

Pediatric Associates of Austin, PA

Child's Name: _____

Date of Birth: _____

PREGNANCY AND BIRTH HISTORY

Place of Delivery _____ Delivered by _____

Previous Pregnancies: Total #: _____ Miscarriages _____ Stillbirths _____

Explanation for Miscarriages (if known) _____

Mother's Health During This Pregnancy _____

Labor was: Normal / Other (please explain if other than normal) _____

Delivery was Normal / Other (please explain if other than normal) _____

Baby's Birth weight _____ Baby was _____ weeks at delivery Baby was hospitalized for _____ days

Any Illnesses or Complications in the Newborn Period? _____

Did baby or mom require any special diet during pregnancy or newborn period? _____

DEVELOPMENTAL AND MEDICAL HISTORY

At what age (approximately) did your child?

	AGE		AGE
Roll front to back	_____	Have first specific word other than mama or dada	_____
Roll back to front	_____	Make a two word sentence	_____
Sit without support	_____	Pedal tricycle	_____
Walk without support	_____	Dress Self	_____

Does your child have school problems, hyperactivity, learning disabilities, or inattentiveness? Yes No (please explain)

CHILD'S MEDICAL HISTORY:

Has your child ever had:	Yes	No	Please explain if answer is yes to any item
Measles, mumps, or rubella			
Chickenpox			
Whooping Cough (Pertussis)			
Seizures			
Tuberculosis			
Any chronic disease			
Tonsillectomy/Adenoidectomy			
Ear Tubes (PET tubes)			
Bedwetting			
Serious injury or poisoning			
Heart, lung, blood, muscle or Bone disease			
Vision or hearing problems			
Skin problems			
Other			

Pediatric Associates of Austin, PA

Child's Name: _____

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CHILD'S HOSPITALIZATION HISTORY:

Date	Hospital	How Long Hospitalized	Reason for Hospitalization / Surgery

FAMILY MEDICAL HISTORY:

Does anyone in the family have:	YES	NO	If answer is yes, please explain
Diabetes			
Rheumatoid arthritis			
Anemia, bleeding problems, or leukemia			
High Blood Pressure			
Seizures (Epilepsy)			
Nerve or muscle disorders			
Cystic Fibrosis			
Asthma, allergic rhinitis, or eczema			
Heart murmurs			
Deaths in infancy or of unknown cause			
Kidney or urinary tract problems			
Other			

FAMILY AND HOUSEHOLD

Names of Family Members	Date of Birth	Health problems, school progress, etc.

ALLERGIES AND MEDICATIONS

Does your child use any medications regularly?	Does your child have any allergies (to medications or otherwise)

Pediatric Associates of Austin, PA

New Patient Information Form/Acknowledgement of Privacy Practices

Today's Date: _____ MEDICAL CHART #: _____

Child's Name: (L) _____ (F) _____ (MI) _____

Date of Birth: _____ Place of Birth: _____ Sex: Female Male

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

Home Phone: _____ Preferred E-mail Address: _____

Parent 1 Name: _____ DOB: _____ SSN#: _____

Occupation: _____ Mobile Phone: _____ Work Phone: _____

Parent 2 Name: _____ DOB: _____ SSN#: _____

Occupation: _____ Mobile Phone: _____ Work Phone: _____

Preferred Pharmacy: _____ **Location** _____

I give consent for PAA to obtain Medication History and ERX benefit information from insurance carrier. **Yes** **No**

Preferred Form of Communication: (Must complete Consent for Electronic Communication, Voicemail of Medical Info & ERX)

Email Address Text Message (Parent 1 or 2) Voicemail to Home Phone Voicemail to Mobile Phone

How did you hear about Pediatric Associates: Friend/Relative Web-site Insurance Plan

Doctor _____ Other _____

Siblings: Child's Name (Last, First, Middle)	Date of Birth	Sex	Chart #
_____	_____	Female Male	_____
_____	_____	Female Male	_____
_____	_____	Female Male	_____
_____	_____	Female Male	_____

Primary Ins. Co. Name: _____ ID#: _____ Group #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Policyholder Name: _____ DOB: _____ SSN#: _____

Home Address: _____ Phone #: _____

Employer: _____ Work #: _____

Employers Address _____

Secondary Insurance: If you have a secondary insurance, please notify the front desk.

I UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS:

1. This office expects payment at the time of service, unless specific arrangements are made in advance with the financial counselor.
2. Insurance claims will be filed only for those insurance plans we have contracted with as a participating provider.
3. Copay's, deductibles and Non-covered services are to be paid at the time of service.
4. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to PEDIATRIC ASSOCIATES OF AUSTIN, P.A.

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH THIS OFFICE'S NOTICE OF PRIVACY PRACTICES , which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

DATE: _____

Parent/Insured's Signature

Pediatric Associates of Austin, PA

Permission to Treat

The Physicians and nursing staff of Pediatric Associates of Austin, P.A. have my permission to diagnose and treat my child,

Name of Child: _____ DOB: _____

in my absence, when he/she is accompanied by the following person(s):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Signature of Guardian/ Parent: _____

Date: _____

Pediatric Associates of Austin

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

Pediatric Associates of Austin, P.A. (PAA) is required by law to maintain the privacy of your protected health information (PHI). This notice applies to all records of the health care and services you received at PAA. This notice will tell you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI. **A more detailed version of this notice may be found on PAA's website and a paper copy will be provided upon request.**

Pediatric Associates Commitment

We are required by law to: (i) make sure that your PHI is kept private; (ii) give you this notice of our legal duties and privacy practices with respect to your PHI; (iii) follow the terms of this notice as long as it is currently in effect (if we revise this notice, we will follow the terms of the revised notice as long as it is currently in effect); (iv) train our personnel concerning privacy and confidentiality; and (v) mitigate (lessen the harm of) any breach of privacy/confidentiality.

How We May Use and Disclose Information about You

The following categories (listed in bold-face print, below) describe different ways that we use and disclose your **protected health information (PHI)**. For each category of uses or disclosures we will explain what we mean and give you some examples, but not every use or disclosure in a category will be listed.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you or providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose your PHI to health care providers that are not affiliated with Pediatric Associates who may be involved in your medical care, such as physicians, who will provide follow-up care, physical therapy organizations, medical equipment suppliers, and skilled nursing facilities.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at/by PAA may be billed to (and payment may be collected from) your insurance company or a third party. For example, we may need to give your health plan information about the procedure you received at PAA so your health plan will pay us or reimburse you for the procedure.

For Health Care Operations. We are permitted to use and disclose your PHI for our business operations. These uses and disclosures are necessary to run PAA and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.

To Business Associates for Treatment, Payment, and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment of health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for health care services we provide.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative, or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person's involvement in your care. WE also may release information to someone who helps pay for your care. We may tell your family or friends that you are at PAA and what your general condition is.

Other Uses/Disclosures. We may use and disclose medical information: (i) to tell you about health-related benefits or services that may be of interest to you; (ii) to give you information about treatment options or alternatives that may be of interest to you; or (iii) to contact you as a reminder that you have an appointment for treatment or medical care at PAA.

Special Situations: We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities: We may disclose your PHI for certain public health activities (e.g., controlling disease, injury, or disability; reporting abuse or neglect; reporting drug reactions), but only if you agree or when required or authorized by law.

Health Oversight Activities. WE may disclose PHI to a government health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court of administrative order or in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. In certain designated situations, we may release PHI if asked to do so by a law enforcement official.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI: (i) to a coroner or medical examiner to identify a deceased person or to determine the cause of death; or (ii) to a funeral director as necessary to help them carry out their duties.

Other Special Situations. We may use and/or disclose PHI: (i) to organizations that handle or facilitate organ procurement or transplantation; (ii) to law enforcement when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person; (iii) as required by applicable military command authorities (if you are a member of the armed forces); (iv) to authorize federal officials for certain national security purposes; or (v) for workers compensation purposes.

