Patient Demographic Information Form

Please fill out every space. If it does not pertain to you, please write N/A for Not Applicable.

Patient Information

Patient's Name (Last, First, Middle (Suffix) (Preferred)

,

If patient is a child, Parents' Names (Last, First - relationship)

, -

, -

Gender
M ◯ F ◯ Other:

Date of Birth

Address **City** **State** **Zip code**

Preferred Phone Number - whose? **Secondary Phone (whose?)**

Email - whose?

Preferred Language **Patient Race (or Decline to Answer)** **Ethnicity**
◯ □ Hispanic ◯ □ Not Hispanic

Communication

☐ **I authorize MD Pediatric Associates to contact me about appointments and reminders for health services via:**
- ☐ **Mobile Phone**
- ☐ **Email**

Is it okay to leave medical information on your voicemail? **Y** ☐ **N** ☐

Insurance

Patient's Relationship to Insurance Holder

Insurance holder Name (Last, First, Middle, Suffix) **Insured Date of Birth**

,

Insured Street Address **City** **State** **Zip code**

Insured Employer

Guarantor of Account Name **Guarantor of Account Phone Number**

Insurance

Primary Insurance Company	**Subscriber's Name (Policyholder)**
Subscriber's DOB	**Patient's Relationship to Subscriber**
Policy ID	**Group #**

Insurance Claims Address

Preferred Pharmacy Name/Phone

Preferred Provider at MDPediatrics

PATIENT'S LAST NAME _____ FIRST NAME _____ DATE OF BIRTH_____

THIS FORM TO BE COMPLETED ANNUALLY; SKIP BIRTH HISTORY IF PREVIOUSLY DOCUMENTED

BIRTH HISTORY	Patient was born:	◯ on time	◯ Premature	◯ late
	Delivery was:	◯ Vaginal delivery	◯ Cesarean section	
	Birth Weight:	___lbs___oz		
	Did mom have any problems with this pregnancy?	◯ Yes	◯ No	
	Did patient have any problems after birth?	◯ Yes	◯ No	
	Did patient stay in the hospital after mom went home?	◯ Yes	◯ No	
SURGICAL HISTORY	Please mark all surgeries the patient has had: ☐ None	☐ Tonsils Removed ☐ Adenoids Removed ☐ Anesthesia complications	☐ Ear tube(s) inserted ☐ Hernia repair ☐ Appendix Removed	☐ Heart surgery ☐ Broken bone(s) / fracture (s) ☐ Other type of surgery: _____
PAST MEDICAL HISTORY	Past Hospitalizations: ☐ None	☐ Asthma ☐ Bronchitis ☐ Cellulitis	☐ Dehydration ☐ Pneumonia ☐ Neonatal fever	☐ RSV ☐ Trauma ☐ Other:_____
	Does your child have any chronic or serious medical condition(s)?	◯ Yes	◯ No	
	Has your child ever had any serious accidents or injuries?	◯ Yes	◯ No	
	How is your child's development compared to other children his/her age?	◯ Average	◯ Accelerated	☐ Delayed
SOCIAL HISTORY	Child Lives With (mark all that apply):	☐ Brother(s) ☐ Sister(s) ☐ Step Sibling(s) ☐ Both Parents	☐ Father only ☐ Mother only ☐ Foster Parent ☐ Grandparent(s)	☐ Other relative ☐ Step parent(s) or parent's partner ☐ Other: _____
	# of siblings: _____ Does anyone in the family smoke?	◯ Yes	◯ No	
	Does the family have any pets?	◯ Yes	◯ No	
	School/Daycare Name: _____			
	School Grade (Current Year) _____			
	Academic performance of child:	◯ Not in school	◯ Remedial/Special Ed ◯ Below Average	◯ Average ◯ Above Average
	Extracurricular activities: _____			
	Is there any violent behavior in the home environment?	◯ Yes	◯ No	
	Parental Marital Status:	◯ Single	◯ Married ◯ Separated	◯ Divorced ◯ Widowed
FAMILY MEDICAL HISTORY	Please Identify any family member with illness and if *Father, Mother, Grandmother (mother or father's side), Grandfather (mother or father's side) Brothers or Sisters.*			

FAMILY MEDICAL HISTORY Please indicate if PATIENT'S FAMILY has had any of the following.

☐ Family History Unknown ☐ Adopted ☐ No Family History of Illness

	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother(s)	Sister(s)
ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Drinking / Drug Problems	☐	☐	☐	☐	☐	☐	☐	☐
Endocrine Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐

	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother(s)	Sister(s)
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Hypercholesterolemia	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Neurologic Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐

MD PEDIATRIC ASSOCIATES, PA
Notice of Privacy Practices

This notice describes how medical information about you/your child (as a patient of this practice) may be used and disclosed and how you can get access to this information. Please review this notice carefully. The use of "you/your" will refer to the patient as represented by the parent or guardian.

