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

8325 Walnut Hill Ln, Suite 225 * Dallas, TX 75231 * 214-691-3535 * fax: 214-691-0404

www.pediatriciansofdallas.com
Joe B. Neely, M.D. * James W Watkins * Matthew Yaeger, M.D. * Somer Curtis, M.D.
Karen R. Halsell, M.D. * Hillary Lewis, M.D. Jerald Mefferd, M. D.

**** Fees for medical records may apply. Please do not fax any record over 25 pages****

Authorization for Release of Information

Printed Patient: Name: _____ Date of Birth: _____

Address: _____ City: _____

Zip Code: _____ Phone Number(s): _____

RECORDS LEAVING PEDIATRICIANS OF DALLAS [ ] I hereby authorize Pediatricians of Dallas to release the information specified below from the medical record(s) or the above names patient.

Recipient of Records: _____

Address, City, State, Zip Code: _____

Phone number: _____ fax #: _____

OR

RECORDS BEING SENT TO PEDIATRICIANS OF DALLAS [ ] I hereby authorize _____

_____ to release the information specified below from the medical record(s) of the above-named patient.

Previous Physician's Address, City, State, Zip Code: _____

Phone Number: _____ fax#: _____

Date of Service: From: _____to_____ Requested information is needed for: [ ] Changing Doctors [ ] Continuing Medical Care [ ] Personal Use[ ] Other: _____
Sending option: __ Mail (CD / Paper) __Email __Fax

The Patient/Responsible Party's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information communicable diseases, HIV testing, psychiatric treatment, and genetic testing. To authorize release of information, please read and initial the information to be released.

I authorize the release of **alcohol and/or drug abuse** treatment and information. _____Patient/Responsible Party Initials
I authorize the release of **HIV test results** and/or HIV treatment information. _____Patient/Responsible Party Initials
I authorize the release of **psychiatric** information. _____Patient/Responsible Party Initials
I authorize the release of genetic testing information. _____Patient/Responsible Party Initials

I understand I may revoke the authorization in writing at any time, except to the extent that POD has relied on this authorization. The written revocation should be addressed to the above letterhead address. Unless otherwise revoked, I understand this authorization expires in Ninety (90) days from the date of signature. A copy of this authorization is considered as valid as the original. I understand the recipient authorized to receive the health information may not be covered entity (e.g. non-health care provider) and the released information may be redisclosed and may no longer be protected by federal and state privacy regulations.

_____

Patient/Responsible Party Signature Patient/Responsible Party Printed Name 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 evaluation 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

Individuals Involved in Your Childs Care or Payment for Your Childs Care

The guardian(step parent's,grandparent,nanny,etc.) and any other person attending the office visit may contribute to the health record. We will only disclose medical information as is 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.

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.

Lab Results: Negative lab results will be left on the primary contact numbers voicemail. If we are unable to reach you about a positive lab result we will leave a voice mail requesting a call back at

the primary contact number noted on your child's account. We may also attempt to reach a parent/custodian by using other numbers associated with the account including emergency contact numbers.

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

Revision Date: 4/21/14

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 is 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.

_____ _____

Parent/Guardian Signature Date

In the event of my absence, I give permission to the following person(s) to authorize medical treatment for my minor child, including immunizations.

_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient

Child's name _____ Date of birth _____

_____	_____
Print name	Relationship to parent

_____	_____	_____
Parent's signature	Phone number	Date

8325 Walnut Hill ln ste225, Dallas, TX 75231
214-691-3535

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Pediatricians of Dallas, PA files insurance claims for all services with primary insurance. Patients are billed for any remaining balance after insurance processes the claim. Any non-covered services are the financial responsibility of the patient(s). If payment for a service performed is denied incorrectly by the insurance carrier, our billing department will appeal on your behalf. If after appeal the insurance carrier continues to deny claims, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. If the patient(s) has no insurance coverage, they are financially responsible for all charges incurred.

Please read and initial below confirming that you have been informed of our billing and filing policies:

- Any co-payment/co-insurance and applicable deductible amounts are to be paid at the time of
- service unless other arrangements have been made with the office.

- Upon receipt of patient payment, the remainder of the bill will be filed with insurance for direct
- payment to our office.

- It is the patient's responsibility to provide current insurance information at each visit, and any
- changes to a current policy must be provided before being seen by the doctor.

- If the insurance claims are paid and the insurance remits payment to the policy holder, payment is to be forwarded
- to the doctor from the patient.

- Any amounts or services not covered by insurance are the responsibility of the patient.

- Any charges due to missed appointments, copying of records, forms fees, after-hour calls or other billing fees are the responsibility of the insured/patient.

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Guardian/
Signature_____Date_____