When Your Authorization is Required

Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with your written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

Your Rights: You have the following rights regarding the PHI we maintain about you:

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for you care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. We will accommodate all reasonable requests.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Psychotherapy notes may not be inspected or copied. We may deny your request to inspect or receive a copy in certain very limited circumstances.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for PAA. You must include a reason that supports your request. We may deny your request for an amendment in certain limited circumstances.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" that has been made by PAA in the past six (6) years.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice (even if you have agreed to receive this notice electronically). You may ask us to give you a copy of this notice at any time.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on PAA premises and on PAA's website. The notice will contain, in the lower left-hand corner, the effective date. In addition, each time you register at, or are admitted to, PAA for treatment purposes, you may request a copy of the current notice in effect.

Requests, Questions, and Complaints

If you have any questions or would like additional information on these rights, you may contact the PAA Privacy Officer at 512-458-5323. Additionally, if you believe your privacy rights have been violated, you may file a complaint with either PAA's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. You will not be penalized in any way for filing a complaint.

Please acknowledge the receipt of this Notice of Privacy Practices by completing and signing the Pediatric Associates of Austin New Patient Information Form. This form is for your records.

Pediatric Associates of Austin, After Hours Kids & SportsSafe

Consent for Electronic Communication, Voicemail Delivery of Medical Information and ERX

Pediatric Associates of Austin (PAA), After Hours Kids (AHK) and SportsSafe (SS) offer Electronic Communication, Voicemail Delivery of Medical Information, as well as e-Prescribing medications, in an effort to provide efficient, quality, patient-friendly medical care. In order to be HIPAA compliant, we ask that you authorize these forms of communication. **(HIPAA (Health Insurance Portability & Accountability Act of 1996) provides specific guidelines to protect patient's privacy specifically restricting Protected Health Information (PHI). Detailed information regarding HIPAA, PHI and patient privacy can be found in the Notice of Privacy Practices, which you received on your first visit to our office, following the enactment of HIPAA. Additional copies of the Notice of Privacy Practices are available at our front desk.)**

Electronic communication means talking through texts and emails. Voicemail Delivery of Medical Information is available in an effort to avoid "phone tag" issues often associated with informing patients of their test results. E-Prescribing allows your physician to send eligible new prescriptions and refills to your pharmacy electronically. E-prescribing is a highly convenient process that maximizes prescription accuracy and eliminates the need for patients to keep up with paper prescriptions. It significantly lessens the wait-time associated with dropping off prescriptions to your pharmacy after your visit, or having a staff member to call it in. Prescriptions arrive to your pharmacist instantaneously.

You may also wish to allow your physician to have electronic access to your medication history using Surescripts* Network. With your consent, your doctor will be able to view critical information about your past and current prescriptions. This will improve your safety and quality of care (e.g., preventing potentially harmful drug interactions or intolerances).

Electronic Communication is a great way for us to communicate with each other.

We use texts and emails:

- To remind you of appointments;
- To notify you of health services that may need to be scheduled, such as well checks, labs and/ or immunizations;
- To notify you of new services available at PAA;
- To notify you of Holiday Closures and/or Bad Weather Delays.

You can use email to:

- Send in school and camp forms to be completed; (Please allow 72 hours to complete.)
- Send non-urgent messages to our nurses/doctor;
- Request a refill for your child(ren)'s prescriptions;
- Request a Specialists name and contact information.

There are risks of using electronic communication, including:

- Someone who does not have permission to see your email may see it. Protect your cell phone, computer, user name, and password. Even if you protect your user name and password, someone might be able to guess it.
- Someone who does not have permission to see your email may break the law and hack into your account.

There may be other risks of using electronic communication not listed here. PAA, AHK and SS are NOT responsible for messages sent by mistake.

However, we do not give emergency care by electronic communication. If you have an emergency, call 911. Additionally, we do not use electronic communication to give you advice about your health, prescribe you a new medicine, or sell any information.

