PATIENT INFORMATION

All About Children Pediatrics

(Please answer all questions....thank you)

Patient's Name _____ Nickname _____ School _____
Date of Birth _____ Sex (Circle One) M F Ethnicity: Black White Hispanic Asian Other _____
Patient's Address _____ City _____ St _____ Zip _____
Phone Number _____ Language English, Spanish Other _____
Siblings:
Name _____ Date of Birth _____ School _____
Name _____ Date of Birth _____ School _____
Name _____ Date of Birth _____ School _____
Name _____ Date of Birth _____ School _____

How did you hear about AACP? _____ Have you seen any of our advertising? Yes No
If so, where did you last see our advertising? _____
If a referral from one of our parents, can you tell us their name so we can thank them? _____

CONTACT INFORMATION

Mother's Name _____ Date of Birth _____
Address(if different) _____ City _____ St _____ Zip _____
SS# _____ Driver's License # _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Place of Employment _____ Occupation _____
If there is a stepfather that may bring in your child periodically, please provide information below:
Name _____ Contact Phone _____

Father's Name _____ Date of Birth _____
Address(if different) _____ City _____ St _____ Zip _____
SS# _____ Driver's License # _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Place of Employment _____ Occupation _____
If there is a stepmother that may bring in your child periodically, please provide the information below:
Name _____ Phone _____

Emergency Contact (other then Parents):

Name _____
Relationship to Patient _____ Phone Number _____

Insurance Information:

Insurance Co _____ Phone Number _____
Address _____
Name of Insured Party (who carries the insurance) _____ Date of Birth _____
SS# _____ Employer _____
ID # _____ Group # _____

Your signature below indicates financial responsibility for all charges incurred and your assignment of insurance benefits to All About Children Pediatrics. THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR ANY COPAY OR ACCT BALANCE. This is a legally binding agreement for All About Children Pediatrics to treat and care for your child. Please note that payment is due at time of service unless prior arrangements have been made and agreed to. **WE WILL NEED TO COPY YOUR INSURANCE CARD AND DRIVER LICENSE. IF YOU HAVE QUESTIONS, PLEASE ASK THE RECEPTIONIST.**

_____ _____
Signature Date

Age 5 and up

Date:_____ **NAME:** _____ **DOB:**_____

Pharmacy:_____

Please Circle One:

Primary Language in home: English Spanish Other

Ethnicity: Not hispanic or Latino Hispanic or Latino

Race: White Asian Native Hawaiian/Pacific Islander Black/African American 2 or more races prefer not to answer

Are you interested in receiving your lab and test results electronically? **Yes** **No**

Email address: _____

Patient's Past Medical History

Prior Testing/Developmental Test	None	Yes	Test:
Respiratory Disease/Asthma	No	Yes	
Allergies	No	Yes	
History of Chicken Pox	No	Yes	Date:
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
GI Disorder	No	Yes	
GU/ Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of injury/trauma	No	Yes	Details:
Other Chronic problems			

Family Medical History

			Please List Family Member and details below
Cancer		No	Yes
Diabetes		No	Yes
Cardiovascular disorder		No	Yes
Eye disorder		No	Yes
Ear disorder		No	Yes
Respiratory disorder		No	Yes
GI disorder		No	Yes
GU disorder		No	Yes
Musculoskeletal disorders		No	Yes
Neurologic disorder		No	Yes
Psychiatric disorder		No	Yes
SIDS		No	Yes
Skin disease		No	Yes
Other			

Patient Smoking Status (13 years & over) *(circle one)*

1 Current everyday smoker
2 Current someday smoker
3 Former smoker
4 Never smoker
5 Smoker, current status unknown
9 Unknown if ever smoked

Surgical/Hospitalization History

				Details
Non-Surgical hospitalizations		None	Yes	
Surgical History		None	Yes	
Ear Surgery		None	Yes	
Nose/Mouth/Throat Surgery		None	Yes	
Respiratory Surgery		None	Yes	
Cardiovasular Surgery		None	Yes	
GI Surgery		None	Yes	
GU Surgery		None	Yes	
Eye Surgery		None	Yes	
Orthopedic Sugery		None	Yes	
Plastic Sugery		None	Yes	
Other Surgery		None	Yes	

