AUSTIN PEDIATRIC SURGERY
PATIENT INFORMATION FORM

PATIENT NAME____ NICKNAME ___________________________
FIRST MI LAST

STREET ADDRESS: ____ DATE OF BIRTH: ___/___/______ AGE: _______

CITY: ______________________ STATE: _______ ZIP: ________ COUNTY: ___________________ SEX: M F

HOME PHONE: (_____) _______-_________ SCHOOL: ____________________ SOCIAL SECURITY #: ___________________

MAILING ADDRESS IF DIFFERENT: ____

REFERRING PHYSICIAN: ____ PHONE (_______) _______-____________

PRIMARY CARE PHYSICIAN: ____ PHONE: (_______) _______-____________

RESPONSIBLE PARTY

NAME OF PARENT/GUARDIAN ACCOMPANYING CHILD: ____

ADDRESS: ________________________________ CITY: _______________ ST: _______ ZIP: ________ COUNTY: ________________________________	SOCIAL SECURITY#: ________________________________ RELATIONSHIP TO PATIENT: __________________________ DATE OF BIRTH: _______/_______/__________ SEX: M F
HOME PHONE: (_______) ________-___________ WORK PHONE: (_______) ________-___________ MOBILE PHONE: (_______) ________-__________ EMAIL: __________________________________	OCCUPATION: _____________________________________ EMPLOYER: _______________________________________ EMPLOYMENT STATUS: _______________________________ BEST WAY TO CONTACT: _____________________________

OTHER PARENT/GUARDIAN: ____

ADDRESS: ________________________________ CITY: _______________ ST: _______ ZIP: ________ COUNTY: ________________________________	SOCIAL SECURITY#: ________________________________ RELATIONSHIP TO PATIENT: __________________________ DATE OF BIRTH: _______/_______/__________ SEX: M F
HOME PHONE: (_______) ________-___________ WORK PHONE: (_______) ________-___________ MOBILE PHONE: (_______) ________-__________ EMAIL: __________________________________	OCCUPATION: _____________________________________ EMPLOYER: _______________________________________ EMPLOYMENT STATUS: _______________________________ BEST WAY TO CONTACT: _____________________________

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _________________________ SUBSCRIBERS NAME: __________________________________

DATE OF BIRTH: ____/_____/________ RELATIONSHIP TO PATIENT: _________ SUBSCRIBERS ID #: ____________________

GROUP #: ____________________GROUP NAME/EMPLOYER: ____

SUBSCRIBERS ADDRESS: ________________________CITY/STATE/ZIP_____________________________________

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME: _________________________ SUBSCRIBERS NAME: __________________________________

DATE OF BIRTH: ____/_____/________ RELATIONSHIP TO PATIENT: __________SUBBSCRIBERS ID #: __________________

GROUP #: ____________________GROUP NAME/EMPLOYER: ____

SUBSCRIBERS ADDRESS: ________________________CITY/STATE/ZIP_____________________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENTS)

NAME: ____ PHONE: (_____) _______- _________

RELATIONSHIP TO PATIENT: ____

PHARMACY NAME/LOCATION: ____ PHONE: (_____) _______- _________

CONSENT TO TREAT

I, ________________________, HEREBY AUTHORIZE MY CHILD, ___________________ TO BE EVALUATED AND/OR TREATED BY THE PROVIDERS OF AUSTIN PEDIATRIC SURGERY.

PRINT PARENT/GUARDIAN: ____ DATE: _____/_____/_______

SIGNATURE PARENT/GUARDIAN: ____DATE: _____/_____/_______

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Austin Pediatric Surgery

This is a consent form. It asks you to permit us to use and disclose information about your child's health. That information is called "protected health information." It is any information we receive or create that identifies (or could identify) your child and deals with your child's physical and/or mental health, any health care we provide your child and/or payment for such health care.

By signing this form, you are consenting to our use and disclosure of your child's health information in order to carry out treatment, payment or health care operations.

We have a "Notice of Privacy Practice" (the "Notice"). The Notice describes in great detail how we might use or disclose protected health information. The notice also discusses your rights and our duties with respect to protected health information. You have the right to review the Notice before signing this consent.

You also have the right to revoke this consent in writing, except where we have previously taken action in reliance on your prior consent.

Additionally, it is your right to request that we restrict how your child's protected health information is used or disclosed for purpose of treatment, payment or health care operations. We are not required to agree to any restriction you request; however, if we do agree to a restriction, we are bound to follow it.