Patient Acknowledgement and Agreement to Electronic Communication, Voicemail Delivery of Medical Information, and e-Prescribing

Please indicate which consents you wish to accept or decline, by checkmarking the appropriate boxes below:

- I have read this form. I fully understand the consent to communicate electronically. I understand the risks and agree to the terms. I agree to follow the rules of the electronic communication services, and understand that PAA, AHK and/or SS may stop communicating with me electronically if I do not follow these rules. I understand that PAA, AHK and/or SS may stop this service at any time and for any reason. Further, I understand that it is my choice to use these services. I can opt-out of, or stop using these services at any time by e-mailing PAA at patientcare@pediatricassociates.net. I AGREE to use these electronic services. I prefer the following forms of communication: Email Text messages
- I DO NOT authorize the use of electronic communication.
- I DO authorize PAA, AHK and/or SS, its physicians and employees to leave detailed messages specific to my child(ren)'s medical care including test results on my voicemail. I understand that once a voicemail message exists, it is no longer covered under HIPAA, and therefore is not protected from unauthorized access. I understand that this authorization can be revoked at any time, by submitting a written request to the practice.
- I DO NOT authorize the use of voicemail to convey information about my child(ren)'s medical care.
- I DO consent to allowing my physician and medical staff to electronically view my child(ren)'s medication history through Surescripts.
- I DO NOT consent to sharing my child(ren)'s medication history using Surescripts* Network.

Name of Each Child in Practice: _____

Preferred Email Address: _____ Preferred Cell Phone: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

Relationship to Children: _____ Pharmacy Telephone: _____

Signature: _____ Printed Name: _____ Date: _____

Pediatric Associates of Austin, P.A.

Financial Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed-care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual benefits of the plans. Each one has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated or which policy you have chosen to enroll in. Please keep in mind, while we do have contracts with most of the major carriers; we are NOT providers for many of the Affordable HealthCare Act Policies they offer.

Please read the following information carefully. If you have any questions regarding our Financial policy, you may contact our billing department.

- Before enrolling or purchasing new healthcare coverage we strongly advise that you verify, with your **INSURANCE COMPANY**, that your healthcare providers are "in- network". We only file claims for insurance policies we have contracts with. If we are "out-of-network", we still welcome you as a patient; however you will be responsible for all charges incurred.
- We verify eligibility at every appointment; however the information we receive is very basic. For detailed information regarding your insurance benefits, please contact your insurance company directly. **ANY SERVICE RENDERED WILL BE THE RESPONSIBILITY OF THE PATIENT IF THE INSURANCE DOES NOT COVER THE SERVICE.**
- **In order for your baby to have coverage, you MUST NOTIFY YOUR INSURANCE WITHIN 30 days after the birth of the baby.** If you miss this deadline, the baby will not be covered until open enrollment with your employer. If this happens and you do not purchase an individual policy in which we are a contracted provider, you will be responsible for payment at the time of service. Some companies will automatically cover the baby for the first 30 days, even if you do not add the baby to the plan. Please contact your insurance company or Human Resources Dept. for a more detailed explanation about newborn (first 30 days) benefits. If parents are both covered by insurance, it is possible that your baby will be double covered for the first 30 days, and you will need to coordinate benefits with both companies.
- All payments are due at the time of service; this includes any co-pay, co-ins, deductibles or private pay charges incurred. We do understand that there may be a time when paying for these services is not possible. In order to set up a payment arrangement, you will need to speak with our billing department BEFORE your appointment.
- Listed below are some of the common services we offer, that are not covered by insurance, or that may be applied to your deductible instead of just co-pay. We are able to provide you with our charges for our services. Simply contact our billing department.

Hearing/Vision Screening	Well-child exams that exceed Ins. Plan limitations
M-CHAT questionnaire interpretation	Vaccines
Dental Fluoride Treatment	After Hours Phone calls to speak with a Nurse or Doctor
Cerumen (ear wax) removal	Breast Feeding Consultations
Wart removal	Rental or purchase of a nebulizer
Any sort of splints or casting	

- **After-Hours Telephone Calls:** For your convenience, a nurse is available to answer after hours telephone calls. Unfortunately, most insurance companies will not pay for this service. The charge is \$25.00 and will be billed directly to you, not to your insurance company. We will provide you with a receipt, if you would like to pursue reimbursement with your insurance plan.
- **Week-end Hours:** Our office is open on Saturday and Sunday for urgent care to help our families avoid an emergency room visit.
- **Health/Camp Forms:** These requests are best managed at the time of your child's well check. Our staff may complete forms at other times as long as your child has had a well-child exam within the previous year. There is no charge for this service at the time of the well check.

