



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

LONE STAR P E D I A T R I C S

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:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> IBS/Crohn's/Ulcerative Colitis <input type="checkbox"/> Thyroid Issues Other: _____
Father:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> IBS/Crohn's/Ulcerative Colitis <input type="checkbox"/> Thyroid Issues Other: _____
Sisters:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> IBS/Crohn's/Ulcerative Colitis <input type="checkbox"/> Thyroid Issues Other: _____
Brothers:	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> IBS/Crohn's/Ulcerative Colitis <input type="checkbox"/> Thyroid Issues Other: _____

LONE STAR

P E D I A T R I C S

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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Complete chart | <input type="checkbox"/> History & physical | <input type="checkbox"/> Operative records | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Lab reports | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Radiology/xray report | <input type="checkbox"/> ER reports |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Vaccination record | <input type="checkbox"/> Discharge summaries | <input type="checkbox"/> Billing Records ONLY |
| <input type="checkbox"/> Other (specify): _____ | | | |

Reason for release:

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> Transfer of care | <input type="checkbox"/> Treatment/consult | <input type="checkbox"/> Patient request | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> Billing of claims | <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genetic testing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS testing/treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> 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:** _____



INSURANCE & BILLING POLICY

At *Lone Star Pediatrics*, we are dedicated to providing your child with the best medical care available. In order to do that, we will need your assistance in providing us with necessary information; this information will be kept confidential and is 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.

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

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 you've visited our office before, 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. You will be provided with a billing summary in order 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.

Patient's name

Parent/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 | 5. Sore throat/Reflux | 9. Allergies |
| 2. Stomach pain | 6. Ear pain | 10. Behavioral |
| 3. Headache | 7. Cough/congestion | 11. Skin conditions |
| 4. Asthma | 8. Digestive issues | 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@LONESTARPEDES.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: _____



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: _____