Pediatric & Adolescent Specialists of Rockwall

Patient Information

First Name_____Middle Initial_____ Last Name_____Age_____ Gender: M / F

Address_____Apt #_____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____ SS#_____Home #_____ Cell/Alt #_____
Is the patient a full-time student? Yes No Is the patient adopted? Yes No Email Address_____

Complete If Patient is a Minor (DO NOT list stepparent info. unless they have legal guardianship!)

Name of **biological** mother/legal guardian: _____ Date of Birth:____/____/_____

Home phone_____ Work phone_____ Cell _____ Marital Status: S M D W Deceased

SS#_____ DL#_____State_____ Employer Name _____

Email Address _____

Name of **biological** father/legal guardian: _____ Date of Birth_____/_____/_____

Home phone_____ Work number_____ Cell _____ Marital Status: S M D W Deceased

SS#_____ DL#_____State_____ Employer Name _____

Email Address _____

Primary Insurance Information
Name of Insurance Co._____ ID#_____ Group #_____

Policy Holders Name_____ **Patient's relationship to Insured** self spouse child other

Insured Date of Birth____/____/____ Insured SS#_____ Employer Name_____

Secondary Insurance Information
Name of Insurance Co._____ ID#_____ Group#_____

Policy Holders Name_____ **Patient's relationship to Insured** self spouse child other

Insured Date of Birth____/____/____ Insured SS#_____ Employer Name_____

Self-Pay / No Insurance ☐

Emergency Contact (other than mother or father) ***or Step-Parent Contact Information:***

Name _____Relationship_____Daytime phone_____

Name _____Relationship_____Daytime phone_____

Pharmacy Name, Address & Phone Number _____

How did you hear about us? (circle one) Existing Patient/Name _____ Friend Office Website Insurance Company Hospital Drive By Daycare Facility Internet Site Physician Referral/Name_____ Childbirth Class Other::_____

The above information is true and accurate. _____ _____
Signature of Patient or Legal Guardian ***Date***
_____***(Printed Name of Signature)***

11/08/23 alr

Patient Preference Regarding Communication of Health Information

Patient_____ DOB_____

Who to Contact

I hereby give permission to Pediatric & Adolescent Specialists of Rockwall to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and /or close personal friend(s):

_____ Relationship_____
Name

_____ Relationship_____
Name

_____ Relationship_____
Name

_____I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact (Please check all that apply)

_____Ok to leave a message on my HOME PHONE with detailed information.

_____ Leave a message on my home phone with a call-back number only.

_____ OK to leave a message on my CELL PHONE with detailed information.

_____ Leave a message on my CELL PHONE with a call-back number only.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient/or Legal Representative Date

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

Gregory Sonnen, M.D., F.A.A.P.
Rana Pascoe, M.D., F.A.A.P.

Permission to Treat Form

NOTE: This form is NOT valid for Preventative/Well Child exams/vaccines.

Only Acute care.

Date: _____

To Whom It May Concern:

I,_____**,Parent/Guardian of** _____**give**

Permission for: _____ _____
(Caretaker's Name) **(Relationship to Child)**

_____ _____
(Caretaker's Name) **(Relationship to Child)**

_____ _____
(Caretaker's Name) **(Relationship to Child)**

to seek medical treatment & make decisions for my child as necessary on my behalf. The duration of this authorization is indefinite and continues until revoked in writing.

Parents Signature_____ **Date**_____

Witness Signature_____ **Date**_____

Revised 11/23

6435 S. FM 549, Ste. 201, Texas 75032
(214) 771-3712 Fax (214) 771-3796

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **DOB:** _____

I understand and agree that I will be financially responsible for all charges for services rendered or not paid/covered by my insurance. This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), preventative exam/physical, lab or diagnostic testing, or any other screening service ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any Deductible, Co-Payment, Co-Insurance, Out-of-Network, Usual and Customary Limit or any other type of benefit limitation for the services I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may results in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

I understand and agree that it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied and I understand this and agree to be financially responsible and make full payment.