Child Social History

Parent information: *(circle all that apply)*

Parents together
Lives w/mother
Lives w/father
Father not involved
Father involved
Mother involved
Mother not involved
Mother / Father deceased
Guardian parents
Same sex partners
Other:

Child care: Circle all that apply

Name of Daycare: _____
Home w/parents
Private home day care
Sitter to home
Family Day care
Other: _____

Home occupants (list all): _____

Parents smokers: (Circle one)

No Yes Outside only

Pets what type? Inside or outside? How many? _____

Extracurricular activities: (sports, music, etc.) _____

Educational/School Information

Name of School: _____
Grade: _____
School performance:
Circle Likes School Dislikes school Advanced Program Honor Roll

Excellent Good Fair Poor

School issues:

None Behavior Problems Peer Problems Non attendance

Expelled Suspended Referred for ADHD testing by school

Menstrual History Female only Age at first menstral cycle: _____ regular?_____

Cycle length _____ Amount of flow _____

All About Children Pediatrics

FINANCIAL POLICY FOR ALL ABOUT CHILDREN PEDIATRICS

Payment is due at the time of the office visit unless previous arrangements have been made with one of our billing staff. As the patient or the patient's guarantor you are responsible for finding out the status of any insurance claims our office may have filed for you. All charges associated with your office visit or any other procedure performed on your child is your responsibility. We will file your claim twice with the insurance you provide to us at the time of your visit. We will then look to you for payment on any unpaid claims. If you fail to make us aware of any changes to your insurance carrier at the time of your visit, the responsibility for payment for your office visit and subsequent reimbursement from your new insurance carrier will be yours. If there is more than one child in our practice and there is an insurance change, you are responsible for making us aware of the changes for each child specifically.

It is your responsibility to determine if our providers are on your specific HMO, PPO, EPO, or POS plan. If we are providers for your health insurance plan and have a copy of your insurance card, we will file your claim. If your insurance is an HMO, EPO, or POS plan and we are not the primary physician listed on your card, we might have to reschedule your appointment since benefits may not be paid. Or you can pay for the office visit and seek reimbursement from your insurance plan.

If you have no insurance coverage you will be made aware of our policy regarding payment of services at the time your appointment is made.

If payment is not received in a timely manner, your account will be turned over to a collection agency and you will be responsible for any and all associated fees of collection.

If the patient is a minor (anyone under the age of 18) a parent or legal guardian must be in attendance to give consent for treatment and be the responsible guarantor. In a divorce situation, the parent who brings the dependent child to our office is responsible for payment. Insurance may be filed, but the parent in attendance will be responsible for any copay or outstanding balances.

AUTHORIZATION FOR PAYMENT

I authorize payment of medical benefits to ALL ABOUT CHILDREN PEDIATRICS.

My signature below indicates that I have read, understand, and agree to the above terms. I hereby authorize ALL ABOUT CHILDREN PEDIATRICS to evaluate the person that I am legally responsible for or me (relationship listed below) for any illness or injury for which I seek medical care.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to ALL ABOUT CHILDREN PEDIATRICS. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature of Responsible Party: _____ Date: _____

Patient's Name: _____ Relationship: _____

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Pediatrics

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO:_____
(Physician or Facility Name)

_____
Address City St Zip

_____
Phone Number Fax Number

I hereby request that my child's complete records or specific information as listed below be released to:

All About Children Pediatrics
Todd Burton, M.D.,
Kelley Smith, M.D., Maryam Saifi, M.D.,
Jennifer Kriska, CPNP, Jordan Weber, PA
2217 Eldorado Parkway
McKinney, TX 75070
972-542-1444 Fax: 972-542-6967

_____
Patient's Name Patient's Date of Birth

_____
Parent's Signature Phone number Today's Date

_____
Information Requested

Please do not fax more than 15 pages. If medical records consist of more than 15 pages, please mail the records.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to the facility receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

Please note that the physician or facility you have requested records from have 15 days by law to send us these records.

