1151 N. Buckner Blvd., Ste 203
Dallas, TX 75218
P: 214-324-4221 F: 214-324-3705

2379 Gus Thomasson Rd., Ste 200
Mesquite, TX 75150
P: 972-686-6400 F: 972-686-6391

COMPREHENSIVE
Pediatric Care

Meenu Jindal DO FAAP
Yasmin Tejani DO FAAP
Gwendolyn Stokes APRN
Janett Galvin APRN

Patient Registration Form

Today's Date _____

1. Tell Us About Your Child

Name (Last, First)_____SS#_____

Date of Birth_____ Age _____ M F Patient resides with _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ Email _____

Cell Phone # _____Work Phone # _____ Home Phone # _____

Emergency Contact_____ Phone #_____

2. Parent or Legal Guardian's Information (The information in this section applies to the main legal caregiver(s) of the child.)

Who should be listed as the statement recipient for the account? _____

Relationship to the patient: __ Father __ Mother __ Other, please specify_____

Father/guardian Name: _____

Date of Birth: _____ SS# _____

Cell Phone # _____Work Phone # _____

Email: _____

Employer: _____

Mother Legal Name: _____

Date of Birth:_____ SS#_____

Cell Phone # _____Work Phone # _____

Email: _____

Employer: _____

3. Insurance and financial information (from person responsible for the account)

Primary Insurance Company Name: _____

Policy Holder Name: _____ Policy Holder's Date of Birth:_____

Relationship to patient: _____ Plan Type: _____ (HMO, POS, PPO)

Group (Employer Name or Self-Insured): _____

Insurance ID#: _____ Group # _____ Insurance Phone # _____

Claims Address:_____

4. How did you learn about our practice?

- ○ Insurance
- ○ Family/Friend _____
- ○ Internet
- ○ Other _____

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Financial and Office policies Agreement

Patient Name: _____ Date of Birth: _____

Financial Agreement:

_____Comprehensive Pediatric Care (CPC), files primary insurance only for services provided to patients with managed care organizations in which we participate. **Co-payments, co-insurance, non-covered services and deductibles are the responsibility of the patient and payable at the time of service.** Managed care patients are billed for any remaining patient responsibility after the insurance company has processed claims. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under an insurance plan in which we are not contracted, are financially responsible for all charges incurred at the time of service. In the event that the insurance carrier erroneously denies payment for a service performed, it is the patient's responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier. It is also the responsibility of the patient to be aware of plan benefits and your right to appeal claims. Insurance contracts are subject to change. Provider directories produced by Managed Care plans may not provide the most current information regarding plan participation and therefore are not a guarantee of our participation. Patients must verify plan participation with your insurance.

It is the parent (guardian's) responsibility to **notify the office of any address, phone, or insurance changes**.

All insurance patients are required to have their current insurance card. If you have Medicaid, you must have your **current monthly issued Medicaid card or temporary Medicaid card** and **Dr. Meenu Jindal DO must be assigned the primary care physician** in order to be seen as a Medicaid patient.

The maximum fee allowed by law will be charged for returned checks. Accounts are considered past due 60 days from the date a service is billed.

I request release of payment information to Comprehensive Pediatric Care, PLLC, (CPC) by third party payers, when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to CPC and I authorize payment of those benefits directly to that provider.

Office Policies:

____We see patients by appointment only. If you are more than 15 minutes late for your appointment, we may ask you to reschedule. The appointment must be made for each child that you want seen by the provider.

All appointments must be **cancelled within 24 hours** or there is a $25.00 charge for each missed appointment. You may also receive a **dismissal letter if you miss more than 3 appointments**.

There are several providers and nurse practitioners that work in this office. We **do not guarantee** which provider you will see.

ACCEPTANCE OF FINANCIAL TERMS and OFFICE POLICIES

By signing this agreement, I accept the financial terms noted above and certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility to present CPC with valid insurance information at each visit and inform CPC should any information on this form change at any time in the future.

Signature of Parent/Legal Guardian: _____ Date: _____

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Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Authorization To Release Protected Health Information:

I, _____, hereby authorize Comprehensive Pediatric Care PLLC to disclose and release the relevant portions of my/my child's medical record(s) from each occasion of treatment to any third party payer (or their representatives), or any other individual as may be necessary to obtain payment for the Physician's services to me/my child, including for the purposes of coordination of benefits and prior authorization. I also authorize the Physician to disclose the medical information to other physicians or healthcare providers who are treating me/my child. Finally, I authorize the Physician to release such information as is necessary for the Physician to perform certain healthcare operations, such as to a utilization review committee or my/my child's insurance case manager and as required by federal, state or local law.

I understand that the information I am authorizing to be disclosed may contain references to psychiatric conditions, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, including HIV or AIDS diagnosis.

A summary of your rights concerning you/your child's medical records is described in the Notice of Privacy Practices, which is being provided to you.

As the party responsible for medical decision making for the child/children represented in this medical record, I hereby give my consent to the physicians and other healthcare employees of CPC to render both emergency and non-emergency healthcare services both in and out of my physical presence, and to perform all necessary diagnostic test. I also assume financial responsibility for any and all healthcare services provided to said patient/s. A separate authorization form must be completed prior to releasing patient records to the patient/guardian, other individuals or agencies. These requests are processed in order of receipt. We do not process routine request for copies of medical records or the completion of health forms on a walk-in basis. Please be aware, there is a fee associated with the duplication of medical records for patients transferring out of the practice. It is illegal to deny patient records or refuse the transfer of records due to an unpaid or past due account balance, however records may be withheld for non-payment of the medical record fee.

ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By my signature below, I acknowledge that I have received the CPC *Notice of Privacy Practices* on or prior to any service being provided to me by Comprehensive Pediatric Care following March 14th, 2016.

In addition, I agree to the above terms of release of health information. I agree that I am voluntarily signing this form and that the authorization is valid only for the purposes described in the first paragraph. This authorization is in effect until revoked by the patient/legal guardian.

Signature of Parent/Legal Guardian:_____ Date:_____

Relationship to Patient:_____

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Health information communication and Child accompaniment

Patient Name: _____ Date of Birth: _____

I wish to be contacted in the following manner (check all that apply)

- o Home phone
- o Cell phone
- o Email
- o Via mail

Security Pin Number

Due to the health privacy laws, this office will now require you to choose a four digit PIN number. **DO NOT LOSE THIS NUMBER.** We will ask you this number when you call in for ANY information regarding your child/children. Should you decide to share this number with other family members or friends, you are giving them permission to have access to your child's private health information.

Four digit Pin: ___ ___ ___ ___

Individuals Authorized To Bring Child for Treatment

I, _____,

authorize the following individuals to bring my child, _____,

to Comprehensive Pediatric Care for treatment.

NAME/relationship to child _____

Address _____

NAME/relationship to child _____

Address _____

NAME/relationship to child _____

Address _____

This authorization can be revoked by the parent /guardian at any time.

Signature of Parent/Legal Guardian:_____ Date:_____

Relationship to Patient:_____