I hereby authorize payment of medical benefits directly to Pediatric & Adolescent Specialists of Rockwall for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Signature:_____ **Date:**_____
Print Responsible Party Name: _____

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

General Office Policies

1. **Routine "well-checks"** are done at ages 4 days, 2 weeks, 2, 4, 6, 9, 12, 15, & 18 months. Also, children are seen **yearly** starting at age 2.
    a. Vaccinations will be addressed at these appointments.
    b. **A biological parent or legal guardian MUST accompany their child to ALL "well-check" & vaccine appointments. Stepparents must have evidence of legal guardianship.**
    c. Parents should bring copies of all vaccinations done by previous doctors.
    d. Well checks are an appointment to evaluate growth, development, nutrition, & vaccinations. If a parent requests other medical problems be evaluated at a well check we do our best to accommodate, but there is a possibility that a separate appointment is necessary for another day to address these issues, depending on the issues.
2. **Appointments:** A biological parent MUST accompany their child to their initial office visit. We will evaluate the problem you indicated at the time the appointment is scheduled. If you need multiple problems evaluated, please let the phone scheduler know this and we will schedule extra time for your child's appointment. If a parent requests additional unscheduled problems be evaluated at the time of the appointment, additional fees or a separate appointment may be needed.
3. **School / day care / camp / sports forms**: These will be filled out only if your child is current on vaccinations and has been seen for a "well-check" appointment in the past 12 months. Allow 1 full business day to complete these forms. More extensive forms will incur a $25 fee to complete.
4. **Medication refills**: Refills for chronic conditions will be approved only if your child has been seen in the past 12 months. Some medications require a follow-up appointment before they are refilled.
5. **Multiple children**: If you are bringing multiple children for evaluation, they will each need an appointment to be examined by the doctor.
6. **School / Work Notes:** An excuse to miss school or work will be provided if you have seen one of our medical providers. Ask the nurse for a note during your appointment.
7. **After Hours Contact:** Our afterhours nurse line is 877-726-9013. Our after-hours nurses are available for phone consultation any time we are closed. One of our doctors is also on-call via phone. The nurse will contact the doctor if needed. Accessing our after-hours nurse incurs a $20 charge.
8. **Changing providers:** If you choose to change primary care providers within our office, this will require approval of both providers involved in the change.
9. **Leaving the practice:** If a parent is dissatisfied with our practice and chooses to leave our practice and assume care with another external primary care provider, we will deny any requests to return and resume care at our practice as our physician-patient relationship has been terminated.
10. **Patients with debt that is in collections and not being paid will not be allowed to schedule any appointments until the debt is resolved.**

By signing this document, I acknowledge full understanding of the policies and agree to comply with these office policies.

_____ _____

Parent / Legal Guardian Date

_____ _____

Patient Name Date of Birth

Revised & Posted 11/20/23

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

Vaccine Policy Statement

■ We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

■ We firmly believe in the safety of our vaccines.

■ We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

■ We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

■ We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the CDC schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** We will alter vaccine schedules only if underlying medical issues mandate this (such as chemotherapy or organ transplantation.)

Finally, if you should absolutely refuse to vaccinate your child or comply with the CDC schedule despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Drs. Pascoe & Sonnen

www.immunize.org/catg.d/p2067.doc • Item #P2067 (10/08)

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

Patient Name:_____ Date of Birth:_____ Age:_____

Your Name: _____

Your relationship to Child:_____

Child's previous doctor/primary care provider:

_____

Present health concerns: _____

_____

Medicines/Vitamins: _____

_____

Herbs/Home Remedies: _____

Allergies/Reactions to medicines or vaccinations:

_____

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: ☐ Birth ☐ Adoption

☐ Stepchild ☐ Other: _____

Please indicate any medical problems during pregnancy

☐ None ☐ Specify: _____

Delivery by: ☐ Vaginal birth ☐ Caesarean

If Caesarean, why? _____

Birth weight: _____ Birth Length:_____

Please indicate any medical problems during the baby's newborn period ☐ None

If premature, how early? _____

Other problems: _____

NUTRITION & FEEDING

Your child breastfed? ☐ No ☐ Yes

If so, how long? _____

☐ Formula Brand: _____

Has your child had any unusual feeding/dietary problems?

