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

www.pediatriciansofdalias.com
8325 Walnut Hill Ln, Suite 225 • Dallas, TX 75231 • 214-691-3535 • fax: 214-691-0404
Joe B. Neely, M.D. • James W Watkins, M.D. • 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

Please email this signed form to records@pod.pcc.com

Fax up to 25 pages to 214-691-0404 and Email over 25 pages to records@pod.pcc.com

Printed Patient Name: _____ Patient Date of Birth: _____

Address:_____ City: _____ Zip Code:_____

Phone Number: _____

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

Pediatricians of Dallas is required by law to maintain the privacy of your medical information both paper and electronic to the extent required by Texas and Federal HIPAA Law; notify affected individuals following a breach of unsecured medical information; and follow the terms of this "Notice of Privacy Practices".

The guardian (parent, grandparent, nanny, etc.) and any other person attending the office visit may contribute to the health record, i.e., symptoms, examination, diagnosis, treatment, and a plan for future care. It is assumed that the guardian present has been granted permission by the custodial parent(s) to contribute to or observe the office visit.

How We May Disclose Medical Information About You

Treatment: To nurses and other health care providers who are providing or involved in the care of your child both inside and outside the practice. This includes referrals, laboratory tests/results, and to physicians and nurses if the patient is transferred to a higher level of care.

Payment: Your health information may be used to seek payment from your health plan, from third party collections, and/or automobile insurers. For example, your health plan may require information on dates of service, service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support day-to-day operations and management of the practice; to support budgeting and financial reporting and used in quality improvement.

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

Public Health reporting: When required by law to report to local and state public health agencies, communicable diseases of public health concern.

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

Photographs: We will display photographs such as Holiday cards or marketing photographs sent to us unless you give specific instructions not to display them.

Business Associates: Billing associates and attorneys may be provided with patient health information for business purposes and legal matters. To protect your information, however, we require that our business associates appropriately safeguard your information.

To Avert Imminent Threat of Injury to Health or Safety: Such disclosure would only be to medical and/or law enforcement personnel to prevent a serious threat to mental, emotional health, or physical safety of another person.

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 a 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.

Special Protections and Consent Requirements for SUD Records: Substance Abuse Disorders, SUD, records are governed by stricter federal law and are not treated the same as other medical information. SUD records generally cannot be used or disclosed for treatment, payment, or healthcare operations without the patient/parent's specific written authorization. SUD records, or testimony describing them, generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against a patient unless the patient gives written consent, or a court issues, a special order after notice and an opportunity to be heard.

Redisclosure Warning: Once patient information is disclosed regarding SUD treatment, payment, and health care operations, it may be redisclosed by the recipient and may no longer be protected by HIPAA.

Other Uses and Disclosures 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 disclosure, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or take back any uses or disclosures of information that occurred before you notified us of your decision to revoke your authorization, and that we are required to retain our records of the care that we provided to you.

Individual Rights

You have certain rights under state and federal privacy standards. These include:

1. The right to request and inspect a copy of your protected medical records in writing using our "Medical Records Release Form"; The fee we may charge for copies of your medical records will be the no more than the amount allowed by state law.
2. The right to amend or submit corrections to information if you feel that it is incorrect or incomplete. We may deny your request for amendment if it is not submitted in writing, if it does not include a reason to support the request, if the information was not created by Pediatricians of Dallas, or if the information is accurate and complete per your MD. If we deny your request, we will notify you of that denial in writing.
3. The right to an accounting of disclosures of how and to whom your protected health information has been disclosed.
4. The right to receive a paper copy of this notice.
5. The right to a breach notification if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined by HIPAA and applicable state law.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices by changes in state and federal 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.

Complaints

If you would like to submit a complaint or concern about our privacy practices, you can do so by sending a letter addressed to:

Privacy Office
Pediatricians of Dallas
8325 Walnut Hill Ln, Ste 225, Dallas, TX 75231

Revision Date: 2/9/2026

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_____