EFFECTIVE
April 14, 2003
Revised May 17, 2005
Revised April 1, 2013
Revised February 14, 2022

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to MD Pediatric Associates, PA, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, laboratories, and other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers. We may use and disclose your information to an Accountable Care organization of which we are participants, for quality and cost saving purposes.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone or text) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. We may use and disclose your information to our Accountable Care organizations We may provide information about you to your patient portal for your information, sharing and use.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization. For example, a parent or guardian may ask that a grandparent take their child to MDPA for treatment. The grandparent will have access to the child's medical information for the visit. Please note that MDPA will request a "Permission to Treat" form on file for anyone to bring the child for medical care other than a parent or guardian.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).

- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in

instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law. We may share your medical information with an interoperability health framework such as a Health Information Exchange or data clearinghouse for permitted purposes, such as to make your records available to another provider on your behalf in an emergency, unless you opt out of such sharing. If you wish to opt out of HIE sharing, please ask a member of the office staff for an opt-out form. We may provide all or part of your medical records to a physician or group to whom you are transferring for continuity of care.

Z. Sale of Practice. We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what

information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

MD Pediatric Associates, PA
Attn: HIPAA Officer
PO Box 2429 Coppell, TX 75019
972-420-1475

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below. Your typed name serves as your legal signature.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____

(Please Print Name)

Patient Date of Birth: _____

SIGNATURES: (your typed name serves as your signature)

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

MD Pediatric Associates - Patient Financial Policy

Effective 1-1-2003
Updated 2-16-22

This is an agreement between MD Pediatric Associates, as creditor and the patient/guarantor names on this form. In this agreement the words “you” and “yours” mean the patient/guarantor. The word “account” means the account that has been established in your name to which charges are made and payment credited. The words “we”, “us”, and “our” refer to MD Pediatric Associates.

If insured, I hereby assign, transfer and set over to MD PEDIATRIC ASSOCIATES all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Monthly Statement: If there is a balance on your account, we will send a monthly statement. It will show the charges on your account and any payment or credits applied to your account.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within thirty (30) days of billing. Convenient payment through https://pymt.pro/mdpedi is available and payment plans may be an option; please call our billing department if you would like to inquire about a payment plan. Self-pay patients may pay in full for their visit at time of service, with a 25% prompt pay discount applied.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We do not file secondary insurance claims; that is the sole responsibility of the insured. We will bill your primary insurance company unless you specify that we should not. Although we can in good faith estimate what your insurance company may pay, it is the insurance company which makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance which are assigned as your responsibility. Please note, we are not providers for any type of Medicaid, CHIP, or government-assisted plans.

Required Payments: Any co-payments, co-insurance and/or deductibles are due at the time of service. We require payment for these, regardless of who brings in the child for his/her appointment. For your convenience we accept Visa, Mastercard, Discover and American Express. We can accept copayments online through https://pymt.pro/mdpedi prior to your visit.

Returned Checks: There is a fee ($30) for any checks returned by the bank. The amount of the check and the returned check fee must be paid with cash, credit card or money order ONLY. This amount must be paid before any children are seen for future appointments. If there has been a returned check with our office, we will no longer be able to accept payment on your account by check. Future visits will require an alternate form of payment.

CUB Advantage Membership: If you are a member of CUB Advantage by MD Pediatric Associates, you will input your card information and we will automatically process your monthly payment through CardPointe. If your card on file is declined for your automatic monthly payment, you will be required to pay any membership fees that are overdue prior to your membership becoming active again and prior to your being seen for an appointment.

Missed Appointment Fee: We require advance notice of 24 hours for the following appointment types: well child exams and ADHD/behavioral health appointments. Unless advance notification of 24 hours is received, a fee of $25 will be assessed for well child exams. A fee of $50 will be imposed for ADHD/behavioral health appointments. This fee must be paid before any children are seen for additional appointments.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect your debt. This may result in referring your account to an outside collection agency.

Waiver of Confidentiality: You understand if your account is submitted to a collection agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party/guarantor responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the party responsible for subsequent charges. If the divorce decree requires the absent parent to pay all or part of the treatment cost, **it is the guarantor/authorizing parent's responsibility to collect from the other parent.**

Medical Records: Medical records will be copied and released in compliance with HIPAA regulations. Charges for medical records are outlined on the medical release form. There is no charge for a one-time transfer of records to a new primary care physician.

Portal/Phone Call/After Hours Triage: It may be necessary to charge or bill your insurance for medical advice that is given via the portal, a telephone call, or after hours triage service. If your appointment is after 5 pm on weekdays, on a Saturday, or on a holiday, it may be necessary to bill your insurance an after-hours code which is associated with a fee.

