Pediatric Associates of Austin, PA

New Patient Information/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, 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
Developmental Screenings (M-CHAT, ASQ, PHQ)	Vaccines (**Including refusal of vaccine resulting in waste**)
Dental Fluoride Treatment	After Hours Phone calls to speak with a Nurse or Doctor
Cerumen (ear wax) removal	Wart removal
Breast Feeding Consultations	Any sort of splints or casting
Rental or purchase of a nebulizer	

- **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. An additional charge applies for these after-hours services, which we will file with your insurance plan; however, depending on your policy coverage, the charge may be "non-covered", meaning you will be responsible for payment.

- **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 <u>initial</u> 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

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 branch 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 you 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 and Voicemail Delivery of Medical Information

Pediatric Associates of Austin (PAA), After Hours Kids (AHK) and SportsSafe (SS) offer Electronic Communication and Voicemail Delivery of Medical Information, 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.

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

We use texts and emails:	**You can use email to**:
To remind you of appointments;	Send in school and camp forms to be completed; (Please allow 72 hours to complete.)
To notify you of health services that may need to be scheduled, such as well checks, labs and/ or immunizations;	Send non-urgent messages to our nurses/doctor;
To notify you of new services available at PAA;	Request a refill for your child(ren)'s prescriptions;
To notify you of Holiday Closures and/or Bad Weather Delays.	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.

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 and Voicemail Delivery of Medical Information

Please indicate which consents you wish to accept or decline, by check marking 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** ☐ **I DO NOT AGREE** to use these electronic services.

I prefer the following forms of communication: ☐ Email -- Preferred Email Address: _____

☐ Text messages – Preferred Cell Phone: _____

☐ **I DO** ☐ **I DO NOT** 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.

Name of Each Child in Practice: _____ _____ _____ _____

Signature: _____ Printed Name: _____

Relationship to Children: _____ Date: _____

Revised June 2017

PEDIATRIC ASSOCIATES OF AUSTIN

PERMISSION TO TREAT MINOR WITHOUT PARENT/GUARDIAN PRESENT

By law, if your child(ren) need(s) medical care, a parent must give permission, except in true emergency situations. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, trying to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

When you cannot be reached for permission, we will look to this document to determine who can consent to your child's general pediatric health care. Additionally, if your child is 16 years of age or older, and you wish for him/her to see the physician without your presence, we will also need your permission.

By providing the information below and signing, you are giving permission to the physicians and nursing staff of Pediatric Associates of Austin, P.A., to diagnose and treat your children, under the care of those appointed below, in the event you cannot be present. **Please remember that those appointed below will need to provide a photo I.D. at the time of the visit. This authorization is valid until rescinded by the parent or guardian.**

Name of Minor(s)	**Date of Birth**	**Children 16 and older can be seen without an appointed adult listed below:**	**Children 16 and older can receive vaccines without an appointed adult listed below:**
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

I/ We, being the parent(s) or legal guardian(s) of the above-named minors(s), do hereby allow the following person (s) to act on my/our behalf in authorizing medical treatment for the above-named minors(s) during the period of my/our absence. I authorize any treatment necessary as deemed by the physicians at Pediatric Associate of Austin. Please also authorize approval or denial of vaccine administration in the area below.

Name (Relative, Friend, Babysitter, etc.)	**Relationship to Child**	**Phone #**	**I authorize vaccines to be administered while under the supervision of the following person (s):**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

_____ _____

Parent/Legal Guardian (Print Name) **Relationship to Child**

_____ _____

Signature of Parent / Guardian **Date**

_____ _____

Signature of Witness **Date**

Pediatric Associates of Austin
e-Prescribing Consent (PBM)

The providers at Pediatric Associates of Austin use an electronic medical record system that allows ePrescribing of medications. ePrescribing is defined as a physician's ability to electronically send accurate, error free, and understandable prescriptions directly to a pharmacy from the point of care, through a secure connection (Surescripts), greatly reducing medication errors and enhancing patient's safety.

Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribing program. These include:

☐ **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan.

☐ **Medication history transaction-** Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.

☐ **Fill status notification-**Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up or partially filled.

By signing this consent form, you are agreeing that Pediatric Associates of Austin, PA may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Pediatric Associates of Austin, PA to enroll me in the ePrescribe program. I have had an opportunity to ask questions and all my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient

PEDIATRIC ASSOCIATES of AUSTIN, P.A.
1500 W. 38TH STREET, SUITE 20, AUSTIN, TX 78731
WWW.PEDIATRICASSOCIATES.NET | 512.458.5323

STEPHEN GRIGGS, MD ● SAMUEL MIRROP, MD ● LANCE HARGRAVE, MD ● WHITNEY MORGAN, MD
ASHLEY GONZALEZ, MD ● BRANDI LOOMIS, MD ● JESSICA MOWRY, MD ● EMILY WOODARD, RN, CPNP

Pediatric Associates of Austin, PA

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 over 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 March 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
March 1, 2018 – February 28, 2019

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.

