PATIENT REGISTRATION

Patient's Name: _____ _____ M/F: ____
Last First Middle Date of Birth

Address: _____
Street Apt # City State Zip

Other Children: Name: _____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

_____ M/F: ___ DOB: _____

PARENT/GUARDIAN INFORMATION

Parent's Name: _____ Parent's Name: _____

DOB: _____ DOB: _____

Cell Phone: _____ Cell Phone: _____

Social Security #: _____ Social Security #: _____

E-Mail: _____ E-Mail: _____

Person Responsible for Payment: _____

Billing Address: _____
Street Apt # City State Zip

Emergency Contact Other Than Parents: _____

Relationship to Patient: _____ Phone #: _____

Primary Doctor (Check One) Hieber ☐
Fernandez ☐

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____

Policy or Subscriber #: _____ Group #: _____ Copay Amount: _____

I authorize my insurance company to make payments to Clinical Pediatric Associates for my insurance claims. I also appoint Clinical Pediatric Associates to act as my authorized representative when requesting an appeal from my insurance company regarding its denial of service or payment.

Please note that claims cannot be filed without this signature on-file

Signature: _____ **Date:** _____

CONSENT TO TREAT PATIENT WITHOUT PARENT/LEGAL GUARDIAN PRESENT

I request and authorize Clinical Pediatric Associates and its personnel to deliver medical care to my child/children listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. Medical care and interventions may include but are not limited to: medical evaluation, physical exam, routine immunizations, injections, and lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, and suturing of lacerations). I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have read, understand, and give my consent as stipulated above.

Signature: _____ **Date:** _____

Clinical Pediatric Associates
8355 Walnut Hill Ln Ste 205 & 225B
Dallas, TX 75231

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.

Protecting Your Privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Clinical Pediatric Associates privacy is one of our highest priorities.

Keeping Your Information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

Working To Meet Your Needs Through Information

In the course of doing business, we collect and use various types of information, such as name, address and claims information. We use this information to provide services to you, to process your claims and to bring you information that might be of interest to you.

Keeping Information Accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How and Why Information Is Shared

We limit who receives information and what type of information is shared.

- Sharing information within Clinical Pediatrics: We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- Sharing information with companies that work for us: To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- Other: Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission. If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

Clinical Pediatrics does not share any customer information with third-party marketers who offer their products and services to our patients. You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the internet.

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Phone: 214-368-3659

PATIENT CONSENT AND ACKNOWLEDGEMENT OF PRIVACY POLICY

I understand that as part of the provision of healthcare services, Clinical Pediatric Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Clinical Pediatric Associates reserves the right to change their notice and practices and prior implementation will mail a copy of any revised notice to the address I have provided. I understand I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that Clinical Pediatrics is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

I understand that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that Clinical Pediatrics and I must: agree to any restriction in writing that I request on the use and disclosure of my protected health information which have been previously agreed upon.

Patient(s) Name _____

Guarantor Name or Authorized Representative _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Clinical Pediatric Associates files insurance claims for all services with primary insurances. Patients are billed for any remaining balance after insurance processes the claim. Any non-covered services are the financial responsibility of the patient. In the event that payment for a service performed is denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. If a patient has no insurance coverage they are financially responsible for all charges incurred.

Please read and initial below confirming that you have been informed of our billing and filing policies:

Any co-payment/co-insurance and applicable deductible amounts are to be paid at the time of service unless other arrangements have been made with the office. _____

Upon receipt of patient payment, the remainder of the bill will be filed with insurance for direct payment to our office. _____

It is the patient's responsibility to provide current insurance information at each visit, and any changes to a current policy must be provided before being seen by the doctor. _____

If, by mistake, the insurance remits payment to the policy holder, payment is to be forwarded to the doctor from the patient. _____

Any amounts or services not covered by insurance are the responsibility of the patient. _____

Any changes to the patients billing address or contact information is to be provided by the patient as needed. _____

Any charges due from missed appointments, copying of records, or other billing fees are the responsibility of the insured/patient. _____

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

Patient(s) Name _____

Parent Name or Authorized Representative _____

Signature _____ **Date _____**

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Fax: 214-691-8801

Online Patient Portal Enrollment Form

When you access our patient portal, you can review a complete health information summary for each child in your care, including:

- Most recent physical date
- Upcoming appointments
- Historical visits
- A summary of labs and medical tests
- A problem list, allergy list and medications list
- A complete immunization record that may be downloaded or printed

You will also be able to communicate with our office by sending and receiving secure messages via our portal.

To sign up for access, complete the fields below and return the form to us upon your next visit to complete enrollment. You will then receive an email from us with your login and temporary password.

Parent Name: _____

Signature: _____ Date:_____

Cell Phone # : _____

Email address: _____

Children's names that you wish to have access to: _____

_____

If you would like to view balances and utilize our online bill-pay functionality, please sign below in order to have access to BluePay:

_____ _____
Signature Date

Clinical Pediatric Associates
Ernie M. Fernandez, MD
J. Patrick Hieber, MD

8355 Walnut Hill Lane
Suite 205 & 225B
Dallas, TX 75231
Phone: 214-368-3659
Fax: 214-691-8801

Text/Voice Reminders Sign-Up Form

I authorize Clinical Pediatric Associates to deliver appointment reminder messages by voice call or **text messaging** using an automatic telephone dialing system or an artificial or prerecorded voice:

I authorize such messages to be delivered to the following phone number*:

_____
Parent Name and Cell Phone Number
*please note that we can only send texts to one phone number

_____
Patient Name(s)

_____
Doctor

I understand that by signing the agreement, I am authorizing Clinical Pediatric Associates to deliver or cause to be delivered to me certain text messages and/or voice calls and that I am not required to sign this agreement in order to receive services from Clinical Pediatrics.

_____ _____
Signature Date