Kids First PEDIATRICS

FAMILY REGISTRATION FORM

Today's Date:	Previous PCP:

FAMILY/CONTACT INFORMATION

Parent #1:	DOB: / /	Mobile #	
Address	City	State	Zip
Email		Alt Phone #	
Parent #2: ❑ same	DOB: / /	Mobile #	
Address	City	State	Zip
Email		Alt Phone #	

Patients resides primarily with: ❑Both Parents ❑ Mother ❑Father ❑ Other_____

Parents are: ❑ Married ❑ Divorced ❑ Other_____

If Divorced, who is the Custodial Parent: ❑1 ❑2 ❑Joint

May all contacts have access to the patients' records: ❑ Yes ❑ No

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the listed patients or from obtaining information about medical treatment? ❑Yes ❑ No If Yes, explain and provide a copy of supporting legal paperwork.

The best way to reach me is: ❑ Mobile # ❑ Alt Phone # ❑ Email

PATIENT INFORMATION

Child	DOB: / /	Sex ❑ M ❑ F
Nickname	Race	Ethnicity ❑ Hispanic ❑ Non-Hispanic
Child	DOB / /	Sex ❑ M ❑ F
Nickname	Race	Ethnicity ❑ Hispanic ❑ Non-Hispanic
Child	DOB / /	Sex ❑ M ❑ F
Nickname	Race	Ethnicity ❑ Hispanic ❑ Non-Hispanic
Child	DOB / /	Sex ❑ M ❑ F
Nickname	Race	Ethnicity ❑ Hispanic ❑ Non-Hispanic

EMERGENCY CONTACT

Name:	Mobile #:
Relationship to Patient:	Contact may accompany the patient in absence of parent: ❑ Yes ❑ No

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FAMILY REGISTRATION FORM

INSURANCE INFORMATION		
Today's Date:	❑ Patient is not covered by insurance (Self-Pay)	
Name of Primary Insurance Company:		Co-Pay:
Group#:	Policy #:	Effective Date: / /
Subscriber's Name:	DOB: / /	Sex ❑ M ❑ F
Address:	Mobile#:	
Employer:	Employer Phone #:	
Employer Address:		
Patient's relationship to subscriber: ❑ Child ❑ Self ❑ Other		
Name of Secondary Insurance (if applicable):		Co-Pay:
Group #:	Policy #:	Effective Date: / /
Subscriber's Name:	DOB: / /	Sex ❑ M ❑ F
Patient's relationship to subscriber: ❑ Child ❑ Self ❑ Other		

PHARMACY INFORMATION	
Pharmacy Name:	Pharmacy Phone #:

HOW DID YOU FIND US?

❑ Internet/Social Media ❑ Insurance Plan ❑ Referred by:_____ ❑ Other:_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I can access Kids First Pediatrics' "Notice of Privacy Practices" at any time either at the front desk or on the website at www.kidsfirstpediatricstx.com.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize Tieh Medical Group, PLLC to treat my child/children. I authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. I hereby authorize release of information necessary to file a claim with my insurance company and assign payment of all medical benefits to Tieh Medical Group, PLLC. In addition to the foregoing, I authorize the release of my child/dependent's medical information by or between any of my treating physicians and my insurer, HMO, PPO, health benefits payer, or any other entity (including but not limited to third party administrators, management companies and provider networks) included in the administration of my child/dependent's health benefits. I understand that I am responsible for informing Tieh Medical Group, P LLC of any and all changes to my insurance.

_____ _____

Patient/Guardian Signature Date

_____ _____

Name Relation to Patient

Kids First PEDIATRICS

PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Name:	DOB: / /	Sex ❑ M ❑ F
Form Completed by:	Date Completed:	

BIRTH HISTORY

Were there any medical problems during the pregnancy? ☐ No ☐ Yes Explain:_____

During the pregnancy, did the mother ☐ Smoke ☐ Drink ☐ Use drugs ☐ Use medications?

Hospital of Birth: _____

Birth Weight: _____

Was the baby born ☐ Term ☐ Early ☐ Late at _____weeks

The delivery was ☐ Vaginal ☐ C-Section

Were there any problems after birth? _____

Any other important information regarding the birth? _____

GENERAL MEDICAL HISTORY

Do you consider the patient to be in good health? ☐ Yes ☐ No, Explain:_____

Does the patient have any serious medical conditions? ☐ Yes ☐ No, Explain:_____

Has the patient had any serious injuries or accidents? ☐ Yes ☐ No, Explain:_____

Has the patient ever had surgery? ☐ Yes ☐ No, Explain:_____

Has the patient ever been admitted to the hospital? ☐ Yes ☐ No, Explain:_____

Is the patient allergic to any medications? ☐ Yes ☐ No, Explain:_____

DEVELOPMENTAL HISTORY

Are you concerned about the patient's physical development? ☐ No ☐ Yes

_____

Are you concerned about the patient's mental or emotional development? ☐ No ☐ Yes