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A Note From Todd Burton, M.D.

Dear Families of All About Children Pediatrics,

We at AACP are aware and constantly trying to improve on wait time. Make no mistake, our #1 priority is providing good quality medical care to your children, and we will never compromise this! There are a number of potential factors which can affect time spent at the doctor's office...some totally out of our control and others that the collective "we" may be able to improve upon. Some of these you may or may not be aware of...

- **In-office emergencies:** lacerations, respiratory distress, severe allergic reactions, etc.
- **No Authorization to Treat on file:** We must have a written authorization in order to treat a minor (patient under 18 years of age) without the presence of his or her parent, legal guardian or other authorized individual.
- **Emergency deliveries:** We attend emergency C-sections or other deliveries at Medical Center of McKinney and Presbyterian Hospital of Allen if there are complications or potential complications and the Obstetrician requests our presence.
- **Certain times of day:** The "after-school rush" tends to make for longer wait times.
- **Our policy of same day sick appointments:** While some physicians would view this as a luxury for parents, we feel strongly about it. If you know you want your children seen today, we will see them today even if every appointment is booked. We may inform you that all of our appointments are booked and we will have to double book you and work you in. We may also decide, together with you, over the phone on a course of treatment to get you through until the next day.
- **Staffing:** We have grown and changed staffing as the Practice population has changed. Part of that has been transitioning from some superb part-time staff to full-time staffing. Seeing the same faces everyday is important for you and your children, but it also allows us to grow, mature, and gel as a work group, which can and will improve the efficiency of the office. We also continue to grow in numbers as the need arises.
- **Being on time for appointments:** Because many times wait times have been long, too long in our opinion, we find it hard to be strict on this. But this is a key factor that can snowball over the day and add up to 45 minutes to an hour or more of delays by the end of the morning or afternoon sessions. We ask that you arrive on time or approximately 5 minutes early (15 minutes if first time patients) to fill out paperwork. Please realize that if you are more than 10 minutes late we have to cancel your appointment slot and "work you back in" or reschedule you. If we are going to improve on wait times, we must address all factors we can control. We realize emergencies happen, or sometimes just getting a new baby or 2-3 children to go anywhere is a chore, especially if they are sick and you are sleep-deprived! We simply ask that if you know that you will be late, please call and we can reschedule you and give your time slot to someone else.
- **Keeping your appointment to what it is scheduled for:** Many times, parents request to change a sick appointment to an overdue well exam, or want to discuss some other major issue/problem other than what the child is there for that day. As you can imagine, this will cause delays. It takes much more time for the staff to "prepare" for a well exam with measurements, graphing, history, etc., not to mention the time for the exam, discussion of development, and immunizations. Sometimes parents want us to see siblings who are not scheduled or even discuss siblings who aren't there.

  These last two points are important to remember and ones with which we would like to request your assistance. Please help us in our effort to serve you better as we are caring for your child and the children and families of this community.

Thank you for your cooperation,
Todd Burton, M.D.

All About Children
Pediatrics

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS - *HIPAA*

I, _____, understand that as part of my child's/children's health care, All About Children Pediatrics originates and maintains paper and/or electronic records describing their health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's/children's care and treatment;
- A means of communication among the many health professionals who contribute to my child's/children's care;
- A source of information for applying my child's/children's diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information and Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my child's/children's health information for directory purposes, and
- The right to request restrictions as to how my child's/children's health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that All About Children Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child/children as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that All About Children Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should All About Children Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my child's/children's health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my child's/children's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient Name _____ DOB_____ _____

_____ _____

Parent/Legal Guardian Signature Parent/Guardian Printed Name

_____ _____

Relationship to Patient Date

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Late and Missed Appointments

If you arrive for your appointment more than 10 minutes late, there is a chance that we will not be able to accommodate you. If you are running late, please call us ahead of time so that we will be able to determine if your child can still be seen despite a late arrival or if it necessary for us to reschedule your appointment. Please notify us of an appointment cancellation as soon as possible for a Well appt.