- **Account Guarantor:** In divorce situations, the parent who brings the child in for the visit is responsible for payment of copays and deductibles collected at the time of service. The parent who signs the financial agreement is the parent responsible for balances remaining on the account after insurance has paid. **WE ARE UNABLE TO NEGOTIATE SETTLEMENT OF YOUR MEDICAL BILLS BETWEEN YOU AND YOUR EX-SPOUSE. IF PARENTS ARE UNABLE TO RESOLVE THESE ISSUES IN ORDER TO KEEP THEIR ACCOUNT CURRENT, YOU MAY BE DISMISSED FROM THE PRACTICE for non-payment.** If you have any questions, you may contact our billing department.
- **Patient Billing/Collections:** We appreciate prompt payment of your account. If your account is past due and if a valid payment arrangement is not made or kept, your account will be sent to an OUTSIDE COLLECTION AGENCY and a 30% fee will be added to the account. In most cases, once sent to collections, the family is dismissed from the practice. To keep this from happening, please pay your bills upon receipt, or call to set up payment arrangements. We understand financial hardships may prevent you from paying your bill from time to time, but we cannot work with you if we don't hear from you. It is your responsibility to contact us about balances on your account.

I understand the Financial Policy of this office. Please initial each line below:

1. The office expects payment at the time of service unless specific arrangements are made in advance with the billing department. _____
2. I understand that it is my responsibility to verify if my well-check benefit schedule is once per calendar year or once every 365 days. _____
3. Copay, deductibles and non-covered services are to be paid at the time of service. _____
4. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to Pediatric Associates of Austin, P.A. _____
5. By signing below, I agree that I am responsible for balances remaining on the account. _____

****Fees are subject to change without notice**

Signature

Relationship to Child(ren)

Date

Printed Name

Pediatric Associates of Austin, P.A.

Value-Added Program

At Pediatric Associates of Austin, we are committed to providing the best possible care to our patients and families. We have been practicing in Austin for a combined 40+ years and we love watching our families grow and thrive. We cherish our relationship with you and hope that you find expertise and consistent quality in the services we provide.

Many changes have taken place in the health care industry in recent years. As insurance payments shrink and administrative costs rise, medical groups struggle to remain viable by squeezing more appointments into the same amount of time. We work to keep our wait times minimal without rushing your visit so that your child can receive our full attention.

We are seeing small private practice pediatric groups dwindle. Physicians are giving up their practices entirely, or they are joining together to form larger groups to share costs. We do not want to be part of a mega-group practice.

At Pediatric Associates of Austin, we want to personally know your child, not just your child's name. By having enough time with you at your visit, we feel that we can provide you with the best care.

For these reasons Pediatric Associates of Austin, and many pediatric practices across the country, now charge an annual fee to cover these costs. We do not want to reduce or eliminate the services and quality that you expect. This annual fee is less than \$10 per month per child and renews April 1st of each year. If you join the practice mid-year, the fee will be prorated.

As a new patient to the practice, we want you to be certain that you will be 100% satisfied with the benefit of our value-added services. If you decide, within your first year, to transfer your records to another practice physician, we will cheerfully refund your money.

If you have any questions or concerns, please contact Cindy Harrington, Practice Manager at 512-458-5323.

Pediatric Associates of Austin, P.A.

Benefits of Joining our Practice

Open Saturday and Sunday mornings for Urgent care appointments.

All vaccines and other injectable medications are administered by **pediatric nurses**; not medical assistants trained to give injections.

E-Prescribing to your pharmacy both new and refilled prescriptions when appropriate so medication may be ready when you arrive there.

No charge for completion of forms for child care centers, schools, sports and camps.

Our own **full-service website** with American Academy of Pediatrics approved medical information.

Breast feeding support to get our babies off to a great start in life.

In-house lab and x-ray is available at your convenience with "while you wait" results. Every time your doctor makes the correct diagnosis the first time because the lab and x-ray are right here, you pay only one co-pay.

Finger-stick technology used whenever possible—outside labs such as Clinical Pathology labs do not use finger-stick technology but rather collect blood by venipuncture (out of the arm).

Ability to **e-mail our office staff** for appointment requests, for questions about insurance and billing, to send in school and camp forms and have us send them back to you.