The annual fee is:

	Fee	Discounted if paid by 4-1-18 – 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 $_____

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

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Who is your preferred doctor? Please circle: Griggs, Mirrop, Hargrave, Gonzalez, Loomis, Mowry or Sanford

---

Credit Card #_____ Exp. ___/___ Visa☐ M/C☐ Discover☐

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, PA

Vaccination Policy

Pediatric Associates of Austin has updated our vaccination policy in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control.

Our first and most important priority is the safety and well-being of our patients. Vaccines are one of the safest and most effective ways to protect your child against diseases that can cause serious illness or even death. Vaccinating all children is an important way to minimize exposure to vaccine-preventable illnesses for our most vulnerable patients, including newborns, children with weakened immune systems and pregnant women.

For these reasons, Pediatric Associates of Austin will now require all of our new patients to begin vaccinations by 6 months of age and have completed required vaccinations by the age of 2.

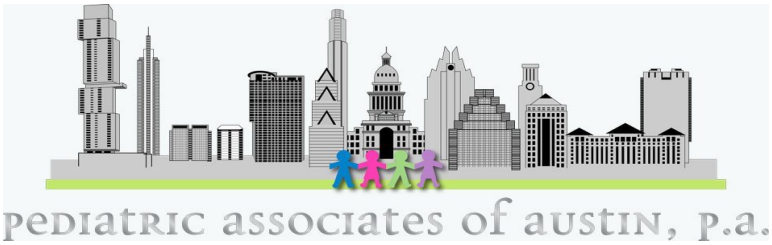
Current families whose children are missing vaccinations will also be required to discuss with their physician a plan to complete required vaccines. As always, we will continue to care for patients who cannot receive vaccines for medical reasons.

Thank you for your understanding. Your child's health is of utmost importance to us.

Please contact our office if you have any questions or concerns.

ACKNOWLEDGEMENT OF VACCINATION POLICY:

SIGNATURE DATE



Well Check Age	Vaccination
Newborn	Hep B #1
1 Month (Must be at least 28 days after 1st Hep B)	Hep B #2
2 Months (Must be at least 6 weeks old)	DTaP, IPV, HIB, PCV, Rotavirus (oral) DTaP=Diphtheria, tetanus & pertussis IPV=Poliovirus HIB = Haemophilus influenzae type b for meningitis and pneumonia PCV = Pneumococcal conjugate vaccine
4 Months (Must be at least 1 month since last)	DTaP, IPV, HIB, PCV, Rotavirus (oral) DTaP=Diphtheria, tetanus & pertussis IPV=Poliovirus HIB = Haemophilus influenzae type b for meningitis and pneumonia PCV = Pneumococcal conjugate vaccine
6 Months (Must be at least 1 month since last)	DTaP, IPV, HIB, PCV, Rotavirus (oral) DTaP=Diphtheria, tetanus & pertussis IPV=Poliovirus HIB = Haemophilus influenzae type b for meningitis and pneumonia PCV = Pneumococcal conjugate vaccine Flu = Influenza vaccine (must be 6 months to the day or older to receive the flu vaccine; 2nd dose at least 28 days from 1st dose.)
9 Months	Hep B #3
12 Months (Must be at least 12 months old)	Hep A, #1, MMR #1, Varicella #1
15 Months	PCV, DTaP, HIB
18 Months	Hep A #2 (must be administered at least 6 months or more from the day of 1st dose)
2 Years	No Shots (if up to date, or flu vaccine is needed.)
3 Years	MMR #2, Varicella #2
4 Years (Must be at least 4 years old)	DTaP, IPV
11-12 Years	Tdap, HPV, Meningococcal
12+ Years	HPV
7th Grade	Check Hep A Status

