Houston Specialty Clinic

Pediatric Neurology | Pediatric Pulmonology | Pediatric and Adult Sleep Medicine

The Offices of Dr. Joshua Rotenberg, Dr. Sarat Susarla and Kara Schmidt, PA-C, RD

NEW PATIENT REGISTRATION FORM - (PLEASE PRINT)

Date:	Primary Care Physician's Last name: First: Phone number: ( )	Referring Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:			Marital status (circle one) Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth Date: / /	Age:	Sex: ☐ M ☐ F
Race:	Ethnicity:	Language:			
Email:		Social Security: - -	Home phone: ( )		
Street address:		Apt #	Cell phone: ( )		
P.O. Box:	City:	State: ZIP Code:	To which phone # do you wish to receive appointment reminders? ☐Home ☐Cell		
Employment Status: ☐ Full Time ☐ Part Time ☐Unemployed ☐ Student ☐ Other:		Employer:	Employer phone: ( )		
Emergency Contact:		Phone: ( )	Relationship to patient:		

INSURANCE INFORMATION

Person Responsible for bill:	Birth date: / /	Address (if different from patient):	Home phone: ( ) Cell phone: ( )
Occupation:	Employer:	Employer address:	Employer phone: ( )

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of primary insurance:	Name of secondary insurance :
Subscriber's name:	Subscriber's name:
Subscriber's S.S.:	Subscriber's S.S.:
Birth date:	Birth date:
Group:	Group:
Policy#:	Policy #:
Co-payment: $	Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other
Patient's relationship to subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Signature of Patient/Parent/Guardian/or Personal Representative:	
Please Print name:	Date:

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Patient Name	Patient DOB
Name of Parent or Guardian	Relationship to Patient

General Office Policies

Welcome to our practice! We are your partners in accessing patient-oriented specialty care. We hope you find this information helpful.

Office Hours: In general, appointments are available on Monday through Friday between 9am and 4pm, with the exception of holidays. Appointment times and days vary for each provider, and thus emergency after-hour times may also vary. Our office is open between 8:00am and 5:00pm on business days.

Phone Calls & Messaging: We have an answering service to answer calls before and after scheduled office hours and during the lunch hour, as well as on weekends. Phones are forwarded to our answering service for lunch between 12:00pm and 1:00pm, Monday through Friday. You may have the on-call physician paged after office hours. Please note that fees may apply for non-urgent calls.

Check-In Procedure: Please be prepared to submit the following documents for **each visit**:

1. A valid insurance card or Medicaid card (where applicable)
2. Government issued photo ID (Driver's license, identification card, or passport)
3. Insurance co-payment, co-insurance and/or deductibles must be collected at the time of the visit.

Late Policy: Please be advised that if you arrive more than **15 minutes LATE** for your scheduled appointment then you may be required to wait for an open appointment, or to reschedule for a later date. If you are running late to an appointment, please call our office to let us know.

Appointment Cancellation: If you must cancel your appointment, **we require a 24 hour notice**. If you do not cancel within 24 hours, you will be charged a fee of $35.00 for the missed office visit. A higher fee of $50.00 is charged for diagnostic appointments (i.e. EEG and developmental testing) and Botox appointments.

Patients Present at Visits: Patients must be present at appointments in order to bill insurance for the office visit. We offer Telemedicine visits or conference appointments as an option when appropriate.

These services may not be covered by insurance companies. In this situation, our office will charge the responsible party for the respective fees associated with the Telemedicine visit. Please review our Telemedicine policy for further details.

My signature indicates that I have read and understand the above content of this document. A copy of this document can be provided to you upon request, and they are also available on our website.

Signature of Patient/Guardian **Date**

Financial Policies

Insurance Claims: For patients with insurance coverage, we will make our best effort to file a claim with your insurance company for covered services. **Any balances on your account for services, after your insurance pays or denies a claim, are your responsibility**. In the event your account becomes past due, your account may be referred to a collection agency.
Insurance Plans: Your insurance policy is a contract between you and your insurance company. We, as a practice, or as individual providers, also carry a contract with your insurance company, and we are bound by the terms of that contract. Each insurance plan has different policies regarding how often services may be rendered and, more importantly, where those services may be performed. We strongly urge you to familiarize yourself with your policy benefits. If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance along with an updated copy of your new card.
Payment at Time of Service: All co-payments, co-insurance, and deductible amounts required by your insurance company must be paid at the time of service. We understand that can be burdensome for some families, but this payment is a requirement by your insurance company. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding the eligibility and benefits.
NSF/Denied Credit Card Payments: You will be charged a $50.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed into the lock box or our office, electronically via the internet, or payments made by phone.
Patients Without InsuranceCoverage: If you do not have insurance coverage, payment for services is expected at the time services are rendered. The rates charged to uninsured patients have been reduced to approximate the payment rates allowed by private insurance companies in the market. Our Self-Pay rates are available upon request.

