TOTS N TEENS PEDIATRICS, P.A.
PATIENT REGISTRATION

Patient 1 _____ Sex ____ DOB: _____
Patient 2 _____ Sex ____ DOB: _____

Primary Phone Number: (Required) _____ Alternate Phone Number: (Required) _____

Pharmacy: (Required) _____

Please check all that apply:
Child(ren) live with Mother ____ Father ____ Step-Mother ____ Step-Father ____ Other ____

Custodial Parent (where the child lives)

Last Name: _____First: _____
Spouse (Step-parent name) _____
Street Address: _____
City: _____State: _____ Zip: _____
Employer: _____ Phone: _____
SS#: _____DOB: _____
Email: _____

Other Parent

Last Name: _____ First: _____
Spouse (Step-parent name) _____
Street Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
SS#: _____ DOB: _____
Email: _____

How did you hear about us? □ Our Website □ Google □ Friend □ Family □ Facebook □ Other _____

Emergency Contact: _____ Phone: _____ Relationship: _____

The following person(s) have permission to bring my child(ren) to doctor appointments. They may receive confidential medical information on above child and may have my child vaccinated/treated in my absence.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

- **I authorize Tots N Teens Pediatrics, P.A. to vaccinate, provide medical attention and treat my child.**
- **I authorize Tots N Teens Pediatrics, P.A. to copy and/or fax my child's immunization record and/or vision/hearing at my request without a signed authorization.**

Financial Agreement

Tots N Teens Pediatrics, P.A. files primary insurance only for services provided to patients with managed care organizations in which we participate. **Co-Payments, Co-insurance, no-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 claims have been processed by the insurance company. Proof of insurance is not a guarantee of payment. **Patients without insurance or covered under an insurance plan that is "Out of Network" are financially responsible for all charges at the time of service.** If services are denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the two. It is also the responsibility of the patient to be aware of plan benefits and your right to appeal claims.

The maximum fee allowed by law will be charged for return checks. Accounts are considered past due after 60 days from the date of service and are sent to collections after 90 days from date of service.

I authorize the release of payment information to Tots N Teens Pediatrics, P.A. by third party payers, when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to Tots N Teens Pediatrics, P.A. and authorize payment of those benefits directly to the provider.

Acceptance of Financial Terms
By signing the agreement, I accept the financial terms noted above and certify that the information above is true and correct. Furthermore, I understand it is my responsibility to present Tots N Teens Pediatrics, P.A. with valid insurance and demographic information for each visit.

Signature of Parent/Legal Guardian: _____ Date: _____

Office Use Only: _____Date: _____

Initial History Questionnaire

FORM COMPLETED BY

DATE COMPLETED

Name

ID NUMBER

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

OFFICE AND FINANCIAL POLICIES FOR TOTS N TEENS PEDIATRICS, P.A.

Payment is due at the time of service:
For patients without insurance, payment is due at time of service for both sick and well visits. Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process. Contact the billing office for any problems with your account.
Should the insurance company deny payment for services performed, it is the insured's responsibility to pursue the issue. Billed services not covered by insurance are the insured's responsibility, including vaccines charges. If correct insurance information is not provided in a timely manner and causes a delay in insurance processing, the insured will be responsible for charges and any previous balances at time of service.
The patient or adult presenting with the patient is responsible for satisfying the copay. Regardless of court decision concerning health care in the case of divorced parents, prompt payment is expected from the presenting parent. It is the presenting party's responsibility to be familiar with the patient's insurance benefits.

General Office Fees:
*There is a $25.00 charge for non-shows for urgent sick visit and follow up appointments and a $40.00 charge for routine well visit and med check appointments not cancelled 24 hours prior to the scheduled appointment time.
* There is a $30.00 return check fee, and future payments must be rendered by means other than check.

Clinical Fees:
*There is a $20.00 admin fee to process a controlled drug RX outside of an office visit.
*There is a $20.00 admin fee to re-process a controlled drug RX when it is not filled within the 21 day deadline. The voided prescription must be returned before a new prescription can be given.
*48 hour prepare time for all RX requests.

Medical Record Fees:
*There is a $25.00 fee for the first 20 pages and $0.25 cent for each page thereafter per patient to have it copied. Fee must be paid in advance.
*There is a $10.00 form fee per patient for forms completed outside a routine checkup appointment.
*Copy of immunizations are free of charge.

After Hour and Weekend Visit Fees:
*There is an additional $30 charge when patients are seen after hours, or on the weekends. This fee will be billed to insurance and private pay patients. This fee may be subject to your deductible or coinsurance.

Identity Theft Protection:
A copy of all parents' drivers' license and insurance cards must be kept on file for the patient's protection in compliance with HIPAA and Red-Flag. Verification must be done for all new insurances prior to the visit; be sure to give all updates to the scheduler when making appointments.
All demographic information will be updated annually. It is the patient's or legal guardian's responsibility to update address and telephone numbers in written form. Therefore, please arrive 15 minutes early to your appointment when needing to update any information.

Office Courtesy:
An appointment reminder is made two business days in advance by text/email/phone call as a courtesy only; it is the patient's or legal guardian's responsibility to remember the appointment date and time.
Scheduled appointments are for one child only. Do not assume a sibling can ben seen at the same time. A call must be made to determine if the doctor's schedule can accommodate an additional child.

All office visits are by appointment only.

_____ _____
Signature **Date**

Tots in Teens Pediatrics, P.A. is committed to protecting the privacy of our patients' health information. This notice describes our privacy practices.

Tots N Teens Pediatrics P.A. Notice of Privacy Practices

Effective Date: January 2019

We respect patient confidentiality and only release personal health information about you in accordance with the State of Texas and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide care, there are times when we will need to share your personal health information with others beyond the practice for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of the practice that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Operations. We may use information about you to coordinate our business activities. This may include reviewing your care and training staff, budgeting and financial reporting, as well as activities to evaluate and promote quality.

Information Disclosed Without Your Consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects.

We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS AND RESPONSIBILITIES

You have the following rights under state and federal law:

Copy of Record. You are entitled to inspect the personal health record we have generated about you.

We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information.

This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this policy or have any complaints you may contact us in writing for further Information. You also may complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.

IMPORTANT: Read all sections before signing. I acknowledge that I have received and read this privacy notice.

_____ _____

Patient Signature **Date**

Tots N Teens
PEDIATRICS

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical records is $25 for the first 20 pages and $0.25 for each additional page.

Patient Name: _____ DOB: _____
Contact Number: _____
I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Tots N Teens Pediatrics □ Forney □ Mesquite □ Plano or □ Organization/Person:	Tots N Teens Pediatrics □ Forney □ Mesquite □ Plano or □ Organization/Person:
Street Address: _____ City,State,Zip: _____	Street Address: _____ City, State, Zip: _____
Phone: Fax:	Phone: Fax:

INFORMATION TO BE RELEASED

□TNT Health Records □ Entire Record □ Billing Record □ Other (please specify) _____
Format for records (Please check only one box): □ Mail □ Fax □ Pick up

PURPOSE OF RELEASE

□ Legal □ Personal use □ Continuing Care □ Transfer to another provider □ School
□ Other: _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Tots N Teens Pediatrics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date or event is entered here: _____
(Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you.)

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1: Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2: Substance abuse and mental health treatment (age 13 and older).

_____
Signature of Minor Patient Date

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_____
Signature of Patient or Legally Responsible Party Date

_____
Relationship to patient