Ancillary Charges Not Covered by Insurance: In the course of recommended preventative well care delivered by MD Pediatric Associates, there are screenings and treatments that we consider essential to patient health. Your insurance company may not include these items in your policy coverage or they may go to your deductible responsibility, and therefore may accrue a cost to you. As your child's medical home, we desire that your child obtain all recommended services. The following list of recommended services are examples which may not be fully covered under your insurance plan.

- 6 months (or when teeth appear) until age 3 years
    - Oral Health Evaluation and Fluoride Application
    - Visual Ocular Screen -- detects astigmatism, gaze deviation, myopia/near-sightedness, and hyperopia/far-sightedness
- 4 years
    - Visual Ocular Screen
    - Hearing Screen

Combined Well & Sick Care: If you present with acute needs at a well care visit, it may be deemed necessary by your provider to charge or bill your insurance for both the well care visit and an acute visit. An acute visit will accrue a payment as required by your insurance company.

Refunds: We will automatically refund overpayments to the credit card that was used to pay the fee initially, if it is still active. If there is a patient-due balance elsewhere on the family account, the credit will be applied to the balance.

Effective Date: Once you have reviewed and signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect. **By executing this agreement I am agreeing to pay for all services that are received.**

_____ _____

Parent/Guardian Signature (your typed signature serves as your legal signature) Date

_____ _____

Patient Name Patient Date of Birth

Patient Name & DOB: _____

MD Pediatric Associates has Nurse Practitioners and Physician Assistants on staff to assist in the delivery of primary care. The American Academy of Nurse Practitioners (AANP) defines Nurse Practitioners as “clinicians that blend clinical expertise in diagnosing and treating health conditions with an added emphasis on disease prevention and health management. A Pediatric Nurse Practitioner (PNP) is a registered nurse who has completed advanced nursing education, generally a Master’s degree or Doctorate, and who has additional pediatric clinical training. The American Academy of Physician Assistants (AAPA) defines Physician Assistants as medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient’s principal healthcare provider. Our mid-level providers can diagnose, treat, and monitor common acute or chronic diseases and provide well care. At any time, a patient/parent may elect to schedule only with a physician dependent upon availability.

By signing below you acknowledge that you have read and understand this notice. Your printed signature serves as your legal signature.

_____ _____

Parent/Guardian Signature Date

Patient Name & DOB: _____

DISCLOSURE OF PHYSICIAN OWNERSHIP IN HOSPITAL

Please review carefully the information contained in this notice.

1. During the course of our physician/patient relationship, our doctors may refer you to Flower Mound Hospital Partners, L.L.C. d/b/a Texas Health Presbyterian Hospital Flower Mound ("Hospital") or one or more other hospitals or physicians who provide specialized medical services.
2. MD Pediatric Associates (MDPA) wants to inform you that we are aware of the services provided at this Hospital because some of the MDPA physicians have ownership in the Hospital. Further, if we refer you to another physician for specialized medical services, that physician also could have an ownership interest in the Hospital.
3. We are providing this information to help you make an informed decision about your health care. You have the right to choose your healthcare providers and facilities. Therefore, you have the option to use a healthcare facility other than the Hospital or the physicians to whom we might refer you.
4. We will not be treating you differently if you choose to obtain healthcare at a facility other than the Hospital and, if you desire, we will be happy to provide you information about alternative healthcare providers and facilities.
5. If you have any questions, please do not hesitate to ask. We welcome you as a patient, and we value our relationship with you. Should you elect to utilize the Hospital or another physician who holds an ownership interest in the Hospital, you acknowledge your decision to decline the option to have your healthcare provided at an alternative healthcare facility. You further acknowledge that you signed this notice prior to our referral of you to the Hospital or another physician with ownership in the Hospital.

By signing below you acknowledge that you have read and understand this notice and that you are aware of our ownership interest in the Hospital.

_____ _____

Parent/Guardian Signature Date

NEWBORN HISTORY (PATIENTS LESS THAN 2 WEEKS OLD)

PATIENT'S LAST NAME _____ **FIRST NAME** _____
DATE OF BIRTH_____

 # OF WEEKS AT TIME OF DELIVERY: _____

VAGINAL OR C-SECTION (circle one)

