8714 Spring Cypress Road
Suite 170
Spring, TX 77379
281-374-8882

Tad Shirley, MD, FAAP
Susan Reed, MD, FAAP
Tamika Bush, DO, FAAP
Roxanne George, MD, FAAP

Patient Demographics

Patient's Full Name: _____

Street Address: _____ Apt._____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: Male or Female

Primary Phone: _____ Secondary Phone: _____

Ethnicity: _____ Preferred Language: _____

Siblings (Family First patients): _____

Patient's Parents Information

Mother's Name: _____Date of Birth: _____

Address (if different): _____

Employer: _____Work Phone: _____

Email Address: _____

Father's Name: _____Date of Birth: _____

Address (if different): _____

Employer: _____Work Phone: _____

Email Address: _____

Insurance Information

Insurance Company: _____

Policyholder Name: _____Date of Birth: _____

Signature parent/guardian:_____ Date:_____

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Patient Questionnaire

Patient Name: _____ **Date of Birth:** _____

1) Please list the family members or other persons, if any, whom may bring your child to an appointment and authorize treatment:

_____

_____

2) Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnosis:

_____

_____

3) Please list the family members or significant others, if any, whom we may inform about your child's medical condition only in an emergency:

_____

_____

4) Please indicate whether or not you allow your child (age 16 and over) to receive medical treatment at our office without you being present (excluding invasive procedures and vaccines/shots): **Yes or No** _____**(Initials)**

5) Confidential messages may be left on your answering machine or voicemail? **Yes or No**

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Printed Name:_____

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Consent to Use or Disclose Information for Treatment, Payment or Health Care Operations

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (Protected Health Information) by Family First Pediatrics in order to carry out treatment, payment or health care operations. The patient should review Family First Pediatrics Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent.

Family First Pediatrics reserves for itself the right to change the terms of its Notice of Privacy for Protected Health Information at any time. If we do make changes to the terms of our Notice of Privacy Practices, the patient may obtain a copy of the revised notice.

Patient retains the right to request that the facility further restrict how his/her Protected Health Information is used/disclosed to carry out treatment, payment or health care operations. Family First Pediatrics is not required to agree to such requested restrictions; however if we do agree to patient's requested restrictions, such restrictions are then binding on Family First Pediatrics.

At all times, the patient retains the right to revoke this consent; such revocation must be submitted to Family First Pediatrics in writing. The revocation shall be effective except to the extent that we have already taken action in reliance on the consent.

Family First Pediatrics may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form except to the extent that is required by law to treat individuals. If patient or representative signs this consent form and then revokes consent, Family First Pediatrics has the right to refuse to provide further treatment to patients as of the time of the revocation.

I have read and understand this information. I have received a copy of this form if requested and I am the patient, or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

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Printed Name of Parent/Guardian:_____

Relationship to Patient:_____

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Privacy Policies

Family First Pediatrics strives to exceed all regulations pertaining to patient records. Our office complies with the regulations dictated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This office complies with all privacy rules that provide open access of medical records to their respective patients and the protection of those records from non-patient parties. We may disclose your child's records only for the following reasons: 1) Treatment, to provide, coordinate and manage care. 2) Payment (to get paid for our services) 3) Health care operation - quality evaluation, audit of records, cost analysis, customer service. Our practice may share information to others by removing all the information that may identify your child. We may contact you to schedule office visits, inform you of test results, or health education. We may take a picture of your child with your verbal permission for educational services or to follow up on a clinical condition.

Rights of the patients:

1) The right to access their medical records.

2) The right to request amendments to their medical records approved by the physician, in a timely manner.

3) The right to receive an accounting of the disclosures made by our medical facility to another facility and getting permission beforehand from the patient to do so.

4) Protection of patient information whether written or verbal.

5) Trained personnel who handle patient information properly and with respect.

We know that your treatment here is your main focus, and we want to make sure you have one less thing to worry about and that is your medical records. Thank you for choosing us as your clinic. If you have any questions, please ask one of our clinic staff.

I have read the above statement and understand my general rights as outlined above. If I have further questions, I will ask to speak to a staff member.

I also acknowledge that I was provided a summary of the notice of privacy practices and was offered a full copy if I desired to receive it.

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Financial Policy

We are committed to providing you with the best possible care and treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to your visit.

Payment is due at time of service

We accept cash, checks, Visa, Mastercard, American Express and Discover Card.

Regarding Insurance:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract however if we have a contract with your insurance company then we will only require your copay and/or deductible payment to be paid at the time of service. Any additional charges will be billed to you once we receive the explanation of benefits from your insurance company. If we do not participate with your insurance company we will be asked that payment be made at the time of service and we will provide you with an itemized receipt, if requested, so you may file a claim with your insurance if desired.

You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information you will be required to pay for the services rendered that day.

We **DO NOT ACCEPT SECONDARY INSURANCE**, third party insurance, social security or auto accident claims. We only accept and file with your primary insurance.

Minor Patients:

The parent/guardian who presents the child for medical treatment is the responsible party. If payment for services is to be made by someone else, the parent/guardian with the child should pay and have the other party reimburse them. Any legal agreement between the parents has nothing to do with this practice.

Other Fees:

We charge a $25.00 fee for all returned checks and may charge a reasonable fee for late payment.

After reviewing the Financial Policy, I understand and agree to its provisions.

Signature parent/guardian:_____ Date:_____

Printed Name:_____

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Acknowledgment

_____ **(Initials)** Late/No Show Policy: We strive to follow a strict schedule to avoid wait times. Due to this, if you are more than 15 minutes late for any appointment, you may be asked to reschedule. If we are not busy, we will try to work you in at the next available appointment time. Any appointment not cancelled 30 minutes prior to the appointment time will be considered a no show. After a third no show you will asked to find another facility to see your child. If you cannot make an appointment please call to cancel or reschedule.

_____**(Initials)** We **DO NOT ACCEPT SECONDARY INSURANCE**, third party insurance, social security or auto accident claims.

_____ **(Initials)** Additional charges may be incurred with any in-house labs (flu tests, strep tests, urinalysis, etc.), shots, or procedures (stitches, wart removals, nebulizer treatments. etc.). Every insurance plan is contracted differently and we are not always aware of the various levels of coverage. Therefore we are not able to anticipate the final out of pocket costs at the time of your visit.

_____**(Initials)** All children must be closely supervised at all times. We want to maintain a clean, well-kept office. Please do not allow children to climb or mark on walls, chairs, tables, books, etc. Any damage caused by your child(ren) will be billed to you for the replacement costs and/or you may be asked to find another provider for your child(ren).

_____ **(Initials)** No food or drinks are allowed into the clinic to prevent spills and to avoid exposure for children with food allergies (baby formula excluded).

I acknowledge that I have been presented with and have read and understood the Policies & Procedures provided to me by Family First Pediatrics, P.A. I agree to abide by the policies of Family First Pediatrics.

Signature parent/guardian:_____ Date:_____

Printed Name:_____