Night & Day PEDIATRICS

PATIENT INFORMATION

Patient's Name (Child):		
Date of birth:	Sex: Male ☐ Female ☐	Primary Phone:
Current address:		
City:	State:	ZIP Code:
Preferred Pharmacy:	Address:	Phone:
Preferred Office Reminder Method:	Cell Phone ☐	Email ☐

PARENT INFORMATION

Parent 1:		Maiden Name (If Applicable):
Address:		Date of Birth:
City:	State:	ZIP Code:
Cell Phone:	Email:	
Employer:	Occupation:	Work Phone:
Parent 2:		Maiden Name (If Applicable):
Address:		Date of Birth:
City:	State:	ZIP Code:
Cell Phone:	Email:	
Employer:	Occupation:	Work Phone:
Person, other than parent, to contact in an Emergency:		
Cell Phone:		
Relationship:		

INSURANCE INFORMATION

Insurance Company (Primary):	
Policy No:	Group No.
Policy Holder's Name:	
Insurance Company (Secondary):	
Policy No:	Group No.
Policy Holder's Name:	

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Night and Day Pediatrics, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

Signature of parent or legal guardian:	Date:

HISTORY SHEET

Name _____ Birth Date _____ Sex _____

Referred by _____

CURRENT PROBLEMS/CONCERNS _____

_____

_____

_____

_____

PAST HISTORY

Hospitalizations, date and diagnosis _____

_____

Current medications _____

Allergies _____

Check if child has had:

- ❑ Chicken pox
- ❑ Rubella (German measles)
- ❑ Measles
- ❑ Mumps
- ❑ Recurrent tonsillitis
- ❑ Ear infections
- ❑ Asthma
- ❑ Hepatitis
- ❑ Urine Infections
- ❑ Pneumonia

BIRTH HISTORY

Birth Weight _____ Feedings: Breast _____ Bottle: _____

Problems as a newborn _____

_____

Problems in pregnancy or delivery _____

_____

Smoking during pregnancy? ❑ Yes ❑ No _____

Alcohol consumed during pregnancy? ❑ Yes ❑ No _____

Medications during pregnancy? _____

_____

GROWTH AND DEVELOPMENT

Age at which sat _____ Walked alone _____

Spoke single words _____ Spoke in sentences _____

School Grade _____ Regular Class _____ Special _____

Problems/Concerns _____

_____

_____

_____

_____

FAMILY HISTORY

Mother's age _____ Health problems _____

Father's age _____ Health problems _____

Sibling's name _____ Age_____ Problems _____

_____ Age_____ Problems _____

_____ Age_____ Problems _____

_____ Age_____ Problems _____

_____ Age_____ Problems _____

Are these both the biologic (natural) parents? ❑ Yes ❑ No

If no please explain _____

_____

Have any siblings died? ❑ Yes ❑ No

If yes, cause _____ age and date_____

Family History: please check if any of the following diseases in close family members. If checked, please explain:

- ❑ Heart attacks/disease in those less than 45 _____
- ❑ Diabetes _____
- ❑ Cancer _____
- ❑ Epilepsy _____
- ❑ Asthma/allergies _____
- ❑ Kidney disease _____
- ❑ Cystic fibrosis _____
- ❑ Muscular dystrophy _____
- ❑ Blood disorders _____
- ❑ Deafness _____
- ❑ Mental retardation _____
- ❑ Depression/other psychiatric problems _____
- ❑ Other _____

Additional Information: _____

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: ____/____/____ Age: _____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name MI

Provider's/Clinic's Name:

_____

Please check the first category that applies; check only one.

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance (uninsured), or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- ☐ (f) is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

☐ (g) has private insurance that covers vaccines (not TVFC eligible).

Signature: _____ Date: _____

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Night and Day Pediatrics

4499 Medical Drive, Suite 280
San Antonio, Texas 78229
Office (210) 614-4499

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we will provide the minimum necessary information to only those we feel are in need of your health care information and in formation about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relies on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent **in writing** after you have reviewed our privacy notice.

Print Name:_____ Signature:_____

Date:_____

Print Child's Name & DOB: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Night & Day PEDIATRICS

NOTICE TO PARENTS

Please read and initial each section.

_____Parent or legal guardian must be present with minor patient at each visit. Anyone other than the parent must provide signed documentation authorizing the care of the patient.

_____Proof of current insurance is required at each visit.

_____Payment is due at the time services are rendered. This includes any co-payments, balances for prior visits due to deductibles, non-covered services, or any amount your insurance deems your responsibility.

_____In the case of divorce or separation, the parent requesting medical treatment is responsible for payment at time of service. We will collect co-payment, deductibles and outstanding balances from the attending parent or guardian.

_____A $25 No-Show fee will be incurred for missed appointments.

_____A $25 Late Cancellation fee will be incurred for sick appointments cancelled with less than 2 hours' notice and Well appointments cancelled with less than 24 hours' notice.

_____More than 3 No-Shows, per family in a 12-month period may result in dismissal from the practice.

_____ We allow a 15-minute grace period. Patients more than 15 minutes late may be rescheduled.

_____There is a $15 form fee for filling out various forms and letters of medical necessity, including but not limited to : school, camp, sports, and daycare forms. The payment is due before or at the time of pick-up.

_____Family and Medical Leave Act (FMLA) forms incur a fee of $50. This payment is due before or at time of pick-up.

_____Parents must call to request referrals for all specialist appointments one week in advance.

_____Please turn off cell phones during your visit.

_____Loitering in the hallways is not allowed for the privacy of all patients.

_____Children must be always accompanied by an adult.

_____**Night & Day Pediatrics requires all children to be fully immunized according to the schedule recommended by the American Academy of Pediatrics and Center for Disease Control. We do not "break up vaccines" or endorse alternate or delayed vaccine schedules.**

This instruction sheet is provided for the information of our patients and your signature is required for our files.

Patient Name:_____ DOB:_____

Parent Signature:_____ Date:_____

CONSENT TO LEAVE MEDICAL INFORMATION BY PHONE OR EMAIL

I (PLEASE CIRCLE PREFERENCE) DO OR DO NOT GIVE NIGHT AND DAY PEDIATRIC STAFF PERMISSION TO LEAVE PHONE OR EMAIL MESSAGES WITH MEDICAL INFORMATION PERTAINING TO MY CHILD,

_____.

(NAME AND DOB OF PATIENT)

I WILL NOT HOLD NIGHT AND DAY PEDIATRIC STAFF LIABLE FOR ANY INFORMATION THAT IS OVERHEARD OR READ BY ANY UNAUTHORIZED PARTY.

NAME OF PERSON AUTHORIZING_____

RELATIONSHIP TO PATIENT_____

DATE_____

PHONE NUMBER AUTHORIZED RECEIVE MEDICAL INFORMATION WITH AREA CODE:

_____

EMAIL ADRESS AUTHORIZED TO RECEIVE MEDICAL INFORMATION:

_____