WELCOME

Today's Date:

Patient			
First Name:	Last Name:		D.O.B.
Address		City	
State	Zip	SSN	M or F

Parent or Guardian 1 (Primary Contact)			
First Name:	Last Name:		Relationship:
Home Phone:	Cell Phone:	Email:	D.O.B

Parent or Guardian 2 (2nd Contact)			
First Name:	Last Name:		Relationship:
Home Phone:	Cell Phone:	Email:	D.O.B

Known Allergies (food/seasonal/medicine):

Past Medical History (hospitalization/surgeries):

Any additional information:

Little Plum Blossom Pediatrics 311 S FM 1187 #300, Aledo, Texas 76008 (817)441-2266 office (877)397-0469 fax

Authorization to Release Health Information

Patient Name:_____Date of Birth: _____

I, the undersigned, authorize the release of or request access to the information contained in the medical record(s) of the above named patient for the purpose of medical treatment.

This authorization permits Little Plum Blossom Pediatrics to request information on the patient's behalf and to discuss health information with the listed provider or facility.

Information to be released may include the scope of: Medical Histories, Treatment Reports, Operative Reports, Laboratory Reports, Pathology Reports, Consultations, Discharges, Radiology Images or Reports, or ER Records.

Medical records are being requested **FROM**:

Provider's Name / Office	
Address	
Phone:	Fax:

Medical records are being released **TO**:

Little Plum Blossom Pediatrics
311 S. FM 1187 #300
Aledo, TX 76008
Ph: 817-441-2266
Fax: 877-397-0469

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition.

_____
Date

_____
Patient or Parent/Guardian Name (Print)

_____
Patient or Parent/Guardian Signature

Little Plum Blossom
PEDIATRICS

May 2017

Office Policies

This document serves to establish rules and policies in order to maintain a quality physician-patient relationship. Our goal is to keep our patients and parents informed and responsibilities clearly defined. Please read each section carefully and sign below. If you have questions, please ask a member of our staff for help.

Appointments

- Call the office directly or email to schedule an appointment. Our staff will contact and confirm your request by phone or email within 1 business day.
- Fees for appointments are collected at the start of the visit. If additional services are provided, those fees will be collected at the end of the appointment.
- We value your time and have set aside a specialized time period to individually treat your child. If you are not able to keep an appointment, please give 24 hours notice. We will **charge you $65 for a missed appointment**, or cancellation made less than 24 hours prior to your scheduled appointment.
- If you are late for your appointment (greater than 10 minutes), we will do our best to accommodate you, however it may be necessary to reschedule your appointment.
- If an emergency arrives, they take priority over a scheduled visit. We appreciate your understanding and will strive to minimize any wait time.

Financial Responsibility

- **Copayments will be collected at the time of services.** For self-pay patients a claim will be supplied to you containing codes and documentation needed for you to receive reimbursement from your insurance company.
- In the event that a special service or procedure is provided that is not able to be immediately paid, then a statement will be mailed.
- Any account balance outstanding longer than 60 days will be charged a $25 re-bill fee for each 30 day cycle. Any balance outstanding longer than 90 days will be sent to collections.
- **Prior balances must be paid before scheduled visits.**
- **We are currently contracted with PPO plans from:** Aetna, BCBS, Cigna, Tricare, and United Healthcare.
- We accept cash, checks, Visa, Mastercard, Discover, and American Express credit cards. **A $50 fee** will be charged for any check returned for **insufficient funds**.

Prescriptions

- Monthly medication refills require 3 business days notice, during regular business hours.
- You authorize Little Plum Blossom Pediatrics to obtain your child's medication history electronically as part of the electronic health record.

Phone Calls / After Hours Calls

- After hours calls are considered "outside" of regular office hours.
- If phone call involves 2 or more issues, or several repeat calls then you will be asked to schedule an appointment or you will be assessed a fee for phone service.
- Calls that are placed after regular office hours could be subject to a $45 fee not covered by insurance per call.
- Patients are expected to call during normal business hours (8 to5) for non-urgent questions.

Photography

- Sometimes photography may be involved in assessment, or treatment or charting growth (ex: rash, height/weight).
- All photography will be limited to the patient's medical record.
- When making a referral any photography related to the problem will be shared only with that physician.

Referrals

- Please allow 5 business days for all non-emergent referrals. You can call the office or send a request by email.
- It is your responsibility to know if a selected specialist participates in your plan.
- You must notify our office 3 business days prior to your specialist appointment if pre-authorization is needed.
- In emergency care, do not wait for authorization. Inform us of the ER or Urgent Care utilized as soon as possible.

Insurance Plans

- It is your responsibility to keep yourself and our staff informed of changes in insurance. Self-pay patients will be provided with a appropriate documentation of your visit so that you may file with your medical insurance company for reimbursement.
- **You are always responsible for payment of your current visit and providing appropriate forms for signatures.** We are not responsible for non-payment of services by your insurance company.
- **It is your responsibility to understand your benefit plan coverage and exclusions. That includes written referrals, specialist authorizations, procedural pre-authorizations, and all covered services.**

Forms

- Fees for forms are not charged to your insurance.
- Absentee forms are available for the date of service only.
- Any additional school, camp, therapy or sports forms are subject to a $10 per form fee if not resolved during a well visit appointment.
- Family medical leave act forms are $35.
- Forms will be completed and available in 3 business days. Payment is due at drop-off.
- Any additional Insurance forms are $25.
- An Authorization to Release Medical Records must be signed when transferring records. Copies for you or another non-medical professional are $25.

Vaccines

- Vaccines will be billed as required by your insurance.
- Not all vaccines are mandatory per Texas requirements for public school or daycare.
- **We require that any child abstaining or delaying vaccination for an alternative vaccination schedule have a current and valid (notarized) vaccination exemption from the state of Texas through the DSHS, Department of State Health Services.**
- There are times that vaccines may be unavailable due to shipping, manufacturer or physician preference. If we do not have a vaccine we will provide references on where to obtain it.
- You will be given a vaccine information sheet regarding all vaccines on the standard AAP schedule.
- It is your responsibility to request specific vaccines outside that schedule due to exposure, preference or medical need.

I certify that I am the individual listed below and I am a parent or authorized guardian for the child listed below. I have read and understand these office policies and agree to comply with the above requests.

Child:_____ **DOB:**_____ **Parent/Guardian:** _____ **Signature:**_____

Little Plum Blossom Pediatrics
Notice of Privacy Practices

We respect patient confidentiality and only release personal health information about you in accordance with the State of Texas and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

Privacy Contact. If you have any questions about this policy or your rights contact our privacy officer.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
In order to effectively provide care, there are times when we will need to share your personal health information with others beyond the urgent care practice for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of the urgent care practice that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Operations. We may use information about you to coordinate our business activities. This may include reviewing your care and training staff.

Information Disclosed Without Your Consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing. Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS AND RESPONSIBILITIES
You have the following rights under state and federal law:

Photography. All photographs taken as part of medical examination, history of growth, or intake will be limited to this office in the context of the patient's medical record. In the event that treatment or evaluation requires these photographs you will be notified before their release. Should the doctor wish to utilize them in a medical journal you will be asked for permission and have the right to deny their use.

Copy of Record. You are entitled to inspect the personal health record we have generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this policy or have any complaints you may contact us in writing for further Information. You also may complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.

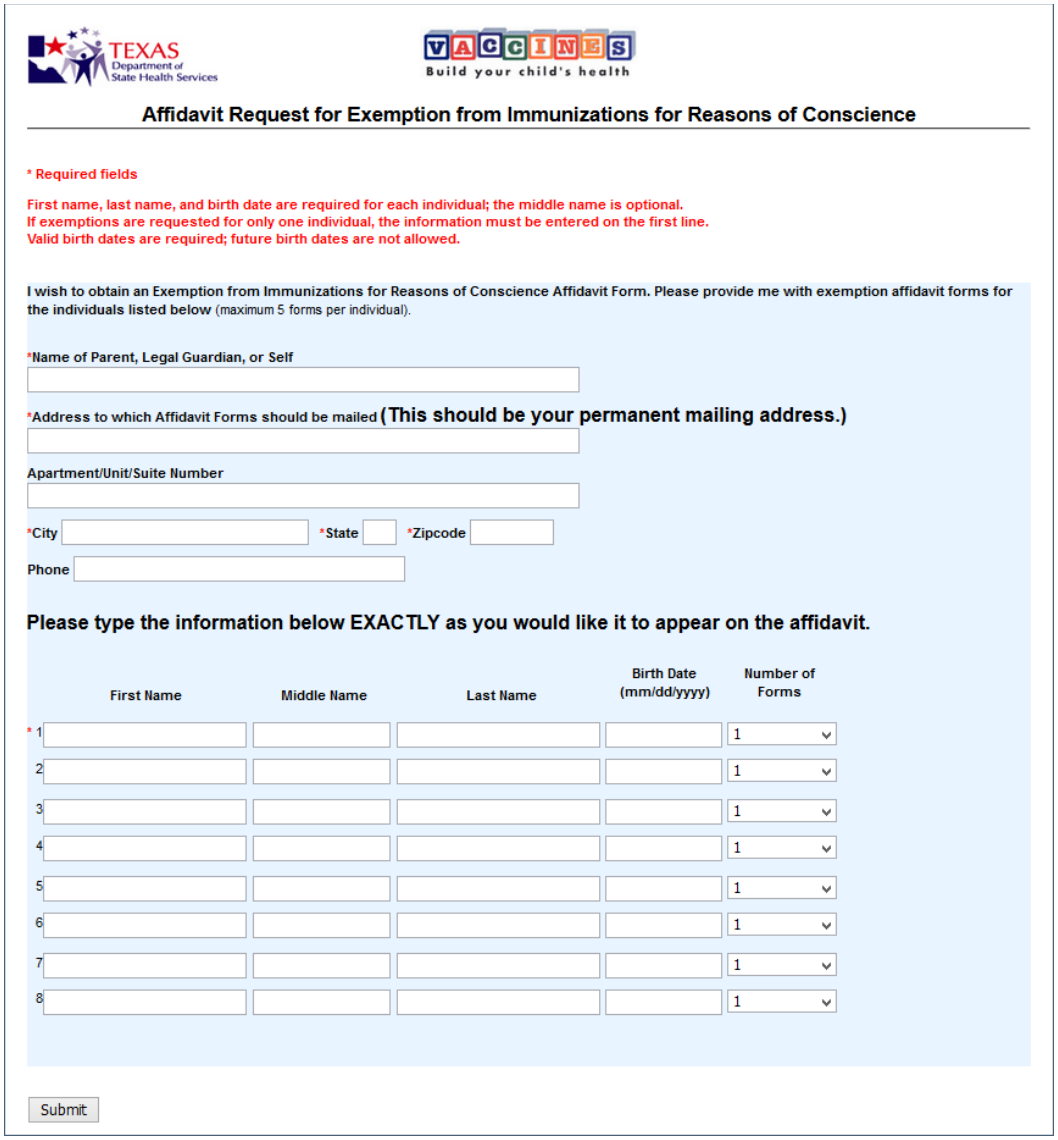
Please sign to indicate your acknowledgment of our privacy policies:_____

Vaccine Exemption Guide

Plum Blossom Pediatrics requires that your child have this form if you are participating in any alternative or no-vaccination schedule.

You are **REQUIRED** to have this document completed and delivered to our office by your child's 2nd visit.

Visit the Texas Department of State Health Services (DSHS) and request an affidavit from this website.
https://corequest.dshs.texas.gov/



TEXAS Department of State Health Services

VACCINES Build your child's health

Affidavit Request for Exemption from Immunizations for Reasons of Conscience

* Required fields

First name, last name, and birth date are required for each individual; the middle name is optional.
If exemptions are requested for only one individual, the information must be entered on the first line.
Valid birth dates are required; future birth dates are not allowed.

I wish to obtain an Exemption from Immunizations for Reasons of Conscience Affidavit Form. Please provide me with exemption affidavit forms for the individuals listed below (maximum 5 forms per individual).

*Name of Parent, Legal Guardian, or Self

*Address to which Affidavit Forms should be mailed (This should be your permanent mailing address.)

Apartment/Unit/Suite Number

*City *State *Zipcode

Phone

Please type the information below EXACTLY as you would like it to appear on the affidavit.

	First Name	Middle Name	Last Name	Birth Date (mm/dd/yyyy)	Number of Forms
* 1					1
2					1
3					1
4					1
5					1
6					1
7					1
8					1

Submit

Fill out the affidavit request accurately and wait for it to arrive by mail.
Fill out the forms sent to you and get it notarized by a notary.