PEDIATRICS

Dr. Shahzad A. Sheikh, MD, FAAP
Pediatric and Adolescent Medicine

Patient Medical History

Name: _____ Male/Female (circle) DOB: _____

Referred by: _____

Name and Address of Pharmacy: _____

Please complete all questions below and provide details if circled YES

1. Are you allergic to any medication/food(s)? Yes/No (if yes, please list reaction)

_____

2. Are you taking any current medication? Yes/No (if yes, please list name, dose and timing)

_____

_____

3. Past Medical History: _____

_____

4. Have you had any surgeries? Yes/No (if yes, please list date of surgery and location)

_____

5. Family Medical History (disease and relation to patient): _____

_____

6. Smokers in the home? Yes/No Smokers outside the home? Yes/No

7. Patient lives with: Mom Dad Stepparent Sister(s) Brother(s) Grandparents Pet(s)

8. Does the patient have problems in the following areas...
   Behavior/Interaction with peers? Yes/No School performance? Yes/No

Parent's Signature: _____ Date: _____

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14855 Blanco Rd., #400, San Antonio, TX 78216 ● Office: (210) 492-0900 ● Fax: (210) 492-0977

PEDIATRICS
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Authorization for Evaluation and/or Treatment of a Minor Child Unaccompanied by Parent or Legal Guardian

Parents or Legal Guardians must accompany a child younger than 18 years of age to consent for all medical treatment provided by Kid-Doc Pediatrics. Please complete this form if your child will be coming for a visit, treatment or procedure without a parent or legal guardian.

Patient Name (s)	**Date of Birth**

Authorization for another person to see medical treatment for above named child(ren). I authorize:

Adult Name	**Relationship to child**

To seek medical care for my child(ren), listed above. I agree that they may have access to test results and other pertinent health information. I understand that I am financially responsible for all medical care provided

Signature: _____ Date:_____

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Patient's Name: DOB:

Release, Assignment and Financial Responsibilities

1. I accept financial responsibility for treatment or testing I agree to or request, regardless of my insurance carrier's responsibility or reimbursement. I acknowledge financial responsibility for services rendered during periods of ineligibility or uninsured. I acknowledge being informed that my insurance may not cover all services requested. When a denial of a payment is received from my insurance carrier, the charge will become my responsibility. My financial responsibility explicitly includes "non-covered" services including but not limited to: immunizations (including influenza and vaccines for travel), immunization administration charge, after hours/weekend/holiday visit fee, vision/hearing screen, treatment for mental health/ADHD and physical exams or well child visits beyond allowance of insurance carrier.

2. I authorize the release of any medical or other information necessary to process a claim with my insurance carrier. I authorize payment of medical payments to the practice of Dr. Shahzad A. Sheikh for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

3. Additionally, there will be a charge for any forms filled out by the provider or staff not provided at time of visit. They are as follows: WIC, Daycare/School/Sport/Camp Physicals $10, FMLA paperwork $20, Immunization record $5, Medical Record $25 for the first 20 pages with an additional $0.10 for each additional page. I understand that I may be charged $25 for appointments not cancelled within 24 hours.

I have read and agreed to the Notice of Privacy Practices and am aware that I may request a copy of these policies at any time.

Parent's Signature: _____ Date: _____

Rev 3/2020

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Notice of Privacy Practices (Use and Disclosure of Protected Health Information) and Financial Policy

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OFFICE FINANCIAL POLICY

PAYMENTS

INSURANCE

APPOINTMENTS

BILLS

HARDSHIP

FORM FEES/LATE FEES

SCHOOL FORMS – IMMUNIZATION RECORDS – RECORDS – FAXES

We receive many requests for records and forms to be completed, mailed, faxed or picked up. We are here to help with these needs. There will be no charge on forms or immunization records at time of service (2-page limit).

If you are mailing/calling/faxing for forms or records, then we ask that you please call us in advance, as it can take up to 5 business days for completion. Please note that there is a nominal charge for this service, as it requires the staff to pull the patient's chart, review the request, prepare the form and transmit the information. Your insurance company does not pay for these services, they are your responsibility.