As provided in the Notice, our privacy practices described in the Notice may change. If there are any such changes, the terms of the Notice will change. If that happens, you may obtain a revised copy of the Notice by contacting our Privacy officer, Janelle Johnson at 1301 Barbara Jordan Blvd., Suite 400, Austin, TX 78723. Phone number (512) 708-1234.

____
Patient Name

____
Parent/Guardian Signature

____
Date

Austin Pediatric Surgery
1301 Barbara Jordan Blvd. Ste 400, Austin, TX 78723
Phone 512.708.1234 Fax 512.708.4567

FINANCIAL POLICY

As we enter this doctor-patient (parent) relationship, we agree to provide quality pediatric surgical care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, MasterCard, Visa, Discover and American Express. If you are not prepared to pay the required amount, we may be required to reschedule the appointment. The estimated financial responsibility for scheduled surgery will be due ***prior*** to the surgery date. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 60 days with no payment activity will be reported to the credit bureau(s).*

- **Your insurance policy is a contract between you and your insurance company. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. You are responsible for obtaining a properly dated referral if required by your insurance company and responsible for payment if your claim denies for lack of one. Failure to provide accurate insurance information within 15 days from the date of service will result in the balance becoming your responsibility. If after 60 days from the initial filing date, we do not obtain payment for services performed by your insurance company, the balance will be transferred to you for payment in full.

- As a courtesy to you, we will file a participating insurance claim for you with proper assignment. Please bring your insurance card with you to every visit.

- We do not file third party insurance for motor vehicle accidents or liability claims. We do not carry balances for claims to be settled in or out of court.

- It is the responsibility of the parents to add your newborn to your policy within 30 days from birth.

- This office is not party to your divorce decree. The financial responsibility rests with the accompanying adult.

- A $25.00 fee will be assessed for all returned checks.

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds will be provided within 30 days from the date all outstanding claims are satisfied.

ASSIGNMENT OF BENEFITS

I request payment of the medical and surgical benefits, otherwise payable to me, directly to Austin Pediatric Surgery for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_______________________________________ ____________________
Responsible Party Printed Name (Must be 18 or over) Date

_______________________________________ ____________________
Responsible Party Signature (Must be 18 or over) Date

Patient History Form

Last Name	First Name MI		Date of Birth
Mother/Guardian		How many brother and sisters?	
Father/Guardian		Who does the patient live with?	
Primary Care Physician/Pediatrician:	Other doctors involved with the patient's care:		

Has the patient recently/chronically been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is the family physician aware of any symptoms/illnesses that you have checked below? o No o Yes

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Birth History			**Cardiac**			**Neurologic**			**Ear, Nose, & Throat**		
Normal			Chest pain			Seizures			Loose Teeth		
Premature			Irregular heartbeat			Weakness			Nosebleeds		
Cesarean			**Respiratory**			Migraines			Sore throat/ear pain		
Prematurity			Asthma			**Musculoskeletal**			**Psychosocial**		
Apnea/Bradycardia			Pneumonia			Back pain			Depression		
Intubation			Bronchitis						ADHD		
Gastrointestinal			Chronic Cough			**Hematologic**			**Breast**		
Diarrhea			Wheezing			Blood Disorders			Lumps		
Constipation			**Genitourinary**			Excessive bleeding			Cancer		
Rectal Bleeding			Kidney Disease								
Abdominal Pain			Frequent urine infection			**Skin**			**Others:**		
Trouble swallowing			**Endocrine/Metabolic**			Rash/pruritis					
Nausea			Diabetes			Bruising					
Vomiting			Thyroid Disorders								

PAST HISTORY OF THE PATIENT

Please explain any YES answers in detailed description in the box provided.

Question		Surgeries	Dates	Hospitalizations other than surgery	Dates
Has the patient ever had any surgery or been hospitalized? **Has the patient had any problems with anesthesia? No ____ Yes _____ If yes, please list below:**	o No o Yes				

Question		Medication	Dose	Times	Medication	Dose	Times
Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	o No o Yes						

Question		
Does the patient have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	o No o Yes	

FAMILY HISTORY: Please indicate if parents, brothers and/or sisters have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Skin cancer No ___ Yes __		Kidney problems No ___ Yes_____		Bleeding/Clotting Problems No ___ Yes ___	
Diabetes No ___ Yes __		Ulcerative Colitis No ___ Yes ___		Crohn's Disease No ___ Yes ___	
Stomach Cancer No ___ Yes ___		Ovarian Cancer No ___ Yes ___		Anesthesia reactions No ___ Yes ___	
Breast Cancer No ___ Yes ___		High Blood Pressure No ___ Yes ___			

_______________________________________ **Person Completing This Form/Relationship to Patient**

_______________________________________ **Reviewed by Provider Date(s)**