PGV PEDIATRICS, P.A.

3417 GASTON AVENUE, SUITE 845

DALLAS, TX 75246

PHONE: (214)823-2552 FAX: (214)823-2551

REQUIRED

EMAIL: _____

PHARMACY: _____

REFERRED BY: _____

Please complete this page and bring it to your appointment.

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

SEX: _____ DOB: _____ SS# _____

HOME PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

FATHER'S NAME: _____ DOB: _____

HOME PHONE: _____ CELL PHONE: _____

ADDRESS (if different from above): _____

CITY: _____ STATE: _____ ZIP _____

SS#: _____

FATHER'S EMPLOYER: _____ WORK PHONE: _____

MOTHER'S NAME: _____ DOB: _____

HOME PHONE: _____ CELL PHONE: _____

ADDRESS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____

SS# _____

MOTHER'S EMPLOYER: _____ WORK PHONE: _____

LEGAL GUARDIAN: (if different from above): _____

PHONE: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT (other than parent): _____ PHONE: _____

INSURANCE CO: _____ INSURED: _____

ID#: _____ GROUP#: _____

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I authorize PGV Pediatrics, P.A. to disclose/provide information at any of the phone numbers listed below. I understand it is my responsibility to notify PGV Pediatrics, P.A. of any change in these numbers. By signing below, I understand PGV Pediatrics, P.A. is authorized to leave a message if I cannot be reached directly.

I authorize PGV Pediatrics, P.A. to disclose the following protected information to the numbers indicated below: lab results, test results, appointment reminders, procedures and other healthcare services.

List in order of priority, which number we can contact you and/or leave a message.

PREFERRED CONTACT: ( ) MOM HOME WORK CELL (circle which is appropriate)

( ) DAD HOME WORK CELL (circle which is appropriate)

SIGNATURE: _____

DATE: _____

PLEASE BRING YOUR INSURANCE CARD OR A COPY OF INSURANCE INFORMATION TO EACH APPOINTMENT

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DISCLOSURE AGREEMENT

Patient's Name: _____

Reason for Office Visit:
[] New Patient Exam
[] Follow-up Exam

FOR NON-INSURED PATIENTS:
I/my child does not have any form of medical/healthcare insurance including Medicare or any form of Medicaid. _____ (initials)

IF WE ARE CONTRACTED WITH YOUR INSURANCE AND WE ARE FILING WITH YOUR INSURANCE FOR YOUR OFFICE VISITS:

Check appropriate box (es).

[] My insurance plan covers New Patient well exams.
[] My insurance does not cover New Patient well exams.
[] I do not know if my insurance plan covers New Patient well exams.
[] My insurance plan covers Follow-up /sick exams.
[] My insurance does not cover Follow-up /sick exams.
[] I do not know if my insurance plan covers Follow-up /sick exams.

I recognize that I am responsible for providing my insurance information to PGV Pediatrics, P.A. at the time of service. If I do not have this information, I must pay for my visit and will be provided a statement to file with my insurance carrier myself. _____ (initials)

I agree to pay for any and all medical services I receive from the physicians of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason (i.e. non-covered services, terminated coverage, my failure to secure an authorization from my insurance company, I will pay for service upon written/verbal notice of their refusal. Failure by your insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. _____ (initials)

_____ _____
Signature of Patient or Responsible Party Date

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DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY MEMBERS/FRIENDS

Patient Name: _____ **DOB:** _____

In our effort to adhere to HIPAA guidelines, PGV Pediatrics, P.A. needs your authorization to release medical/financial information connected to your child's/your care. Please complete the information below so that we may release any necessary information to your family member(s) or friends (this does not apply to patient or parents).

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Name: _____ Relationship: _____

Contact information: _____

Type of information that PGV Pediatrics, P.A. can provide to them:
O Medical **O** Financial **O** Both

Name: _____ Relationship: _____

Contact information: _____

Type of information that PGV Pediatrics, P.A. can provide to them:
O Medical **O** Financial **O** Both

Please check box below if you **DO NOT** want this information to be released to anyone other than the patient or parents.

O Please **DO NOT** release this information

_____ _____
Signature of Parent/Patient Date

_____ _____
Witness Name Printed Date

_____
Witness Signature

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CREDIT POLICY

All services rendered by this association are charged directly to the patient. As a courtesy we will file your insurance claims at no charge and credit their payment to your account.
Unless we are contracted with your insurance carrier as a participating provider to accept what they approve, your deductible or the percentage not covered by the carrier is due at the time of service. Managed care co-pays are due at the time of service.
If you do not have insurance payment is due in full at the time of service.
Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.

FEE DISCLOSURE ACKNOWLEDGEMENT

We will make available our fee schedule for medical procedures upon request. Most fees are for office and/or hospital procedures. However, fees will also be incurred when you request special services *in addition to* your regular services. **Fees are not covered by your insurance plan.**
The following is a brief, non-comprehensive listing of such services:

1)	Telephone conferences	25.00 first 15 minutes,
2)	Records processed for transfer	25.00 and up
3)	Returned checks (NSF)	50.00
4)	Form completion or Written Correspondence for employer or school	10.00-30.00
5)	Replacement of lost or expired prescriptions	20.00
6)	After Hour Non Urgent Telephone Consultation	50.00
7)	After Hour Prescription Call-in Fee	75.00

BENEFICIARY LIABILITY

The Services listed below may be considered as a Covered Benefit under your Health Insurance, however, we do not bill the insurance company. Should you choose to receive these services; you will be personally responsible for the payment of such services. Payment is due at the time of service.
These Estimated Services may include but are not limited to, and as recommended by your Provider, are listed below:

RAPID STREP	$30	RAPID FLU	$30
LAB COLLECTION FEE	$10 - $20	HEARING	$30
VISION	$30	ALTERNATE VACCINATION	$50

By signing this waiver, I acknowledge that I have been informed in advance of receiving these services. If the above referenced item or service is performed, I agree to be financially responsible for the full amount.

PARENT NAME PATIENT NAME

PARENT SIGNATURE DATE

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SIGNATURE VERIFICATION FORM

For identification purposes, please sign your name below in as many variations of your signature as you may use. This form will be used to verify your signature on future documentation.

_____

Signature

_____

Initials

_____ _____

Printed Name Date

_____

Signature

_____

Initials

_____ _____

Printed Name Date

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Acknowledgement of Receipt of Notice of Privacy Practices and General Consent for Medical Treatment

I hereby give my consent to the physicians of PGV Pediatrics, P.A. to use the medical information of my child for the purposes of treatment, payment, or health care operations. I understand that should my child's physician be absent, this consent is transferable to the physician covering the practice.

Assignment of Benefits: I request that payments of medical benefits be made to PGV Pediatrics, P.A. directly. I authorize release of medical information necessary to provide treatment, payment of claim, or other health care operations. A photo static copy is as valid as the original.

My signature below verifies I have been provided a copy of the "Notice of Privacy Practices" for PGV Pediatrics, P.A. (3310 Live Oak St., Ste. 201, Dallas, TX 75204) and that I have also been provided with a copy of the office policy. I understand fees are payable at the time services are rendered.

_____ _____

Parent Name (please print) Patient Name (please print)

_____ _____

Parent Signature Date