Mansfield Pediatrics Patient Information

Patient Information:

Name:_____

Date of Birth: ___/___/_____ Sex: M / F

Address:_____

City:_____State:_____ Zip:_____

Home Phone: (_____) _____-_____

Parent Email _____

Preferred Pharmacy (Address, Phone Number and/or Cross Street):

_____

Parents or Guardians Names:

Child lives with: Mother___ Father___ Other_____

Father's Name:_____ DOB _____

Address:_____

City:_____State:_____Zip:_____

Home Phone:(_____) _____-_____

Employer: _____

Work Phone: (_____) _____-_____

Cell Phone: (_____)_____-_____

Mother's Name:_____ DOB _____

Address:_____

City:_____State:_____Zip:_____

Home Phone(_____) _____-_____

Employer: _____

Work Phone: (_____)_____-_____

Cell Phone: (_____) _____-_____

Emergency Contact:_____ Relationship: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Insurance through: Mother___ Father___ Effective Date: _____

Primary Insurance: _____

Group Number:_____ID Number:_____

Address:_____

City:_____State:_____Zip:_____

Phone:(_____) _____-_____

HOW DID YOU HEAR ABOUT US: *Please take a moment and let us know ~ THANK YOU!*

__ Friend / Family Referral __ Internet Search __ Chamber of Commerce __ Facebook

__ Mansfield Cares __ OB/GGYN Referral __ Mansfield Methodist Hospital

__ Other_____

MANSFIELD PEDIATRICS, PLLC
1825 Cannon Drive
MANSFIELD, TEXAS 76063
PHONE (817) 453-7770 / FAX (817) 453-7703

Non-Parental Authorization for Consent to Medical/ Surgical Care and Treatment

I, _____, parent / legal guardian of:

Child(ren):

NAME	DOB
NAME	DOB
NAME	DOB
NAME	DOB

Do hereby give my authorization and consent for my child (named above) to be seen by Providers at Mansfield Pediatrics, PLLC and consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations that are routinely given at the well visit.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

Signature	Relationship to Child(ren)	Date

Parent/Guardian Names and Relationship:

Printed Name	Relationship to Child(ren)
Printed Name	Relationship to Child(ren)

Authorized Person(s):

Name	Relationship to Child(ren)
Name	Relationship to Child(ren)
Name	Relationship to Child(ren)
Name	Relationship to Child(ren)

Mansfield Pediatrics
OFFICE FINANCIAL POLICY

Please read the following carefully and direct any questions you may have to the front office staff.

PAYMENT FOR SERVICES WITHOUT HEALTH INSURANCE:
Payment for services is due on the day of your child's visit. Our cash prices are based on an insurance reimbursement average.

PAYMENT FOR SERVICES USING HEALTH INSURANCE:
Please sign in at the front desk and present your child's current insurance card at every visit. This is your verification of the correct insurance and consent to bill for services on your child's behalf.
IF THE INSURANCE PLAN THAT YOU DESIGNATE IS INCORRECT OR NOT IN FORCE, THEN YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT AND YOU WILL BE BILLED FOR THE VISIT UNTIL YOU PROVIDE THE CORRECT INSURANCE PLAN INFORMATION FOR THE OFFICE TO FILE FOR PAYMENT OF SERVICES. THIS INFORMATION MUST BE RECEIVED WITHIN 30 DAYS OF THE DATE OF SERVICE DUE TO INSURANCE FILING DEADLINES. . . NO EXCEPTIONS!

Some insurance plans will not pay for services unless your child's physician is designated as his Primary Care Provider (PCP). Make sure that your child's physician's name or phone number appears on your card and /or the insurance company has been informed of your child's PCP name as of the date of service, **OTHERWISE YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT.**

IF YOUR CHILD'S PHYSICIAN DOES NOT ACCEPT OR PARTICIPATE IN YOUR INSURANCE PLAN, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR CHILD'S VISIT.

If you participate in a **HIGH DEDUCTIBLE HEALTH PLAN**, you are required to **PAY IN FULL THE ALLOWED AMOUNT ON YOUR INSURANCE UNTIL YOUR DEDUCTIBLE IS MET.**

COPAYMENTS:
Co-payments are due **AT THE TIME OF SERVICE** and are collected at **CHECK-IN** at the front desk.
THE PARENT, LEGAL GUARDIAN, AUTHORIZED RELATIVE OR OTHER AUTHORIZED ADULT WHO IS ACCOMPANYING THE CHILD IS RESPONSIBLE FOR PAYING THE CO-PAY ON THE DAY AND TIME OF SERVICE.
COPAYMENTS MAY NOT BE WAIVED.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS:
You are responsible for knowing what benefits and services your health insurance covers for your child. Insurance benefits **VARY WIDELY. Not all services provided in the office are covered by every insurance plan.** For example, some plans do not cover well child visits at all or have a limited maximum amounts for well child care per year, or cover only immunizations required by the state. Please check with your insurance plan before scheduling annual health check-ups especially after the age of 4. NOTE: Some annual well child check-ups are covered once every 365 days whereas other health plans allow 1 well child check-up per calendar year.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS – Con't:
This office does try to verify your child's insurance coverage and benefits several days in advance of your child's scheduled well child visit, but **YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES DETERMINED NOT TO BE COVERED BY YOUR PLAN.**