_____

Are you concerned about the patient's attention span? ☐ No ☐ Yes

_____

Are there any concerns related to school (behavior, academics)? ☐ No ☐ Yes

_____

FAMILY HISTORY

Is there any significant family history? Please explain (relation, medical problem)

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____

DOB_____

I, _____hereby authorize the release of medical information

TO:

Kids First Pediatrics
7025 N Fry Road, Suite 200
Cypress, TX 77433
832.975.7288 (office) 832.975.7287 (fax)

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

_____

Telephone: _____

Fax: _____

Please release the following:

- ☐ All health information (including growth charts and vaccination records)
- ☐ History/Physical
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Other (specify):_____
- ☐ Diagnostic Test Reports
- ☐ Radiology/Images
- ☐ Lab Results
- ☐ Pathology Reports

I consent to the release of information related to infection or communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

- ☐ Yes, I consent to the release of this information
- ☐ No, I do not consent to the release of this information

Purpose of Disclosure:

- ☐ Treatment/Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise this authorization shall remain valid until such that it is revoked in writing.

Signature:_____Date_____

Print Name:_____

Relationship to Patient:_____

KIDS FIRST PEDIATRICS FINANCIAL POLICY AGREEMENT

Insurance

Kids First Pediatrics participates with most insurance plans. Each insurance policy is different, and it is therefore impossible for us to know what your particular benefits may be. Therefore, it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Newborn Coverage

Not all insurance policies offer automatic coverage for new babies. You typically have 30 days from birth to add your child to an insurance plan. Please bring the insurance card of the parent to the first office visit, and then present the child's card to the office once available.

Sick at Well Visits

We are required to document any ADDITIONAL concerns or conditions that arise at well visits. The codes used may have charges and therefore may require a CO-PAY at your child's well visit as well as other fees that may not be covered by your insurance or that are applied to your deductible. Examples of this include fever, ear infection, strep throat, or other illnesses that require attention.

Credit Card on File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Once processing the visit with your insurance, you may owe part of the patient responsibility fee, as spelled out in your Explanation Of Benefits (EOB). If we do not receive payment for the amount listed on your statement within 14 days, we will run the credit card on file for the full amount owed. Once your card is charged, a receipt will be sent to you by email.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill. We will provide a cash price list at the time of service.

Administrative Fee

At Kids First Pediatrics, coordination of care is central to making sure that children get good quality healthcare. This means several hours are spent providing services that insurance does not pay for. Some of these services include processing various administrative requests, handling refill requests outside of office visits, providing after hours calls to parents, performing phone consultation with other pediatric specialists, and filling out any forms needed for school or camp without charging a fee for each form.

In addition, we offer a patient portal where you are able to access medical records, print immunization records, request forms, and send messages to office staff. We offer electronic prescriptions for all medications, including ADHD medication.

To cover these services, we charge a small annual fee of $25 per family.

No-Show Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of at least 1 business day for all cancellations. Failure to notify the clinic in a timely manner will result in a no-show fee. Repeated no-shows will result in the family being advised to transfer care out of the practice.

Insufficient Funds, Past Due Accounts, and Collection Process

A $50 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. Overdue bills are assessed a $25 fee.

I understand that if my account is over 120 days past due, the process of being sent to collection will be initiated. Should the account be referred to a collection agency, I will pay all reasonable fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate. I will be able to receive emergency care for my children for 30 days but will not be able to schedule appointments until my account is settled.

Divorced/Separated Parents and Custodial Arrangements

Kids First Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child’s other parent. We will be happy to provide receipts for paid medical bills for you as requested.

I have read and understood the above policy and agree to it.

Signature _____

Date _____/_____/_____

Name _____

Relationship to patient _____

HIPAA Release of Information

MEDIA RELEASE AUTHORIZATION FORM

I, _____,

Authorize (Kids First Pediatrics), its duly authorized employees or agents, to publish the following personal health information/story/photograph/other identifying information that may be used in print media, on our website, blog and/or on the social media platforms such as Facebook or Instagram. (Please check one)

☐ I agree

☐ I do **not** agree.

The following information about me will **not** be disclosed:

_____

This authorization is valid from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to this practice. However, this authorization may not be revoked if (Kds First Pediatrics), its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Signature of Patient/Guardian: _____

Date: _____

WAIVER FOR NON-COVERED CHARGES

Developmental Screening Policy
At Kids First Pediatrics, we follow the guidelines of the American Academy of Pediatrics in performing specific periodic screening tests during the preventive health well child visits. These screens are intended to identify and address health problems at an early stage.

Insurance company rules and policies change all the time and may not fully cover these important screens or may assign full or partial patient responsibility as either a co-payment, co-insurance, or toward your deductible. As prompt and appropriate treatment of your child is a primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests, and non-covered services as we deem necessary for comprehensive, quality care. Please sign to acknowledge that you will be billed for any balance due after the insurance processes the claim.