Additional Services Identified During Treatment: Please be aware additional charges may be incurred if during a physical-exam the physician addresses diagnoses or treats a problem-focused health concern unknown at the time of check-in. You will receive a statement with those charges following the visit.

Non-Covered Medical Services: Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", or "non-covered" by your health plan. You are responsible for payment of these services. Please be aware that Houston Specialty Clinic reserves the right to modify the cost of any services.

Form/Medical Letters & Medical Records: There is a fee for completion of FMLA paperwork. The fee is collected before the paperwork is completed. We require 3-5 business days to complete this paperwork. Requests for your medical records must be in writing via a special release form. The cost is $25.00 for the 1st 20 pages and $0.50 for each additional page.

Prescription Refills: Please have your pharmacy send over an electronic refill request. When contacting the office, please leave a message with the patient's date of birth, the name of the medication, dosage required by day, your pharmacy name, number and location, along with a call back number. There is a nominal charge for refills of Category 2 (controlled) prescriptions. We require at least two business days to refill a prescription at a $5.00 cost.

Authorization to Release Information: I hereby authorize Houston Specialty Clinic to **1)**release any information regarding my illness and treatment to my health insurance company; **2)** process insurance claims generated in the course of an examination or treatment; **3)**allow a photocopy of my signature to be used to process insurance claims.

Authorization of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), including Medicaid, private insurance, and any other health/medical plan, to issue payment check(s) directly to Houston Specialty Clinic for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility: I acknowledge that I have requested medical services from Houston Specialty Clinic on behalf of myself and/or dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of

the treatment authorized. I agree to pay Houston Specialty Clinic for all services. If I participate in a managed care plan, such as an HMO or a PPO, I promise to pay for any out of network charges for any services or products administered that are not covered under the plan, were not certified by the plans as medically necessary, or were denied by the plan as a result of inaccurate, incomplete, or untimely insurance information updates provided by the patient.

Payment Agreement: I further understand that fees are due and payable on the date of services rendered, and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

My signature indicates that I have read and understand the above content of this document. A copy of this document can be provided to you upon request, and they are also available on our website.

Signature of Patient/Guardian **Date**

Electronic Prescriptions

We subscribe to an electronic prescription service. For your convenience, our physicians transmit E-Prescriptions on a secured internet network directly to participating pharmacies.

Houston Specialty Clinic has the ability to download my pharmacy benefits and medication history through a secured network. This will improve my physician's ability to prescribe medications covered by my health insurance plan, to increase safety and to prevent duplicate prescriptions. Prior authorizations can be achieved more easily with this service.

By signing below, I give permission for Houston Specialty Clinic to download this information from any current or future pharmacy or clearinghouse.

Administrative fees may still apply for written prescriptions for controlled substances and for administrative work related to chronic care.

This is an optional added service provided by HSC. If you do not wish to participate, do not sign below.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

My signature indicates that I have read and understand the Electronic Prescriptions section of this document.
A copy of this document can be provided to you upon request, and they are also available on our website.

Signature of Patient/Guardian **Date**

Telemedicine Consent

I understand that I and/or my healthcare provider Dr. Rotenberg, Dr. Susarla, or Kara Schmidt, PA-c, RD wish for me to have a telemedicine consultation. This means that I and/or my healthcare provider or designee will, through interactive video communication, be able to consult with the above named consultant about my condition. My healthcare provider has explained to me how the telemedicine technology will be used to do such a consultation.
The benefits of a telemedicine consultation are: You may not need to travel to the consult location; you have access to a specialist through this consultation; improved continuity of care; etc…

I understand there are potential risks with this technology: the video connection may not work or that it may stop working during the consultation; the video picture of information transmitted may not be clear enough to be useful for the consultation; I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis; a telemedicine visit may not be as complete as a fact-to-face visit; although reasonable precautions are taken to ensure safety and privacy, one cannot guarantee protection against all types of hacking. Using encrypted systems, the risk of hacking is small but should still be understood.

I give my consent to be interviewed by the consulting health care provide. I understand other individuals may be present to operate any video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained. I understand that a limited physical examination will take place during the video conference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting health care provider. I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers, and other health care providers who may need this information for continuing care purposes. I hereby release the Houston Specialty Clinic, its personnel, and any other person participating in my

care from any and all liability which may arise from the taking and authorized use of such videotapes, digital films, and photographs.
I understand that the financial responsibilities of telemedicine are the same as face-to-face visits and will abide by HSC policies. I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the conditions described in this document.

My signature indicates that I have read and understand the Telemedicine section of this document.
A copy of this document can be provided to you upon request, and they are also available on our website.

