

Copper Grove



Pediatrics



New Patient Registration

We need a copy of the driver license of guarantor before or at the time of visit, we also need a copy of insurance card (both sides), 3 to 4 days before your visit.

Patient Information

First: _____ Middle: _____ Last Name: _____

Date of Birth: _____ o Male o Female

Marital Status: ☐ Single ☐ Married ☐ Divorced

Mailing Address _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Employer: _____

School: _____

Cell Phone: _____ Work Phone: _____

How did you hear about us ? ☐ Friend/Relative ☐ Doctor Referral ☐ Facebook ☐ Internet Search/Google

Parent/Spouse/Emergency Contact Information

Name of Parent/Spouse/Legal Guardian: _____ Cell #: _____

Relationship to patient: _____

Is Mailing Address same as patient address? ☐ Yes ☐ No If no, please provide address below:

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Is the above listed parent/guardian responsible for patient account? ☐ Yes ☐ No If no, please list below:

Responsible party: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Signature of Guarantor: _____ Date: _____

Insurance Information

Insurance Carrier: _____ ID #: _____

Group #: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Relationship to patient: _____

Secondary Insurance Information

Insurance Carrier: _____ ID #: _____

Group #: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Relationship to patient: _____

Primary Care Physician

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Preferred Pharmacy

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

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.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization requires you to disclose PHI to any other care provider not currently involved in your care. **Example:** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. **Example:** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked

or test results. **Example:** We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about the service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy: Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claims or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and

use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer. If you have questions and would like additional information, you may contact your office:

***ADHD Houston/Copper Grove Pediatrics
Attn Privacy Officer
15322 Copper grove Blvd, Houston, TX, 77095***

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient (if over 18) or Patient's Personal Representative

Date

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for Personal Health Information (PHI) attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Please check the following if applicable:

- ☐ You may call my home and leave a message with someone or on an answering machine if I am not available.
- ☐ You may call my place of employment and leave a message on an answering machine or with someone if I am not available.
- ☐ You may call my cell phone and leave a message on my answering machine if I am not available.
- ☐ You may communicate confidential information to me, including invoices for services, to the address and/or phone numbers that is given in my patient information. If not, please indicate the address or phone number that we may use: _____

☐ You may discuss by electronic communication or phone, my child's symptoms (if pediatric patient), diagnosis and treatment with teachers and school representatives.

☐ I agree to use the patient portal for questions pertaining to medication management and discussion of symptoms/side effects.

☐ I agree to secured communication through the patient online portal for medication management including discussion of symptoms/side effects. I realize that this communication is a part of the patient's permanent medical record.

☐ I authorize ADHD Houston/Copper Grove Pediatrics to release my medical records to the referring provider.

☐ I authorize ADHD Houston/Copper grove Pediatrics to access my prescription history in the Athena system.

☐ I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

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

Check all that apply to names above:

☐ All my medical information

☐ Specific medical information (test results, scripts, etc.): _____

☐ Information necessary to help my family member(s) take care of me.

☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers.

☐ I authorize ADHD Houston/Copper Grove Pediatrics to correspond with my Primary Care Physician.

☐ I authorize ADHD Houston/Copper Grove Pediatrics to obtain my medication history from the pharmacy database.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ SS#: _____/_____/_____

Patient Address: _____ Date of Birth _____

(City, State, Zip Code) _____ Phone : (_____) _____

I hereby authorize: _____ to release/disclose my health information as described below.
(Physician's Name)

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Please identify the information to be released:

____ Please Release ALL Records ____ Office Notes ____ Testing Results ____ Surveys ____ Medication List

The identified information will be used for the following purpose:

____ Change to another Physician ____ Personal Records ____ Attorney/Legal
____ Continued Care (Consult/Referral) ____ Other

Please initial each item below to indicate your understanding:

____ I understand once the information above is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The identified information following individual(s) or

may be used by or released to the organization(s):

ADHD Houston/Copper Grove Pediatrics
15322 Copper Grove Blvd
Houston, TX, 77095
Fax (281)859-0175

This authorization will expire on (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Patient (if over 18)/Legal Guardian/Parent Signature: _____

Relationship: _____ Date: _____

Witness Signature: _____ Date: _____

Financial Policy

This financial policy contains important information about payment for our professional services. It is intended to help us provide the best medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients. It is the patient's responsibility to make payment at the time of service for all services rendered if it is determined that the patient's insurance policy may not cover our services. **The contract with your insurance company mandates that we collect copays at the time of service.** If a patient finds that they will be unable to pay in full upon check-out, they will be responsible for determining a payment

plan agreed upon by ADHD Houston/Copper Grove Pediatrics *prior to the scheduled appointment*. Payment for professional services may be made by cash, check, credit/debit card and are due at the time of service.

Additional Fees:

NO Show/Late Cancellation Initial Evaluation	\$100
NO Show/Late Cancellation Follow-Up Appointment	\$30
Accommodations request/diagnosis letter (detailed)	\$25
Accommodations request/diagnosis letter (brief)	\$ 15
Returned Check	\$35
Medical Records	\$5 search fee/\$1 per page (1 st 25pgs) /\$0.50 per page 26+

We require **24-hour advance notice for cancellations or rescheduling**. Less than 24 hours is considered "Late". As a courtesy, you may receive a reminder of your upcoming appointment by e-mail or text message. You are still responsible for honoring your appointment even if you do not receive a reminder. Unless other arrangements are made, the parent or guardian of patients less than 18 years of age will be responsible for payment according to the terms described above.

Students, 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent / guardian or themselves. For those students whose parent / guardian(s) will maintain responsibility for payment, an authorization for services must be signed by that parent or guardian. As a convenience, the parent / guardian may provide a credit card number and authorize that the co-pay be billed to that card at each visit.