☐ No ☐ Yes If yes, specify:_____

Type of Current Milk Intake now:

☐ Cow's milk ☐ Nonfat ☐ 1% fat ☐ 2% fat

☐ Whole ☐ Soy milk ☐ Rice milk ☐ Breast milk

Average ounces per day (Note: 8 oz = 1 cup): _____

SLEEP

Hours per night: _____

Naps (number & length): _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone: _____

Walk alone: _____ Say words: _____

Toilet train (daytime): _____

Girls only: Age at first menstrual period: _____

DENTAL HISTORY

Has your child been seen by a dentist? ☐ No ☐ Yes

If so, how often? _____

Date of last visit_____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

☐ Chickenpox ☐ Measles ☐ Mumps

☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates:

_____

_____

_____

Hospitalization/operations (with dates):_____

_____

Broken bones or severe sprains:_____

_____

FAMILY HISTORY

Please indicate any deaths of your immediate family members:_____

_____

Please indicate family members *(parent, sibling, grandparent, aunt or uncle)* with any of the following conditions:

Alcoholism/Drug abuse_____

High cholesterol_____

Cancer, specify type_____

High blood pressure_____

Kidney disease_____

Psychiatric disorders_____

Bleeding or clotting disorder_____

Genetic disorders/Birth defects_____

Asthma_____

Diabetes_____

Thyroid disorder_____

Seizure_____

Other:_____

SOCIAL HISTORY

Who lives at home?

Name Age Relationship to child

_____

_____

_____

_____

Are your child's parents ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

If divorced or separated, when? _____

Mother's Occupation_____

Mother's Employer_____

Father's Occupation_____

Father's Employer_____

Child care situation ☐ Parents ☐ Other (specify who and how often) _____

Concern about your child: ☐ Alcohol use ☐ Tobacco ☐ Sexual Activity ☐ Aggressive Behavior

Is violence at home a concern? ☐ No ☐ Yes

SCHOOL HISTORY

Did/does your child attend school or preschool?

☐ No ☐ Yes Current grade_____

Name of school_____

Any concerns about school performance? _____

_____

Any concerns about relationship with:

Teachers ☐ No ☐ Yes Peers ☐ No ☐ Yes

If over 4 yrs old: does your child have a best friend? ☐ No ☐ Yes

Sports/Exercise: Type_____

How often? _____ How long (minutes)?_____

REVIEW OF SYMPTOMS:

Please check any current problems your child has on the list below:

General
___ Fevers/chills/excessive sweating
___ Unexplained weight gain/loss

Eyes
___ Squinting/"crossed" eyes/asymmetric gaze

Ears/Nose/Throat
___Unusually loud voice/ hard of hearing
___ Mouth breathing/snoring
___ Bad breath
___ Frequent runny nose
___ Problems with teeth/gums

Neurological
___ Headaches
___ Weakness
___ Clumsiness

Respiratory
___Cough/wheeze
___Chest pain

Gastrointestinal
___Nausea/vomiting diarrhea
___Constipation
___Blood in bowel movement

Genitourinary
___ Bedwetting
___ Pain with urination
___ Discharge: penis or vagina

Musculoskeletal
___Muscle/joint pain

Skin
___ Rashes
___ Unusual moles

Allergy
___ Hay fever/ itchy eyes

Cardiovascular
___Tires easily with exertion
___ Shortness of breath
___ Fainting

Psychiatric/Emotional
___Speech problems
___Anxiety/stress
___Sleep issues
___Depression
___Nail biting/thumb sucking
___Bad temper/breath holding/jealousy

Blood/Lymph
___Unexplained lumps
___Easy bruising/bleeding

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

ACKNOWLEDGEMENT OF THE RECEIPT OF PEDIATRIC & ADOLESCENT SPECIALISTS OF ROCKWALL'S NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Pediatric & Adolescent Specialists of Rockwall is furnishing you with the attached notice, which provides information about how Pediatric & Adolescent Specialists of Rockwall may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Pediatric & Adolescent Specialists of Rockwall's Notice of Health Information Practices.

_____ _____

Patients Name Date

_____ _____

Signature of Patient/Parent/Legal Rep. Date

6435 S. FM 549 | Suite 201 | Heath, TX | 75032 | P 214.771.3712 | F 214.771.3796

PEDIATRIC & ADOLESCENT SPECIALIST OF ROCKWALL

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.

When you receive treatment or benefits from Pediatric & Adolescent Specialists of Rockwall, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;
- For health oversight activities such as audits, investigations, and inspections of Pediatric & Adolescent Specialists of Rockwall facility;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

YOUR PRIVACY RIGHTS

Although your health record is the property of Pediatric & Adolescent Specialists of Rockwall, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the PASR, PLLC privacy officer of your provider's office. You can reach PASR, PLLC at (214) 771-3712.

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website at www.pediatricsrockwall.com and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer listed in this notice or to the Secretary of the Department of Health & Human Services.

We will not retaliate against you for filing a complaint.

Privacy Officer Contact:

PASR, PLLC

214-771-3712