Our own pediatric nurses available 24 hours a day, 7 days a week including all holidays. Advice given during regular business hours for free and available after hours for a \$25.00 fee. As always, the on-call physician supports them.

Our On-call team will minimize unnecessary visits to the emergency room or urgent care center where they do not know your children or their medical information. This can save you hundreds of dollars on unnecessary high copayments and facility fees.

Documenting with an electronic health record system that is designed specifically for the practice of pediatrics.

**Our goal is to provide comprehensive, high quality medical care to your family.
We are honored to be your family's medical home!**

I want to maintain a relationship with my pediatrician's office and understand that in order to prevent services from being reduced or eliminated, an annual value-added service fee will be charged. I agree and accept the annual fee for these value-added services. These services are not covered or required under my managed care plan. If you are experiencing a financial hardship, we will work with you so you can remain in our practice.

<u>The annual fee is:</u>	<u>Fee</u>	<u>Discounted if paid by 4-1-16</u> – in addition the family will receive one waived convenience fee at our After Hours Kids Clinic
1 Child	\$115.00	\$103.50
2 Children	\$220.00	\$198.00
3 or More Children	\$250.00	\$225.00

Print Name: _____ Email: _____

Signature: _____ Enclosed is my payment of \$ _____ Date _____

Who is your regular doctor? Please check: Griggs Mirrop Hargrave Morgan Gonzalez Loomis Mowry

Credit Card # _____ Exp. ____/____ Visa M/C Discover

Please list your child/children below. (use back if needed)

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

**To pay by phone, call 512-814-1600. To pay by mail, send to: 1500 W. 38th Street, Suite 20, Austin, TX 78731
Payments may be spread over a three-month period. Please complete the partial payment form, if you choose this option.**

Pediatric Associates of Austin, P.A.
Value Added Service Fee Waiver Information

We realize that from time to time families can develop financial hardships. If you are experiencing such a time and the Value Added Fee is a financial burden, drop us a line explaining your situation and we'll try to help. You can mail the letter to us at: Pediatric Associates of Austin--VAS Fee Waiver Program, 1500 West 38th Street Suite 20, Austin, Texas 78731 or send an email to cindy@pediatricassociates.net.

Date received _____

**Request for Medical Records to be Released to
Pediatric Associates of Austin, P.A.**

Office: (512) 458-5323 Fax: (512) 458-2030

TO: _____
(PHYSICIAN'S NAME)

(STREET ADDRESS)

(CITY, STATE, ZIP CODE)

I hereby request the medical records on:

(PATIENT'S NAME)

(PATIENT'S DATE OF BIRTH)

for _____
(DATES, ILLNESS, ALL RECORDS, ETC.)

be released to: _____
(PHYSICIAN'S NAME)

Mail to: Pediatric Associates of Austin, P.A.
1500 W. 38th St., Suite 20
Austin, TX 78731

The purpose of this request:

- Moving
- Insurance Change
- Other – specify _____

I understand that I may revoke this authorization at any time. My revocation must be in writing and provided to Pediatric Associates of Austin, P.A., but if I do, it will not have any effect on any actions the releasing took before they received the revocation.

(PATIENT'S OR AUTHORIZED SIGNATURE)

(DATE)

(RELATIONSHIP TO PATIENT)

Pediatric Associates of Austin, P.A.

Newsletter Signup

Pediatric Associates works very hard to communicate with our families through our Monthly Newsletters. Our Newsletters will provide valuable information relating to children's growth and development and overall health, vaccines, allergies, and seasonal topics.

We also use our Newsletter as a tool to notify you of Holiday Closings, Bad Weather Closures, Insurance plan updates, as well as dates of our seasonal Flu Clinics each year.

You may visit our website at www.pediatricassociates.net and choose "Newsletter Signup" located under "Parent Resources" on our Home Page, or complete the information below and provide to our staff at your upcoming appointment.

Thank you.

Pediatric Associates of Austin, P.A.

Pediatric Associates of Austin Newsletter Signup	
Parent Name:	_____
Preferred Email Address :	_____
Preferred Phone:	<input type="checkbox"/> Home <input type="checkbox"/> Cell: _____