TIME OF BIRTH: _____ **AM / PM**

BIRTH WEIGHT: _____ **lb** _____ **oz**

DISCHARGE WEIGHT: _____**lb** _____**oz**

BREAST OR BOTTLE: _____

HOW OFTEN DOES THE BABY FEED: _____ **hrs**

 # OF WET DIAPERS IN LAST 24HRS: _____

 # OF DIRTY DIAPERS IN LAST 24HRS: _____

NEWBORN HEARING SCREENING DONE AND NORMAL: yes / no normal/abnormal

HEART SCREENING DONE AND NORMAL: yes / no normal/abnormal

HEP B VACCINE GIVEN: yes/ no _____ **date**

PEAK TOTAL BILIRUBIN: _____

MATERNAL BLOOD TYPE: _____

INFANT BLOOD TYPE: _____

HOSPITAL NAME: _____

OB DOCTOR NAME: _____

PREGNANCY COMPLICATIONS: yes/ no Describe: _____

LABOR & DELIVERY COMPLICATIONS: yes/ no Describe: _____

PROBLEMS AFTER BIRTH: yes/no Describe: _____

BABY IN THE NICU: yes/no Length of stay: _____

MOTHER'S AGE: _____

FATHER'S AGE: _____

TOTAL # OF PREGNANCIES: _____ **TOTAL # OF LIVE BIRTHS:** _____

Statement of Permission to Treat

Date

To Whom It May Concern:

I am the parent of:

Date of Birth

I give permission to the following listed person(s) to obtain medical treatment for the above- referenced child(ren) with a provider of MD Pediatric Associates or any facility which the provider deems necessary. This person(s) has my permission for medical decision making including but not limited to: administration of medication, administration of immunization, diagnostic or therapeutic procedures, admission to the hospital, etc. I will be responsible for payment for care. This permission remains in effect until I sign a document rescinding this permission.

Name: **Relationship to child:**

In an emergency, the parent(s) may be reached at:

Phone

Parent Signature (typed name serves as signature)

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only.

Child's Gender: ◯ **Male** ◯ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Carequality Clinical Document Exchange

What is Clinical Document Exchange?

Clinical Document Exchange (also referred to as Query Based Clinical Document Exchange, or QBCDE) allows different healthcare organizations to exchange patient records. Your participation would allow other providers who treat you to obtain our patient records for treatment purposes, as defined in the Health Insurance Portability and Accountability Act (HIPAA). The purpose is to improve patient care by making sure other health organizations have a complete and current picture of your health when it is needed for treatment or care.

The Carequality Framework

Carequality is an organization that maintains a framework of secure technical, data, and privacy standards that allows organizations who implement that framework to directly exchange data. MD Pediatric Associates and our electronic medical software company, PCC, are utilizing Carequality to exchange medical documents securely.

MD Pediatric Associates may in the future use Clinical Document Exchanges other than the one offered by Carequality (also referred to as Health Information Exchanges). The provisions of this policy shall apply to all Clinical Document Exchanges entered into by MD Pediatric Associates.

What Data will be Shared?

The patient's most up-to-date Summary of Care Record is made available for exchange and contains our records of the following information:

- Demographic data (Name, D.O.B., Address, Phone)
- Clinical data
- Diagnoses
- Allergies
- Medications
- History of Procedures
- Diagnostic and Laboratory Test Results
- History of Immunizations
- Insurance Policy

Who has Access to Patient Data?

Other healthcare organizations that participate in clinical document exchange through the Carequality interoperability framework are able to retrieve your records. They may retrieve your records for treatment purposes only.

Is Clinical Document Exchange Safe and Secure?

Yes. Many layers of security protect patient data both in storage and when it is transmitted to a different healthcare organization.

How do I opt-in?

MD Pediatric Associates has an opt-out policy, meaning that all patients are considered to have consented to clinical document exchange unless otherwise indicated. If you do not choose to opt-in, you must request an opt-out document from the office staff and complete and return. By signing below, you verify that you have received a copy of our policy for Clinical Document Exchange.

_____

Signature of Parent/Guardian (your typed name serves as your signature)

_____ _____

Relationship to patient Date

Authorization for Release of Medical Information

Patient Name_____ Date of Birth_____

Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ FAX#_____

C) For the purpose of:

- ◯ Litigation
- ◯ Insurance
- ◯ Self/Personal Copy
- ◯ Continuity of Care
- ◯ Disability/SSI
- ◯ Work Comp
- ◯ Other
- ◯ Transfer of Care (Permanently Leaving)

Date Range_____ to_____

- ☐ Physician Office Notes
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Other _____
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire after release unless I specify an expiration date:_____ (Expiration date of authorization)

***PLEASE READ** Fee Information: **MD Pediatric Associates** contracts with an outside organization to copy and provide most medical records requested from our office. The company reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay for your records if a charge is incurred. In the case of continuity of care or personal copy to patient, we may transfer a summary of your records as a courtesy rather than the complete and total record.

P.O. BOX 2429, COPPELL, TX 75019 P: 972.420.1475 F: 469.671.5437 WWW.MDPEDI.COM