



New Patient Registration

Patient 1 _____ Sex _____ Date of Birth _____
Patient 2 _____ Sex _____ Date of Birth _____
Patient 3 _____ Sex _____ Date of Birth _____

Patients Insurance Information-Primary Insured / Custodial Parent

Last Name: _____ First Name: _____
Date of Birth _____ SS# _____ DL# _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Alternate Phone: _____
Employer: _____ Phone: _____ Ext: _____
Insurance Company: _____ Insurance Phone: _____
Policy# _____ Group/Plan #: _____

Other Parent / Non-Custodial Parent

Last Name: _____ First Name: _____
Date of Birth _____ SS# _____ DL# _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Alternate Phone: _____
Employer: _____ Phone: _____ Ext: _____

Children live with: Mother Father Guardian Other: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____

Authorization of Treatment and Assignment of Benefits

I authorize Pediatricians of Dallas, P.A., Dr. Joe Neely, Dr. James Watkins, Dr. Matthew Yaeger, Dr. Somer Curtis, Dr. Karen Halsell, Dr. Chafen Hart, and Dr. Hillary Lewis to treat my child. I further authorize payment directly to Pediatricians of Dallas, P.A. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

Parent's Signature

Date



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding your health record/information

Each time you visit Pediatricians of Dallas, a record of your visit is made. This record can be either written, oral, or in electronic format. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care. This information is often referred to as your health or medical record.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support day-to-day activities and management of Pediatricians of Dallas. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Additional Uses of Information

Photographs: We will display photographs that are sent to us unless you give specific instructions not to display them.

Appointment reminders: Your health information will be used by our staff to remind you of your upcoming appointments.

Other uses and Disclosure Require your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclose of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.



Individual Rights

You have certain rights under the federal privacy standards. These include a) the right to request restrictions on the use and disclosure of your protected health information, b) the right to receive confidential communications concerning your medical condition and treatment, c) the right to inspect and copy your protected health information, d) the right to amend or submit corrections to your protected health information, e) the right to receive an accounting of how and to whom your protected health information has been disclosed, and f) the right to receive a printed copy of this notice.

Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices." We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Front Office Manager or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Office
Pediatricians of Dallas, P.A.
8325 Walnut Hill Ln #225
Dallas, Texas 75231



Acknowledgment of Receipt for Notice of Privacy Practices

I was given the opportunity to review Pediatricians of Dallas, P.A.'s Notice of Privacy Practices. This notice is displayed on line and in each of the waiting areas. I understand any and all records whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as provided by law and so as set forth in the Notice of Privacy Practices. A copy of the Group's Notice of Privacy Practices will be provided upon request.

Pediatricians of Dallas, P.A. reserves the right to modify the privacy practices outlined in the notice.

First and Last Name

Signature

Date



Medical Authorization

In the event of my absence, I give permission to _____

to authorize medical treatment for my minor child, including immunizations.

I authorize Pediatricians of Dallas, P.A. to provide medical care to my teenage child without an accompanying adult. If immunizations are to be given, I agree to be available by phone for a verbal consent.

Child's name _____

Date of birth _____

Signature

Phone number

Date