Signature of Patient/Guardian	**Date**

Appointment Notification System

Dear Patients,

Our automated appointment reminder system uses Email, Phone Calls, and Text Messaging to provide you with information about our practice and your appointments.

- Upon setting the appointment, our system automatically sends you an email with links to our office webpage that allow you to familiarize yourself with our practice and locations.

- Three days before your appointment, our system automatically confirms your appointment with a phone call, text message, and/or email

Please provide the phone, text, and email information where you would like to receive our updates. We do not share your private information with anyone.

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☐ **DO NOT CONTACT**. Initialing this box and signing below indicates I will take the responsibility to keep track of my upcoming appointments. I understand that if I miss my appointment with fewer than 24 hours notice, I will be charged a $35 no show fee.

My signature indicates that I have read and understand the Appointment Notification section of this document.
A copy of this document can be provided to you upon request, and they are also available on our website.

Signature of Patient/Guardian	**Date**

Advance Beneficiary of Non-Coverage

Dear Patient,

Thank you for choosing our practice for your child's or your care.

As you know, there are many state of the art medical services and equipment required for specialty care.

Though recognized by the AMA and CMS, sometimes these procedures are deemed as "non-covered" or "non-priced" services by THIRD PARTY payers (e.g. Insurance companies, Medicaid, etc). Insurance policies may determine that services and/or supplies are not medically necessary, non-covered or investigational.

As a result, some valid and important procedures (even those recognized by CMS/Medicare) are not reimbursed by insurances.

As an example, telemedicine offers quality and convenience for routine follow-up or for urgent concerns. Also, the doctors and nurse practitioners may need time after your visit to confer or research your condition. Yet, some insurances do not reimburse for these services and these services may be considered "NON-COVERED."

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We want to make sure that you are aware that some of our services, though valuable and even convenient for you, may NOT be covered services.

To the best of our ability, we extend efforts to warn you if your insurance will not offer coverage for these services. We update our list of known non-covered services from time to time. However, benefits can change without warning. Please take the time to understand your medical insurance policy.

We ask for written acknowledgement that you understand this process.

Please ask our office if you have any questions.

Warmest regards,

Dr. Joshua Rotenberg
Dr. Sarat Susarla
Kara Schmidt, PA-C, RD

Acknowledge Statement

I am hereby requesting that the following services to be provided to me by: Dr. Joshua Rotenberg, Dr. Sarat Susarla and Kara Schmidt, PA-C, RD or other providers of Houston Specialty Clinic or Neurology & Sleep Specialists.

I understand that some services may not be considered eligible benefits (e.g. services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider.

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services. I also understand that I am responsible for payment of the services or items I request and/or receive if these services or items are determined not to be reasonable and medically necessary for my care.

Examples of these non-covered items include but are not limited to: telemedicine, actigraphy; prolonged services in the office, observation or inpatient setting (Face-to-face or otherwise); health & behavior interventions; report writing; medical conferences, family conferences and/or meetings; certain form completion and supplies. I agree to be financially responsible for any and all related charges if they are not covered by my health insurance.

Signature of Patient, Guardian, or Responsible Person- Signing below indicates that you have received and understand this notice. You will also receive a copy.

Signature of Patient/Guardian **Date**

E-mail Policy - PATIENT PORTAL USE

PLEASE USE THE PATIENT PORTAL FOR SECURE COMMUNICATIONS.

Access your personal Patient Portal by visiting:

https://health.healow.com/hsc

Add the healow app onto your smartphone and enter our practice code

JDCFAD

If you do not have your portal log in information or you are having difficulty

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Acknowledgement of Notice of Privacy Practices and HIPAA Compliance

(Available for review at the Front Desk and on our Website)

I have reviewed 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.

Signature of Patient/Guardian	**Date**

Patient's name and date of birth:

_____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ DOB: _____
I authorize the following individual or organization to disclose the above named individual's health information:

NAME: _____

ADDRESS: _____
This information may be disclosed TO and used by the following individual or organization:

NAME: _____

ADDRESS: _____
For the purpose of:
Please release the following: ☐ Entire record **OR:**
☐ Problem List ☐ Genetic testing information ☐ Medication List ☐ Allergies ☐ Progress Notes ☐ H&P
☐ X-Ray/Imaging Reports-from (date) _____ to (date) _____
☐ Laboratory Results-from (date) _____ to (date) _____
☐ Other diagnostic reports _____
☐ Other (specify) _____
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
☐ **YES, I consent to the release of this information** ☐ **NO, I do not consent to the release of this information**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or 30 days from the date of this request.
I understand that authoring the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager.

_____ _____ _____ _____
Signature of patient/guardian | Please print name | Date | Relationship to patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Houston Specialty Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____ _____ _____
Signature of patient/guardian | Please print name | Date | Relationship to patient