You, the patient, have a contract with your insurance carrier. Our services may or may not be covered by your policy. It is your responsibility to contact your carrier to determine if these are covered services under your contract **prior** to the date of service. **A referral may be required by your insurance company for services to be paid. It is the patient's responsibility to obtain the required referral for treatment prior to the visit.**

Our staff is happy to help with general questions relating to a claim or to provide additional information requested by your insurance carrier in order for the claim to be processed. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually located on the back of the insurance card.

I have read and understand the financial policy as stated.

Guarantor Print Name (Parent/Guardian/Patient)

SS # of Guarantor

Relation to Patient

Date

Patient (if over 18) or Guarantor Signature

Patient Name

(Please bring your credit card to office and do not send credit card info via email)

NON-COVERED SERVICES POLICY

As our patients, we want to provide you the best care possible. There may be certain services that are necessary that are not covered by insurance carriers. Also, some insurance policies may not pay for services that include diagnostic codes for ADHD and related conditions.

- You will be expected to pay for those services in full at the time they are provided.
- Policy holders of insurance carriers other than those currently contracted with our Providers will be expected to pay in full at the time of service.
- If requested, we will bill your insurance for all services and procedures provided and issue you a refund if your insurance pays for them. We will also give you a receipt for your payment which can be used to get reimbursed from your HSA, FSA, insurance, etc

These procedures are frequently used by ADHD Houston/Copper Grove Pediatrics providers and may not be covered under your insurance policy.

Procedures / Tests:

- Office visits with adhd and related diagnoses
- **QbTest/Qb Check/TOVA**
- Clinicom
- Vanderbilt Assessment, NeuroPsych Questionnaire, Adult ADHD Self-Report Scale, ADHD Rating Scale IV
- Vision screen
- Hearing screen
- Removal of cerumen
- Chronic care management
- Hemoglobin
- Allergy test, allergy extracts
- Phone consultations

Procedures / Tests Codes:

99205, 99204, 99215, 99214, **96132 & 96138**
96103, 96127, 99490,
85018, 99174, 99177, 92552, 95004, 95165,
99441, 99442

I have read and understand that charges for services not covered by my insurance plan will be my responsibility to pay in full the day the services are rendered.

Parent/Guardian/Patient Signature (if over 18)

Patient Name (Please Print)

Date

Patient DOB:

Cancellation Policy Statement of Understanding

Our provider's time is reserved for you. We do not double-book our patients in order to provide adequate time for each patient. We strive for exceptional care through individual attention.

Patient: _____

DOB: _____

- Any appointment cancelled *less than 24 business hours in advance* is considered a No Show.
- A No Show on a new or extended patient appointment will result in a \$100 fee that is not covered by insurance.
- A No Show on an established patient appointment will result in a fee of \$30 that is not covered by insurance.
- Exceptions to this policy will be reserved for verifiable emergencies only and will be at the sole discretion of management.
- Repeated No Show appointments will result in unconditional discharge from care at this facility.

I, _____, (patient/parent/legal guardian) acknowledge that I fully understand ADHD Houston/Copper Grove Pediatrics cancellation policy.

Patient's Signature (if patient is over 18)

Date

Guarantor's Signature (if patient is under 18)

Date



Consent-Electronic Transmission of Protected Health Information (PHI)

I give Dr Manaf Ahmad my consent to send (please check the appropriate box):

☐ Medical Records

☐ Protected Health Information

☐ Educational materials

for (name of patient) Date of Birth:
to the following e-mail address:

.....
I acknowledge that I have the legal rights to obtain medical records, I also understand that:

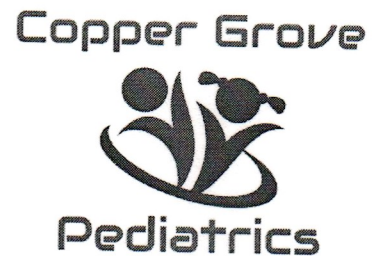
1. I have the right to revoke this authorization, in writing, at any time.
2. E-mail is not appropriate for urgent or emergency situations.
3. Health care providers cannot guarantee but will use reasonable means to maintain security and confidentiality of electronic mail (E-mail) information sent and received.

Furthermore, I accept the risks associated with the use of unsecure E-mail communications.

I understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth. By signing this form, I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent for the purpose of medical advice, education, and treatment.

Signature Cell Phone Number

Date



Billing Policy

Please review our billing policy **before** you make your initial appointment:

1. Our practice is in network with major payers but not Medicaid, Medicare, ACA insurance and small commercial payers.
2. We need a copy of your insurance card (both sides).
3. Our office can bill your insurance, but we require all new patients to pay the allowable fee in full at the time of service. We cannot guarantee that your insurance will pay for the initial adhd evaluation.
4. Most insurance policies do not pay for adhd TOVA test but we can bill your insurance for it. We expect patients to cover the cost of TOVA test at the time of service.
5. Patients will get a full refund if insurance pays for initial evaluation and / or TOVA test.
6. Follow-up visits are needed every 90 days on average, and they are billed like any regular medical visit. Cost depends on insurance and complexity of visit.
7. **Payment is due at the time of service.**
8. Patients with HMO policies are responsible for obtaining a referral from their primary care physician (PCP) before their evaluation and follow up visits. A referral is usually good for 6 months at least and requires a phone call from you to your PCP.
9. Patients who have insurance but do not want to use their insurance are required to sign a waiver form.
10. A \$ 100 refundable deposit is required to secure an appointment for an initial adhd evaluation. patients who miss their initial visit lose their \$ 100 deposit. Established patients who miss their visit are charged \$ 30. We require a minimum of 48 business hours' notice to avoid cancellation fee.

I _____ have reviewed and accepted the above policy.

Patient's Name:

Date:

