WELCOME

Today's Date:_____

Patient:
First Name_____Last Name_____D.O.B._____ M or F

Address_____City_____State_____Zip_____

Allergies:_____Medications_____

Past Medical History
(hospitalization/surgery):_____
Additional Information:_____

NO PO BOXES please for address. Must have a street address.

Parent 1-Primary Contact
First Name_____Last Name_____D.O.B._____

Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Relationship_____

Email Address_____

SSN_____ (for Insurance Verification) Employer_____

Parent 2-Secondary Contact

First Name_____Last Name_____D.O.B._____

Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Relationship_____

Email Address_____

SSN_____ (for Insurance Verification) Employer_____

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:

Providers 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, diagnosis, 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.

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 Name (Signature) _____

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, while providing clearly defined responsibilities. **Please read each section carefully,** and direct any questions to our staff. Please sign at the bottom of each form, acknowledging the receipt and understanding of the updated office policies.

Appointments:

-Call the office directly to schedule an appointment.
-Fees for appointments are collected upon check-in.
-We value your time and set aside special time to treat your child. **Missed appointments** or cancellations with less than 24 hours notice will be **charged $65**.
-Late arrivals that are more than 10 min past your scheduled appointment time may need to be rescheduled.
-Emergency illness visits take priority over scheduled visits. We will try to minimize any wait time to you and your child
-New Patients must confirm their appointment 48 hrs in advance or they will be removed from the schedule.
-No food, drinks, crayons, markers or play dough in exam rooms.
-Due to our office layout, you must take all of your party into the exam room for safety and exposure. No lingering in the waiting area.
-Child must be seen in clinic for issues before PT/OT/ST/ADHD or Developmental Delay forms can be completed.
-Visits are by appointment only. If you walk-in for an unscheduled appointment and we are **not busy**, we will do our best to work you in. Please be aware that walk-ins are treated like urgent care visits and a higher level of care is charged to insurance for urgent services.
-Dr. Fowler does not second guess other physicians treatments or intentions. If you see another PCP for any issue, then you are no longer under our care and will be discharged from the practice. If you want a second opinion on lab work done by another primary care provider, naturopath, or online laboratory, then the visit will be considered an Integrative Consult, not subject to insurance billing. Dr. Fowler reserves the right to run labs only for specific conditions as required by insurance and standard of care.

Phone Calls/ After Hours calls:

-Phone calls to the clinic for non-urgent issues during 9am-4pm Mon-Thurs are answered by clinic staff and are free of charge. However, if **after more than 2 calls in one week**,we have not been able to resolve your concerns, you will be asked to come into the clinic for an exam or **you will be charged $65 for medical advice** per call thereafter.
-Calls placed after office hours and on the weekends/holidays will be assessed $65 for medical advice. This is not covered by insurance.
-If you call the clinic, and we are not available to answer your call, please leave one message. Multiple calls tie up our lines and prevent us from calling you back right away. Multiple calls also create noise stress and further delay our responsiveness. Depending on staffing, and number of patients in the clinic, we may need to return your call at the end of the day.

Staff Interaction:

-We strive to provide you with the best service possible. **We love our patients and want the best for them.** If there is a concern that can't be handled by the staff, then please ask to speak to Dr. Fowler. We do not tolerate rude or disrespectful behavior by parents, patients, or staff. Harrassment and threats to staff or Dr. Fowler via phone, email, internet, and facebook will not be tolerated and may be prosecuted to the full extent of the law. Dr. Fowler reserves the right to discharge parents and patients from the practice at will.
-If staff recommends you take your child to an Urgent Care or Emergency department for your child's health and you do not go, this is considered noncompliance or against medical advice and you can be discharged from the practice.
-There may be times that misunderstandings occur. We will attempt to resolve them. If they cannot be resolved, alternative Integrative Pediatricians located in the metroplex will be recommended.
-We practice collaborative care. That means we prefer parent input for the best care of their child. Recommendations for both conventional and integrative alternative care will be given and parents can choose the best treatment for their child based on cultural, family norms and standard of care.

Parent Signature:_____Date_____

Prescriptions:

-Monthly medication refills require 3 business days notice.
-You authorize Dr. Fowler to obtain your child's medication history electronically as part of the medical record.

Forms:

-Forms require time, attention, documentation and review. Signatures from the doctor act as legal documentation. While we prefer to devote our time to patient care, time for forms will be charged a fee. .
-Fees for forms are **not charged to insurance**. You are responsible to **pay the fee before the form is signed** and completed. Forms are completed in 3 business days.
-Daycare, Physician health statement, Vaccine record, and Sports physicals **are free if done on the day of the exam**. If you need the form filled out after the appointment, it takes 3 days for completion and fee must be paid prior to pickup.
-Vaccine or shot records are $5.
-Allergen forms, Daycare, Health Statement, Simple Camp forms, School OT/PT/ST Therapy forms are $10 (1 page).
-FMLA, Sports Physicals, Camp Physicals, Government forms, Specialty forms, and Forms longer than 1 page are $35.
-Medical records, Tax forms, Summary documents, Insurance Claim Statements are $25.
-Before school forms, daycare, or health statements are completed, you must have an up to date vaccine record or a vaccine exemption form on file. Daycare, Physician **health statement forms will not be filled out for sick visits** because by definition you must **be well** to attend school or daycare.
-Medical records are provided to other medical professionals for free with appropriate signed medical release only. We can only release records of care given in our office. We cannot release the records of other doctors or offices.
-Parents are responsible for completing all personal information on forms before Dr. Fowler can sign.

Financial Responsibility:

-Co-pays, deductibles and past due balances, will be collected upon check-in.
-For Self Pay visits, a summary of billing codes will be printed out for you to submit for reimbursement purposes. Please collect this at the end of your visit.
-Any account balance outstanding longer than 30 days will be charged a late fee of $50. Balances longer than 30 days will be sent to collections.
-Prior balances must be paid BEFORE scheduled visits.
-We currently accept PPO plans through Aetna, BCBS, and United Healthcare.
-We accept cash, checks, Visa, MC, Discover, Amex. A $75 fee will be charged for any returned check. All sales are final.
-There will be separate charges added to the account for after hours medical advice, telemedicine via email, any school forms, and any record requests.
-You are always responsible for payment on your account. Insurance is an extension of credit on your behalf for payment. Insurance is not a guarantee of payment. If insurance does not pay, is terminated, or incorrect information was given to us for filing, you are responsible to pay your full balance within 30 days of statement date or you will be sent to collections. IF insurance requests a refund because coverage was terminated prior to the visit, you will be charged a $100 service fee in addition to the cost of the visit. Please note, insurance companies can request this refund for up to two years after a visit.
-Insurance will only be filed 1x for any visit. For claims that need re-submission, you must pay in full and re-file the claim on your own to receive payment. We are not responsible for lack of coverage at the time of service. If necessity requires that we re-file the claim for incorrect numbers given, or new coverage, then there will be a $10 refiling fee not chargeable to insurance.
-If any one child in your family has an account balance overdue, then none of your children can be seen or treated until that balance is paid in full. If any one child is sent to collections, then the whole family will be discharged from the practice.

Parent Signature_____Date_____

Referrals:

-All referrals will need an appointment regarding the issue before the referral can be made. Most specialists require documentation of the issue by the PCP before they will see the patient..
-Please allow 5 days for all non-emergent referrals, studies, tests, and prior authorizations. Please call the office if you have not heard from us at that time.
-It is your responsibility to know if a selected specialist participates in your insurance plan.
-For emergency care, do not wait for authorization. Go to the ER and ask them to send us a copy of the visit for our records and follow up.

Photography:

-All photography for assessment or treatment will be limited to the patient's chart.
-Parent or family may not photograph or audio/video record exams without express written permission from Dr. Fowler.

Insurance Plans:

Because we contract **with insurance**, if you use insurance as a payment, **we must follow certain rules**. These rules include timely filing, mandatory visits for referrals, annual well checks, release of visit information to insurance compliance officers, monitoring of prescriptions by insurance, monitoring of vaccine administration by insurance, recording of diagnosis by insurance, and oversight in general. All our policies reflect these restrictions and help us to maintain compliance. Your privacy is very important to us, but insurance has a right to review a visit because they are paying for the visit. If you have medicaid or medicare, we cannot see you. You must go to a medicaid provider per their contract rules. By signing below you confirm that you do not have medicaid or medicare insurance.

-You must bring your insurance card to every appointment for validation. If you do not have your insurance card for first visits, you must pay cash for the visit. If your insurance cannot be validated online during the visit, you must pay cash for the visit.
-It is your responsibility to understand your benefit plan coverage, exclusions, and deductibles.
-You are responsible for non-payment of services by your insurance company.
-As a courtesy, we file insurance for services on your behalf. **Insurance is not a guarantee of payment.**
-The balance for services will accrue **a monthly service charge if** insurance has not paid in a timely manner, if insurance denies payment, and if insurance is terminated. Any amount charged to insurance will be your responsibility to be paid in full within 30 days.
-Documentation for self pay patients will be provided at the end of the visit. If you require documentation after the visit, at the end of the year, or near tax time, there will be a $25 forms fee.
-After insurance has paid, denied, or is terminated and your account has **not been paid in full within 30 days, you will be sent to collections.**
-Insurance will only be filed with the primary insurance company one time for your child. You must give us the correct information regarding coverage or the claim will be denied. You will then be responsible for the full amount of the claim.
-We will not file with secondary payors. You are responsible for filing any secondary claims on your own.
-All claims are filed within 24 hours of the office visit. If your insurance is not active and the claim is denied, your account will be charged the full cost of the claim sent to insurance and there will be a $100 service fee added. Please make sure your insurance is accurate at the time of the visit.
- Once insurance has rejected a claim, a new statement will be issued and the amount must be paid in full immediately.
-Parents of new babies must add child before the first visit and bring evidence of insurance coverage before claims will be filed. Please note that some insurance companies require a birth certificate before coverage begins. We do not retroactive file claims.
-Insurance may request refunds up to two years after a visit if insurance is not active at time of visit. Then a $100 service fee will be added to the account in addition to the full balance of the claim and this will be due immediately.
-We do not accept COBRA plans. We do not accept Cigna, Freedom Life, Tricare, Meritain Health or Golden Rule insurance.
-If Insurance denies, rejects or requests a refund at any time from 0-5 years after the claim was submitted, you will be responsible for the full amount of the claim. This will include a $25 claims fee.

Parent Signature_____Date_____

Vaccines:

-We are a vaccine friendly practice and we support those parents who do and don't choose to vaccinate.

-**We require that any child entering our practice with delayed or alternative vaccine schedules have a current and notarized Vaccine Exemption on file by the second visit**. Otherwise your child will not be seen in clinic and your family may be discharged from the practice.

-There are times when vaccines are unavailable due to shipping or manufacturer shortage. During these times, you may go to the health department or some pharmacies as needed.

-Not all vaccines are mandatory per Texas requirements for public school or daycare. We will provide you with the recommended schedule at each visit along with appropriate vaccine information sheets.

-It is your responsibility to request specific vaccines outside that schedule due to exposure, preference, or medical need.

-It is your responsibility to notify Dr. Fowler immediately regarding any and all vaccine reactions.

-We cannot give medical exemptions based on history of reaction that we did not witness.

-Medical exemptions are given only for documented evidence in the child of an immunocompromised condition or concurrent medication that puts the child at risk of exposure. They cannot be given for family history of various conditions. Ask doctor for more information regarding medical exemptions.

-At times, the AAP and ACIP may recommend NOT to do certain vaccines (for example: Flu Mist) based on evidence for lack of efficacy. We follow those guidelines as directed annually.

-We give single dose vaccines which may increase your overall number of shots. If you prefer combination vaccines to decrease the total number of shots, then you will need to go to the health department, pharmacy or other doctor's office for access to those vaccines.

