# PATIENT DEMOGRAPHIC FORM

**Patient/Child Information**

Child Name:_____________________________________ □ Male □ Female □ Other Date of Birth: ________________

Child Name:_____________________________________ □ Male □ Female □ Other Date of Birth: ________________

Child Name:_____________________________________ □ Male □ Female □ Other Date of Birth: ________________

Child Name: _____________________________________ □ Male □ Female □ Other Date of Birth: ________________

**Parent 1: _______________________________________ Date of Birth: _____________________________________________**

Home Address: ___________________________________ City, State, Zip: ____________________________________________

Contact Phone Number: ___________________________ Alt. Phone Number: _______________________________________

Email Address: __________________________________________________________________________________________

**Parent 2: _______________________________________ Date of Birth: _____________________________________________**

Home Address: ___________________________________ City, State, Zip: ____________________________________________

Contact Phone Number: ___________________________ Alt. Phone Number: _______________________________________

Email Address: __________________________________________________________________________________________

**Primary Insurance Information**

Primary Insurance: ______________________________

Member ID: _______________ Group #: _____________

Subscriber Name: ________________________________

Relation to Patient: ______________________________

Subscriber DOB: _________________________________

**Secondary Insurance Information**

Secondary Insurance: ______________________________

Member ID: ____________ Group # __________________

Subscriber Name: _________________________________

Relation to Patient: ________________________________

Subscriber DOB: ___________________________________

**Pharmacy Information**

Name: _____________________________________________

Phone Number: ______________________________________

Address: ___________________________________________

Fax Number: ________________________________________

**Emergency Contact**

Name: ___________________________________________

Relationship:______________________________________

Contact Phone Number: ____________________________

Alt. Phone Number: ________________________________

____________________________________________ ________________________________________________

**Parent/Guardian Signature** **Date**

## Child Health History Form

**Child's Name: ________________________________________ DOB: _____________________________________**

**1. Has your child had any medical issues and/or hospitalizations (asthma, diabetes, etc.)? N/A**

**2. Has your child had any surgery (tubes, tonsils, appendicitis, etc.)? N/A**

**3. Is your child currently taking any prescribed medications? N/A**

**4. Is your child allergic to any medications? N/A**

**5. List any family medical history conditions N/A**

| ***Family Member*** | ***Medical Problem(s)*** |
|---|---|
| **Father** | |
| **Mother** | |
| **Brothers** | |
| **Sisters** | |

## Patient Responsibility/Financial Agreement

- ➔ Full payment is expected at the time of services as well as any past due balances.
- ➔ Payment is due regardless of who brings the child in for the service.
  - Grandparents, aunts, caregivers, etc.
- ➔ For families in which parents are separated and/or divorced, the parent bringing the child to the appointment is authorizing treatment and is therefore, the parent responsible for payment on the date of service. If there is a divorce decree requiring the other parent to pay a portion or all the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request to assist in the collection of fees from the other parent.
- ➔ Insurance must be presented and active in order to utilize your benefits. If Insurance cannot be determined as active, the patient will be considered self-pay.
- ➔ Self-Pay patients
  - Visits are provided at a discounted rate
  - Payment is collected at time of service
- ➔ Your insurance determines if you have a co-pay, deductible and/or co- insurance.
- ➔ Insurance co-payments are due at each visit. Please note that we are required by the insurance company to collect payment. If your insurance plan has a deductible that has not been met, you are required to pay for services provided. **VERIFICATION OF INSURANCE IS NOT A GUARANTEE OF PAYMENT!** You are responsible for all services provided to your child/children.
- ➔ Acceptable payments include **CASH, CHECK, AMEX/DISCOVER/MASTER/VISA card**

****NO SHOW AND CANCELLATION FEES WILL BE ASSESSED WITHOUT 24 HOUR NOTICE PRIOR TO APPOINTMENT TIME.**

**$50.00 FEE APPLIES FOR WELL/ADHD/MED-CHECK/TELEHEALTH APPOINTMENT**
**$30.00 FEE APPLIES FOR SICK/NURSE/FLU APPOINTMENT**

________________________________ ________________________

**Patient Name (Please Print)** **Relationship to Patient**

________________________________ ________________________

**Signature of Patient or Representative** **Printed Name**

________________________________

**Today's Date**

# Consent to Treat and Prescription Policy

I hereby give permission for the following people to obtain medical care for my child, and to have access to my child's medical records (this could be adult relatives/babysitters/nanny etc.):

| ______________________________ | ______________________ |
|---|---|
| (Name) | (Relationship) |
| ______________________________ | ______________________ |
| (Name) | (Relationship) |
| ______________________________ | ______________________ |
| (Name) | (Relationship) |
| ______________________________ | ______________________ |
| (Name) | (Relationship) |

***Nxt Step Pediatrics is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our prescription request policy. In order to fill prescriptions in a timely manner, we need your assistance with the following:***

1. Typically, a child must be seen before a medication can be prescribed for the first time Exceptions are at the physician's discretion only.