Paperwork fees:

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1. School / Camp /Sports Physical Forms	**$10.00**
2. Immunization Record/Fax	**5.00**
3. Daycare Medication forms	**5.00**
4. Billing forms	**5.00**
5. Computer chart summary*	**25.00**
6. Medical Records/chart copy*	**25.00** (First 20 pages, subsequent pages $0.10 each)
7. URGENT status	**30.00**
8. FMLA/ HR forms	**20.00**

Billing – Late / Collection fees:

1. Returned checks	**$25.00**
2. 30 Day late fee	**10.00**
3. 60 Day late fee	**10.00**
4. 90 Day late fee	**10.00**
5. Missed appointment	**25.00**

These fees cover our expenses for delivering the service. **Remember that all of these services are included with an office visit, if requested during the office visit for that child, except the ones that have a (*)**.

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Immunization Consent

Patient's Name: _____ Date of Birth: _____

At Kid-Doc Pediatrics we are dedicated to providing the very best quality medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and the Advisory Committee of Immunization Practices (ACIP).

At Kid-Doc Pediatrics we strive to the provide the highest quality of care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Kid-Doc Pediatrics feels that this decision not only puts your child at risk of serious preventable diseases, but also contributes to the health risks of others. Therefore, please be advised that if you desire and "alternate" vaccine schedule or intend to refuse vaccines, you will do so against the advice of Kid-Doc Pediatrics, the AAP, AAFP and ACIP. Because we believe that this decision puts your child at risk for vaccine preventable diseases, we therefore do not think we can provide the best care possible for your child. Kid-Doc Pediatrics will respectfully decline to be the pediatrician for your child. Should you at anytime choose to resume the recommended immunization schedule, we will be happy to welcome you back to Kid-Doc Pediatrics.

I have been provided a copy of the appropriate Centers for Disease Control (CDC) and Vaccine Information Sheet (VIS) to have and read, or have had explained to me, information about disease preventable vaccines that will be administered by Kid-Doc Pediatrics. I have had the chance to ask questions that were answered to my satisfaction. I believe and understand the benefits and risks of the vaccines that will be administered by Kid-Doc Pediatrics and allow consent for the vaccines to be administered.

Parent's Signature: _____ Date:_____

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NO SHOW/MISSED APPOINTMENT POLICY

We, at Kid-Doc Pediatrics, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (minimum 24-hour notice). You can cancel appointments by calling the main office number at 210-492-0900.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment text reminder is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time. We do allow for a 15-minute grace period past your appointment. If you arrive late, it is up to the discretion of the office if the appointment needs to be rescheduled.

Please review the following policy:

- » If less than a 24-hour cancellation is given, this will be documented as a "No-Show" appointment
- » If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment
- » For each "No Show/Missed" appointment, you will be assessed a $25 fee. This is not billed to your insurance.
- » If you have 3 "No Show/Missed" appointments within a 12-month time, dismissal from the practice will be considered. You will be notified in writing if the dismissal was approved.

I have read and understand Kid-Doc Pediatrics No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly. I will notify Kid-Doc Pediatrics appropriately if I have difficulty keeping my scheduled appointments.

Patient Name | Date of Birth | Today's Date

_____

Patient/Parent Signature (if minor) | Relationship to patient

_____ _____

Staff Signature | Date

Rev 3/2020

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Registration Request for My Kid's Chart (Patient Portal)

Email Address: _____

Parent's First Name:_____ Last Name:_____

Patient's to add to the account

Name	**Date of Birth**

Once your account is created, you will receive an email with a link to patient portal with a temporary password that is active for 1 week only. You will need to sign into the portal in order to complete your set up. Be sure to verify your name appears correctly and that the names of the patients appear on the screen.

Once the patient turns 18 years old, the record for that patient will automatically become private. It is at that time; we advise the patient to create their own portal access. Messages can still be sent but the information on the chart can not be viewed. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the provider.

Signature: _____ Date:_____

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