Below is the current schedule for these screens so that you can check your insurance benefits.

Screens/Test	CPT Code	Age Administered (may vary as needed)
Vision Screen via Computerized Photoscreen	99174	Annually starting at age 6 months
Lead Screen	83655	1 year
Hearing Screen	92552	Annually for 4-5 years
Autism Screen	96110	18 mos, 24 mos.
Behavioral Screen (e.g. depression)	96127	Annual starting at 12 years old
Hemoglobin Screen	85660	9 mos
Cholesterol Screen	85660	Age 9-11 years (once) and 17-21 years (once), age 4 years (if predisposing condition)

If you wish to opt out of hearing or vision screens, please let us know at the start of your visit. Declining screening may lead to delays in diagnosis.

In-office Lab Testing
Kids First Pediatrics offers rapid in-house testing for flu, strep, urinalysis, etc., which is convenient and rapid testing that can aid in quicker diagnosis and treatment of your child's ailment. Such testing is generally covered by insurance companies; however, some insurers do not pay for in-office testing because of contracts with external labs that provide these services. Sending certain tests to outside labs results in longer waiting days for results that we can provide quicker with in-house testing.

Waiver Signature:
Please sign the following waiver acknowledging that you are aware of these charges in the event that your insurance company does not cover the above services. By signing the waiver, you acknowledge that it is your responsibility to pay the balance in full for non-covered services by your insurance company.

Patients name(s): *please list all in family

_____

Guarantor/Responsible Party's Name: _____

Guarantor/Responsible Party's Signature:_____Date_____

TELEHEALTH POLICY ACKNOWLEDGMENT FORM

Patient's Name: _____

Date of Birth: _____

- I understand that my provider at Kids First Pediatrics recommends I engage in a telehealth appointment that may be conducted using videoconferencing, video images, still (high quality photo) images, or telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

- I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or myself can discontinue the telehealth appointment at any time if connections are not adequate for the situation.

- I understand that my healthcare provider may share information with other individuals for scheduling and billing purposes. I also understand that all information provided is confidential.

- I understand that chronic conditions and management can often be done over telehealth (ex. ADHD medication checks, asthma medication checks). Other consults related to mental health, development, simple rashes, and behavior can also be done via telemedicine.

- I understand that some parts of the exam including physical tests (ex. flu, strep, urinalysis) require in person physical exams. I understand that *antibiotics typically will NOT be prescribed via telehealth visits.* I also understand that *well checks cannot be done via telehealth.*

- In an emergency situation, I understand that it is my responsibility to take the advice of the healthcare provider to obtain further evaluation either in the clinic or at the emergency department upon the termination of the telehealth conversation.

- I understand that many insurance companies are now covering provider telephone advice calls and telemedicine visits. However, I also understand that it is my responsibility to contact the insurance company prior to telehealth conversations regarding billing and coverage for virtual visits.

- I understand that billing for telehealth consultations are still placed in a schedule for your provider during specific office hours. Telehealth visists will be billed to your insurance and copays will be collected when appropriate.

By signing this document, I acknowledge that I have read all terms and conditions, especially the risks and benefits of the telehealth appointment. I also acknowledge that I have had my question regarding payment, procedures and treatment explained and I hereby consent to the participation in a telehealth consultation appointment under the terms described.

_____

Signature of Legal Guardian or Patient (>18 years of age)

Date and time: _____

CREDIT CARD POLICY

In order to make sure that we can collect your portion of the bill ounce your insurance company processes claims, we require that a valid credit card or debit card be kept on file with the practice·

Your credit card information is kept confidential and secure. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation of Benefits (EOB). If we do not receive payment for the amount listed on your statement within 14 days, we will run the credit card on file with the full amount owed. Once your card is charged, a receipt will be sent to you by email.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

I understand, authorize and request Kids First Pediatrics to charge my credit card, as provided, for balances due for services rendered by my insurance company for services provided to me by Kids First Pediatrics.

This authorization will remain in effect until I cancel this authorization. To cancel this authorization, I must give a 60 day notification to Kids First Pediatrics in writing and the account my be in good standing.

Patient's Name (Print)_____

Cardholder's Name_____

Cardholder's Signature_____

Date_____

ADMINISTRATIVE FEE POLICY

At Kids First Pediatrics, coordination of care is central to making sure that children get good quality healthcare. This means many services are provided to our patients that insurance does not pay for. At Kids First Pediatrics, we offer a patient portal where you are able to access medical records, print immunization records, request forms, and send messages to office staff.

We also offer services including processing various administrative requests, handling refill requests outside of office visits, providing after hours calls to parents, performing phone consultation with other pediatric specialists, and filling out any forms needed for school or camp without charging a fee for each form. To cover these services, we charge a small annual administrative fee of $25 per family. This administrative fee will be charged to the credit card on file annually on September 30.

Print Name_____

Signature_____

Date_____