Our No Show policy is for all patients. Each appointment you miss, you will be charge $25 per child per visit unless you call to cancel appointment 3 hours prior to the scheduled visit time. This charge is not covered by insurance is patient responsibility.

To avoid these charges PLEASE call us to cancel your scheduled WELL appointment no later than 24 hours in advance and sick appointment no later then 3 hours before the appointment. If your appointment is early in the morning, please call the previous day to avoid the NO Show charge. This will allow us time to fill the appointment time with other children who need to be seen.

I have read the above Late and Missed Appointment and I understand and agree to its terms.

_____ _____

Patient Name **DOB**

_____ _____

Patient /Guardian Signature **Date**

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All About Children Pediatrics

Authorization to Treat

Prior authorization is required by All About Children Pediatrics in order to treat a minor patient (under 18 years of age) without the presence of his or her parent, legal guardian or other authorized individual.

Do you authorize All About Children Pediatrics to treat_____
Without your presence? Name of Minor

_____Yes, I do authorize and consent to All About Children Pediatrics providing medical treatment to the above minor without my presence.

_____No, the above mentioned minor will be accompanied to the office by their parents, legal guardian or other authorized individual for all medical treatment.

In my absence, I authorize the following individual(S) to consent to the treatment of my child/children.

_____ _____
Name/Relationship Telephone

_____ _____
Name/Relationship Telephone

_____ _____
Signature Date

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ADDITIONAL SERVICES AUTHORIZATION

Dear Parent,

Our office is pleased to have an opportunity to serve your family. Our primary mission is to provide your child with quality cost effective medical care. Together we (parents and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance company or managed care plan.
We will ask for your insurance card at EACH VISIT. Specifically bring to our attention any changes (new card, new group# etc.) since your last visit. This protects you from paying a bill because we had the incorrect insurance information.
Insurance companies can deny payment for services if they are not included in your coverage plan. These services include but are not limited to:

- After hours (late clinic)
- Hearing and vision services
- Saturday hours
- Flu vaccines

In office surgical procedures such as wart removal, frenectomy, removal of foreign body or ear wax, circumcision and sutures will be processed under the surgical guidelines of your insurance plan. It may be applied to your deductible with applicable coinsurance or may not be covered benefit at all.

I agree to be responsible for all charges in full once they have been processed by my insurance company, if any balance remains due.

Payment Guidelines:

- Payment is due at the time of the office visit unless previous arrangements have been made with one of our billing staff.
- We accept cash, checks, money orders and credit cards (**Visa, Mastercard and Discover)**
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If by mistake, your insurance company remits payment to you, please send it to us along with all paperwork sent

_____ _____
Signature of Responsible Party Date

_____ _____
Name of Patient Date of Birth

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All About Children Pediatrics

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of All About Children Pediatrics, PA Notice of Privacy Practices on the date indicted. If you have any questions regarding the information in All About Children Pediatrics, PA Notice of Privacy Practices, please do not hesitate to contact a clinic representative or All About Children Pediatrics, PA Privacy Officer as indicated on our Notice. In addition to this notice, please advise how, whom and your preferences regarding how you prefer to receive communication from All About Children Pediatrics, PA regarding your care and protected information.

Patient Name (printed)_____ Date of Birth_____

Patient Representative Name (printed)_____

Relationship to patient:_____

Signature:_____

Date Notice Received_____ _____ _____

I authorize All About Children Pediatrics, PA to communicate with me via the methods below. I understand that this authorization allows All About Children Pediatrics, PA to leave a message or send an e-mail to the specified individuals regarding test results, appointments, referrals, or other information regarding the above patient's care.

Email:_____

Telephone/Voicemail:_____

Alternate Telephone/Voicemail:_____

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