BALANCES AND BILLS:
You will be advised of any outstanding balances due when you **CHECK IN AT THE FRONT** desk for your child's visit. Payment of outstanding balances **MUST BE ADDRESSED** prior to your child's visit. Balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB) by the billing department. Your bill is due upon receipt of your bill by mail. Please contact the billing office at the number on your statement to discuss bills, balances and payment questions during office business hours.

NON-SUFFICIENT FUNDS CHECKS:
Please save everyone time, money and embarrassment by not writing a potential NSF check.
Please inform the front desk receptionist of any problem you have making proper payment and let her assist you.

There is a $35.00 fee for each check returned for NSF or any other reason AND you will need to pay with cash or valid credit/debit card for any visits in the future.

MISSED APPOINTMENTS:
As a courtesy to other families in the practice who may need appointments for sick children, please give at least 24 hour notice to the office when you will not be able to keep an appointment previously scheduled. **Missing 3 scheduled appointments without prior notice to the office may be grounds for your child's dismissal from the practice.**

I have read and understand the office financial policy and agree to comply and accept responsibility for any payment that becomes due as outlined.

Patient Name(s)_____Date_____

_____Date_____

Parent Name(s) (printed)

Mom_____

Dad_____

Parent Signature_____

Relationship to child/patient_____

01/18

Mansfield Pediatrics
Medical Records Release Form

I hereby authorize my child's former physician:

Dr/Hospital_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone (_____) _____-_____ **Fax** (_____) _____-_____

To release the specified information below from the medical record of

Patient Name _____ **Birth Date** _____/_____/_____

Information may be released to the following party(s):

Mansfield Pediatrics
1825 Cannon Drive
Mansfield, TX 76063
(817) 453-7770 Fax (817) 453-7703
****We have EPIC EMR****
****NO CD'S PLEASE ****

INFORMATION OR MEDICAL RECORDS TO BE RELEASED BY MEANS OF THIS AUTHORIZATION INCLUDE THE FOLLOWING:

(list dates of admission and discharge or treatment)

__All Health Information
__History & Physical
__Discharge Summary
__Operative Record & Pathology
__Patient Allergies
__Past/Present Medications
__Diagnostic Testing & Results
__Radiology Report and Images
__Physician's Orders
__Progress Notes
__Billing Information
__EKG/Cardiology Reports
__Lab Results
__Consultation Reports
__Other

Initials are required to release the following information:

__Mental Health Records (excluding psychotherapy notes)
__Drug, alcohol, or substance abuse records
__Genetic information (including Genetic test results)
__ HIV/AIDS test results/treatment

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose of reason for this release is as follows: (Choose only 1 option) __Treatment/Continuing Medical Care __Personal Use __Billing or Claims __Insurance __Legal Purposes __Disability Determination __School __Employment __Other _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, alcohol or chemical dependency will not be released unless I have given my specific consent to release this information as indicated above.

I also understand that I may revoke this authorization at any time except that action has been taken in reliance upon it.
I understand that a photocopy or facsimile of this authorization is valid as the original.

_____ _____/_____/_____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian

_____
Relationship to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

Mansfield Pediatrics
Medical Records Release Form

I hereby authorize,

Mansfield Pediatrics
1825 Cannon Drive
Mansfield, TX 76063
(817) 453-7770 Fax (817) 453-7703

To release the specified information below from the medical record of

Patient Name _____ **Birth Date** ____/____/_____

Information may be released to the following party:

Dr./Parent_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone (_____) _____-_____ **Fax** (_____) _____-_____

INFORMATION OR MEDICAL RECORDS TO BE RELEASED BY MEANS OF THIS AUTHORIZATION INCLUDE THE FOLLOWING:

(list dates of admission and discharge or treatment)

__History & Physical
__Discharge Summary
__Operative Record & Pathology
__Diagnostic Testing & Results
__Other _____

Please initial space prior to following statement:
__I authorize you to INCLUDE information pertaining to the diagnosis and/or treatment of HIV testing, Aids, psychiatric illness, and alcohol and/or chemical abuse dependency.

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose of reason for this release is as follows:

_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except other wise provided for by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, alcohol or chemical dependency will not be released unless I have given my specific consent to release this information as indicated above.

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I understand that a photocopy or facsimile of this authorization is valid as the original.

_____ ____/____/_____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian

_____
Relationship to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.