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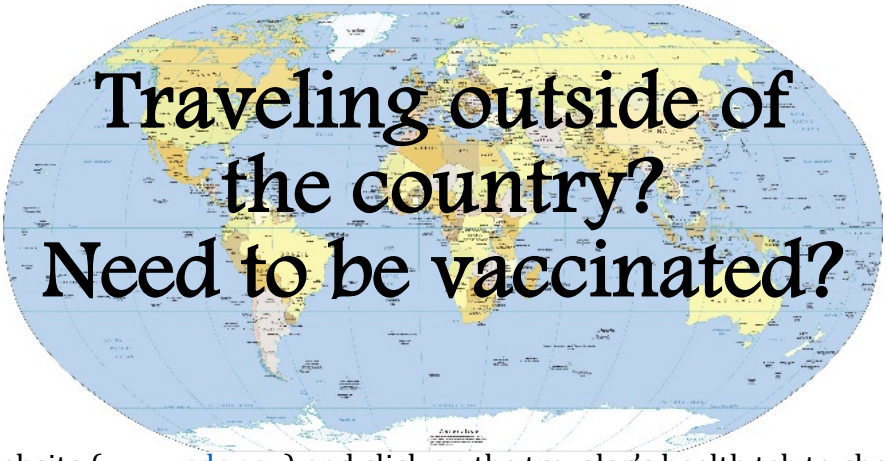
1500 W. 38TH STREET, SUITE 20, AUSTIN, TX 78731 • 512-458-5323 • WWW.PEDIATRICASSOCIATES.NET



If so, visit the CDC website (www.cdc.gov) and click on the traveler's health tab to choose your travel destination. You will then find information on what vaccines are recommended and other traveling tips.

At Pediatric Associates of Austin, we can provide all routine vaccines, but if you are needing travel vaccines such as typhoid or yellow fever, you will need to visit a travel clinic.

Remember that it is recommended that you receive vaccines at least 2 weeks before you travel, as it takes 2 weeks for vaccines to be effective. Some medications may need to be started prior to travel as well.

Traveling Vaccine Clinics

Passport Health Locations:

- 631 W. 38th Street, Suite 1
  Austin, Texas 78705
  512-459-0672
- 4501 Spicewood Springs Rd, Unit 1033
  Austin, Texas 78759
  512-459-0672
- 6600 South Mopac Expressway, Ste 2180
  Austin, Texas 78749
  512-459-0672
- 12801 Shops Parkway, Suite 400
  Bee Caves, Texas 78738
  512-459-0672
- 100 Heritage Center Circle
  Round Rock, Texas 78664
  512-459-0672
- 1335 E. Whitestone Blvd., Suite 100
  Cedar Park, Texas 78612
  512-459-0672

Austin Regional Clinic:

- 6835 Austin Center Blvd.
  Austin, Texas 78731
  512-421-4865

Walgreens and CVS have vaccines such as typhoid or yellow fever as well. Call your local pharmacy to see if they have these vaccines available.

If you have any questions about your child's vaccines or any other travel related concerns, please leave a message for our nurses at 512-458-5323.

If you receive any travel vaccines, please let our practice know, so that we can update your child's vaccine record.

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Vision Screening Waiver

Child(ren)'s Name_____ Date of Birth_____
_____ _____
_____ _____

Dear Parent,

Every child needs regular vision screenings, and our doctors follow the American Academy of Ophthalmology (AAO) and Bright Futures Protocol, which suggests routine clinical vision screenings. This is done at every well exam by your Pediatrician. Beginning at 3 years of age, or at any time the parent requests, we offer an advanced vision screening.

To effectively address vision issues in your children, our practice uses Automated Vision Screening Technology. This technology is a rapid and highly reliable method that instantly detects the most common treatable sight threatening conditions in children such as: refractive errors (nearsightedness, farsightedness, unequal power and astigmatism), amblyopia (lazy eye), strabismus (crossed eyes), and media opacities (cataracts).

By offering the latest technology, our practice is taking a leadership role in the community to identify vision issues that can hinder your child's ability to learn. The prevalence of vision issues has a profound social impact.

"An undiagnosed or untreated vision disorder clearly leaves a child behind in the classroom…the factors related to a student's vision are significantly better predictors of academic success than is race or socioeconomic status." Association for Supervision and Curriculum Development (ASCD).

Automated Vision Screening does not replace a complete or comprehensive eye exam by an Optometrist or Ophthalmologist, nor can it detect all eye diseases or conditions. The Automated Screening helps determine if your child requires the immediate attention of a Vision Care Specialist.

While the Automated Vision Screening Technology is designed to determine if your child should be referred to a Vision Care Specialist, some insurance companies often do NOT cover expenses associated with the Automated Vision Screening.

Unfortunately we cannot offer this service for free, thus by checking "YES" below, you are accepting responsibility for any uncovered expenses associated with this screening. The Cost of the Automated Vision Screening is $35.00 if your insurance doesn't cover it.

- ○ YES, I want to have the Automated Vision Screen performed on my child
- ○ NO, I will seek vision care from an Eye Care specialist independently.

_____ _____
Parent/ Guardian Signature Date

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.

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Pediatric Associates of Austin Newsletter Signup

Parent Name: _____

Preferred Email Address : _____

Preferred Phone: ☐ Home ☐ Cell: _____

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)