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 Email Address_____

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 _____

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 ☐

CONSENT TO CREDIT BUREAU INQUIRIES

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number and to any telephone number provided during my registration process I understand that these collection attempts could be performed by Codes Billing Company or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents.
Y_____ N_____

Emergency Contact (other than mother or father)

Name _____Relationship_____Daytime phone_____

Pharmacy Name, Address & Phone Number _____

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

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

6/25/18 alr

Patient_____ Patient DOB_____

PEDIATRIC & ADOLESCENT SPECIALISTS of Rockwall

Patient Preference Regarding Communication of Health Information

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):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____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 ~~WORK~~ Cell PHONE with detailed information.

_____Leave a message on my work phone with a call-back number only.

_____OK to mail to my home address _____

_____OK to mail to my work/office address_____

_____OK to fax to this number_____ _____

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/Parent/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.
Chris Becker, 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,_____,guardian of_____give my
(Biological Parent/Guardian's Name) (Child's Name)

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 7/19

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

SPECIALISTS

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ DOB:_____

I understand and agree that I will be financially responsible for any and all charges for services rendered or not paid 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

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. Step-parents 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 evaluated 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 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 $20 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 after hours 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 $17 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 05/07/2019

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