- All vaccines given in our office will be uploaded automatically into the Texas Vaccine Database for school administration.

Parent Signature_____Date_____

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:_____

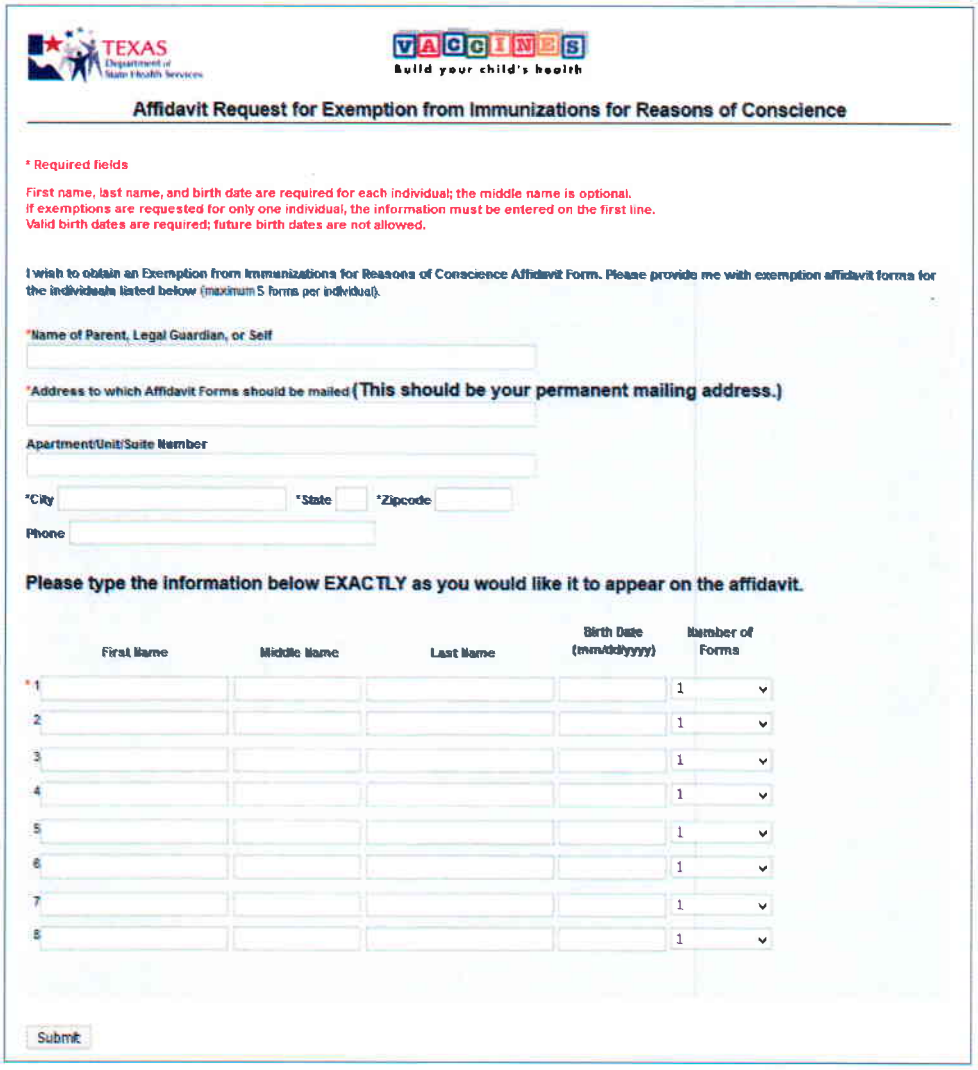
Vaccine Exemption Guide

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.

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	**Varicella vaccine** protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	**DTaP*** vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	**Hib** vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	**HepA** vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	**HepB** vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	**Flu vaccine** protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	**MMR**** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	**MMR****vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	**DTaP*** vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	**IPV** vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	**PCV** vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	**RV** vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	**MMR**** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	**DTaP*** vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated December 2016 • CS272886-E