2. Please allow 7 DAYS for a prescription to be filled after it is requested. With this in mind, please allow adequate time for the provider to complete your request BEFORE your child's prescription runs out.

***IMPORTANT****: If your child is prescribed a medication and appears to be having a reaction to it, please call our office immediately. It is imperative that our providers are aware of any reactions that need to be documented and followed up on.*

| ______________________________ | ______________________ |
|---|---|
| Parent/Guardian Signature | 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. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

**Treatment:** We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

**We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.**

The Following is a statement of your rights with respect to your protected health information. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us**, upon request, even if you have agreed to accept this Notice alternatively (i.e., electronically).

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

**Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/or before December 1, 2021

**NxTStep Pediatrics, PLLC**
**11330 Legacy Drive, Ste 202**
**Frisco, TX 75033**

# Acknowledgement of Notice of Privacy Practices and Disclosure of Protected Health Information

By signing the acknowledgement to the Notice of Privacy Practices and Disclosure of Protected Health Information, I further authorize NxTStep Pediatrics to allow the following:

| | |
|---|---|
| To leave a message on my answering machine or on my voicemail | □ Yes □ No |
| To send me information via text message. | □ Yes □ No |
| To send me information via e-mail. | □ Yes □ No |
| To discuss my Child's condition with the person(s) listed below. | □ Yes □ No |

***I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Nxt Step Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent. By signing below, I certify that I have read and understand the HIPAA Notice of Privacy Practices, which explains how my child's medical information will be used and disclosed.***

| ______________________________ | ______________________________ |
|---|---|
| **Patient Name (Please Print)** | **Relationship to Patient** |
| ______________________________ | ______________________________ |
| **Signature of Patient or Representative** | **Printed Name** |

______________________________

**Date**

## WELLNESS CARE ACCORDING TO THE AFFORDABLE CARE ACT

At Nxt Step Pediatrics, we want to inform you about how we expect your insurance company to cover your wellness appointment. A ***well child exam*** is defined as an annual, routine physical exam and immunizations (if performed) to patients at no additional copay, deductible, or coinsurance. These services are exceedingly limited and apply only to:

1. Evaluation of growth/milestones
2. Immunizations
3. Developmental screening
4. Dietary & lifestyle counseling

Depending on your age, gender, family history and other circumstances, we may suggest more extensive diagnostic or preventative testing, and we want you to be mindful that some of these services may not be covered or paid fully, by your insurance provider. We find that many patients who come in for their wellness care visit also have additional medical conditions that they would like to address at the same time.

Some of these conditions are:

I. Fever
2. Stomach pain
3. Headache
4. Asthma
5. Sore throat/Reflux
6. Ear pain
7. Cough/congestion
8. Digestive issues
9. Allergies
10. Behavioral
11. Skin conditions
12.Specialist referrals

**Assessing and treating new or existing medical concerns during a well child visit falls under "medical management" and is not part of a wellness exam as defined by the Affordable Care Act. We understand, however, that your time is valuable, and we strive, when time permits, to address your medical concerns along with your wellness exam.**

**Please note, you will be billed for two visits on the same day and consequently, any additional concerns addressed (that do not fall within the parameters of a well child check) will require a copay, deductible, or coinsurance payment.**

**PLEASE NOTE:** Since the nature of behavioral evaluations tend to be lengthy, these issues will likely need to be discussed at an additional appointment. Your provider may require you to schedule a behavioral specific appointment at check-out and complete additional forms prior to your child's appointment.

Child Name: ___________________________ ▢Male ▢Female ▢ Other Date of Birth: _____________________________

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Child Name: ___________________________ ▢Male ▢Female ▢ Other Date of Birth: _____________________________

Child Name: ___________________________ ▢Male ▢Female ▢ Other Date of Birth: _____________________________

_____________________________________________ _________________________________________________

Parent/Guardian Signature Date