the age of two while in our building. Your mask must remain on the entire time you are in the building, and it is **mandatory** your mask cover both your mouth and nose.

Please do not argue with any member of our staff regarding our mask policy.

Our entire team has worked incredibly hard to remain healthy, so we are here to take care of your children. Wearing a mask properly in our office is mandatory to remain a family with Lone Star Pediatrics. Please help protect our staff and their families, as we do our best to protect yours.

We will continue to minimize the number of people in the building at a time as well as the number of people in exam rooms where social distancing is not possible.

For well child visits over the age of two, only ONE adult can attend the appointment.

Only ONE adult can attend any sick appointment, regardless of age.

If you feel you need additional help with your children during a visit, please email the office manager at SNORWOOD@LONESTARPEDS.COM or you can speak to someone in reception regarding the request. We can make accommodations if needed as understand there are circumstances that would require a second adult.

Patient's Name: ____

Parent/Legal Guardian Signature: _______________________________

Date: ____

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME: ____________________ **PATIENT NAME:** _____________________
PATIENT NAME: ____________________ **PATIENT NAME:** ____________________
PATIENT NAME: ____________________ **PATIENT NAME:** _____________________

The purpose of this form is to authorize *Lone Star Pediatrics* to retain a valid credit card number on file for you as our patient. **All self-pay patients are required to complete this form. All custodial parents who want the non-custodial parent (or another party) billed for charges are required to complete this form.** This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. reserves the right to charge the credit card listed below for all current patient balances (see “note” below).
2. If you miss a scheduled appointment without a 3-hour notice to cancel or reschedule, LONE STAR PEDIATRICS reserves the right to charge the credit card listed below $75.00 for our standard no-show fee. *As a courtesy, a representative from LONE STAR PEDIATRICS will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24-hours prior to your scheduled appointment. It is the patient’s responsibility to ensure we have a correct telephone number on file & an active voicemail box to leave messages.*
3. If we receive notice from the bank that a payment is returned to us for any reason, LONE STAR PEDIATRICS reserves the right to charge the credit card listed below a $25 insufficient funds fee plus the outstanding balance (see “note” below).

** Note: All balances not paid in full at the time of service will incur a 20% interest fee after 30 days of non-payment.*

Other than the conditions mentioned above, under NO circumstance will LONE STAR PEDIATRICS charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with the billing office staff, my signature on the following page acknowledges that I voluntarily give my authorization to *Health Kids Pediatrics* to charge my credit card according to the conditions listed above and that I can call the office at any time to request a payment receipt.

CREDIT CARD AUTHORIZATION FORM

Patient Name(s): ____
Account Number(s): ____
Street Address: ____
City: ____________________________________State:__________Zip:______________

DEBIT/ CREDIT CARD:

Credit Card Number: __________________________________Exp Date:____________
Cardholder Name: ____CVV:____________
Billing address: ____

This authorization will remain in effect until cancelled by myself, *Lone Star Pediatrics* or my financial institution. I can cancel this authorization at any time by calling or writing to Lone Star Pediatrics using the information below. A $25 service charge will be applied to any returned payment and will not be waived. If further attempts at submitting a payment to your bank are unsuccessful you will be mailed one statement and will forfeit the prompt-pay discount as well as incur a 20% interest charge. You will have 45 days to resolve your outstanding account.

X Guarantor Signature: ________________________________ Date: _______________

OR

Refusal to Provide Credit Card Details:

Refusal to complete and agree to this authorization dictates the following:
The patient acknowledges that no prompt-pay discounts will be given without a valid card on file. Since there is no credit card on file with Lone Star Pediatrics, LSP reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice (this will include a 20% interest charge). It is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and potentially having your account closed with our practice.

Signature of refusal: ________________________________ ***Date:*** ___________________

SELF-PAY/UNINSURED FINANCIAL POLICY

Lone Star Pediatrics is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our financial policy. Our staff is instructed to make every effort to clarify any questions concerning payment for your treatment, however, if you need further information about any of these policies, or about the amount you will be asked to pay, please ask to speak with our billing manager prior to your appointment. Your clear understanding of the Self-Pay Financial Policy is important to our professional relationship.

The amount you pay for your office visit depends on several factors including:

1. the type of visit that is scheduled (consultation/sick/well etc.)
2. whether you are a new patient or you've visited our office before;
3. the complexity of your visit; and
4. the doctor's examination (which will not always be known at checkout until the physician completes and signs-off on your medical chart).

The amount our office charges for services is based on fees set forth each year by our contracting agency that is in accordance with fair health for our geographical region. We are not allowed, by Texas law, to charge less to patients than what is billed to insurance companies (Tex. Ins. Code §552.003), however, self-pay patients are eligible for a prompt-pay discount on services they receive, if **full** payment is made at checkout on the date of service. These discounts are not published as doing so would be a violation of the above law as well as our contracts with insurers.

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. We strive to avoid balance billing our self-pay patients, however, in the event that it is necessary please be advised that the prompt-pay discount will still be honored. If the patient does not pay the balance for any additional charges at the discounted rate within 30 days from the date of the first statement, the patient will no longer be eligible for the prompt-pay discount on any additional charges and will be responsible for the standard charges for all appointments going forward. In addition, balances not paid at the time of service will incur a 20% interest fee from our office to carry your balance.

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. You can request an estimate of any service prior to a procedure being performed, however, once the procedure has been performed you are responsible for full payment.

You must bring all payments with you on the day of your appointment or you will be asked to reschedule. If you have not visited our office in the last **three years** you will be considered a new patient. We accept cash, check, MasterCard, Visa, Amex and Discover. You may pay your bill in our office, mail your payment, or call us on the phone to make a payment on your account using your debit or credit card. You are expected to pay your bill in full when you receive it in the mail. 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.

____
Patient's name

____ _________________________
Parent/Guardian Signature Date

VFC Participation Consent Form

The Texas Vaccines for Children (TVFC) program provides low-cost vaccines to eligible children from birth through 18 years of age who meet one or more of the following criteria:

- Eligible for participation in the Medicaid program
- Enrolled in the Children's Health Insurance Program (CHIP)[1]
- American Indian or Alaska Native (As defined by 25 U.S.C. 1603)
- Uninsured Children: Children who do not have health insurance
- Underinsured Children: Children with private insurance but coverage [2]:
  - Does not include vaccines
  - Only includes select vaccines

[1.] Though children whose insurance pays for vaccines do not qualify for TVFC vaccine, CHIP children do qualify by special arrangement.

[2.] Underinsured children must be seen by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or deputized clinic.

I consent to participating in the Texas Vaccines for Children (TVFC) program. By signing this form, I understand that it is my responsibility to have contacted my insurance company **PRIOR TO RECEIVING TVFC VACCINES,** if I am underinsured, to verify whether vaccines are covered under my policy. I further agree if I elect not to do so, and the health department recoups the cost of vaccines because they were covered under my plan, that I am solely responsible for payment.

______________________________	______________________________
Patient Name	Parent Name
______________________________	______________________________
Parent Signature	Date