

# PATIENT



(Please answer all questions....thank you)

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ School \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex (Circle One) Male Female Phone Number \_\_\_\_\_  
Patient's Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Siblings:  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

How did you hear about AACP? \_\_\_\_\_ Have you seen any of our advertising? Yes No  
If so, where did you last see our advertising? \_\_\_\_\_  
If a referral from one of our parents, can you tell us their name so we can thank them? \_\_\_\_\_

## CONTACT INFORMATION

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
**Is this the guarantor on the account? Y/N** Driver's License# \_\_\_\_\_ SS# \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
If there is a stepmother that may bring in your child periodically, please provide information below:  
Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address (if different) \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
**Is this the guarantor on the account? Y/N** Driver's License# \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
If there is a stepfather that may bring in your child periodically, please provide the information below:  
Name \_\_\_\_\_ Phone \_\_\_\_\_

## Emergency Contact (other than parents):

Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Phone Number \_\_\_\_\_

## Insurance Information:

Insurance Co \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
Name of Insured Party (who carries the insurance) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
SS# \_\_\_\_\_ Employer \_\_\_\_\_  
ID # \_\_\_\_\_ Group # \_\_\_\_\_

Your signature below indicates financial responsibility for all charges incurred and your assignment of insurance benefits to All About Children Pediatrics. THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR ANY COPAYS OR ACCOUNT BALANCE. This is a legally binding agreement for All About Children Pediatrics to treat and care for your child. Please note that payment is due at time of service unless prior arrangements have been made and agreed to. **WE WILL NEED TO COPY YOUR INSURANCE CARD AND DRIVERS LICENSE. IF YOU HAVE QUESTIONS, PLEASE ASK THE RECEPTIONIST.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



## FINANCIAL AND OFFICE POLICY FOR ALL ABOUT CHILDREN PEDIATRICS

This policy confirms that an agreement exists between All About Children Pediatrics and the Patient/Guarantor named on this form. The Patient/Guarantor has read and understands the policy outlined below and has been given the opportunity to ask questions.

Payment for coinsurance and co pays are due at the time of service unless prior arrangements have been made with one of our billing staff. We are contracted with most major payers, and as a courtesy, we will file your insurance for you. It is your responsibility to determine if our providers are on your specific HMO, PPO, EPO, or POS plan. If your insurance requires a referral, it is your responsibility to obtain that referral prior to your office visit. Failure to obtain a referral will result in a denial or reduced benefit from your insurance company.

We will collect your co pay and estimate any coinsurance or deductible portions due at the time of service. The portion collected is just an estimate as contract allowable and eligibility changes and is determined by your carrier when your claim is received. It is your responsibility to add a new baby/child to your plan as soon as possible, as this often results in a claim denial. If you fail to make us aware of any changes to your insurance carrier at the time of your visit, the charges incurred will become your responsibility to pay. If there is more than one child in our practice and there is an insurance change, you are responsible for making us aware of the changes for each child specifically.

If you have no insurance coverage you will be made aware of our policy regarding payment of services at the time your appointment is made. Self pay patients are required to pay at the time that services are rendered. Due to the nature of electronic medical records, some charges for testing or labs may not be available at the time of checkout. We will estimate your portion and bill you for any incurred charges once they are processed, reviewed and signed by the physician.

Statements are initially sent when we receive notification and payment from your insurance company. Any applicable copay, deductible or coinsurance due from you that is not covered by your insurance company is due upon receipt. If the balance has not been remitted, you will then receive a statement in our monthly statement run, and will be considered past due if payment has not been received within 30 days. If your account becomes Past Due, we will take the necessary steps to collect the debt. We have options to report your account status to any credit reporting agency, such as the credit bureau; including turning your account over to a collection agency and assessing a \$25 administrative fee on your account.

Returned checks are assessed a \$35 charge for each occurrence and must be picked up immediately and paid for by cashier's check or money order. If the check is not paid, we will forward the returned check to the warrant division for collection and you will be subject to any monies due on their behalf.

Our No Show Policy went into effect May 1<sup>st</sup> for all patients. Missed appointments are assessed a \$25 fee per child if we don't receive a 24 hr notice prior to the scheduled visit time. This charge is not covered by insurance and the amount is the patient/guarantor's responsibility to pay.

Late and Missed Appointments affect our ability to provide prompt and efficient patient care for all of our patients. If you arrive more than 15 minutes late for your appointment, there is a chance that we will not be able to accommodate you. If you are running late, please call ahead of time so that we can determine if your child can still be seen despite a late arrival or if the appointment will need to be rescheduled. To avoid any unnecessary late or missed appointment charges for a scheduled WELL visit, PLEASE call us to cancel your scheduled WELL appointment as soon as possible, especially the day before if your appointment is scheduled early the next morning. If you scheduled a sick appointment and need to cancel it the same day, please do so at least 4 hours before the appointment time to avoid any canceled appointment fees.

Consent for All About Children Pediatrics to treat your child. If the patient is a minor (anyone under the age of 18) a parent or legal guardian must be in attendance to give consent for treatment and be the responsible guarantor. ***In a divorce situation, the parent who brings the dependent child to our office is responsible for payment.*** Insurance may be filed, but the parent in attendance will be responsible for any co pay or outstanding balances.



## **AUTHORIZATION FOR PAYMENT**

***I authorize payment of medical benefits to ALL ABOUT CHILDREN PEDIATRICS.***

My signature below indicates that I have read, understand, and agree to the above terms. I hereby authorize ALL ABOUT CHILDREN PEDIATRICS to evaluate the person that I am legally responsible for or me (relationship listed below) for any illness or injury for which I seek medical care.

**I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to ALL ABOUT CHILDREN PEDIATRICS. This assignment will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.**

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## **OFFICE COMMUNICATIONS**

I authorize All About Children Pediatrics, PA to communicate with me via the method listed below. I understand that this authorization allows All About Children Pediatrics, PA to leave a message or send an email to the specified individual(s) regarding test results, appointments, referrals, or other pertinent recommendations, or information regarding the above patient's care.

Email : \_\_\_\_\_

Telephone/Voicemail: \_\_\_\_\_

Alternate Phone/Voicemail: \_\_\_\_\_

Authorization to Release/Refusal to release information to: \_\_\_\_\_

Account # or Medical Record #: \_\_\_\_\_



**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS - HIPAA**

I, (Parent/Guardian) \_\_\_\_\_, understand that as part of my child's/children's (Name) \_\_\_\_\_ DOB: \_\_\_\_\_ health care, All About Children Pediatrics originates and maintains paper and/or electronic records describing their health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's/children's care and treatment;
- A means of communication among the many health professionals who contribute to my child's/children's care;
- A source of information for applying my child's/children's diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information and Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges listed below:

- The right to review the **Notice of Information and Privacy Practices** prior to signing this consent,
- The right to object to the use of my child's/children's health information for directory purposes, and
- The right to **request restrictions** as to how my child's/children's health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use or disclosure of my child's/children's health information:

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I understand that All About Children Pediatrics is not required to agree to the restrictions that I request, and can legally refuse the restriction request if it involves the safety or well being of my child/children. I understand that I may revoke this consent to All About Children Pediatrics in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child/children as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that All About Children Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should All About Children Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my child's/children's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



**REQUEST FOR RELEASE OF MEDICAL RECORDS**

TO: \_\_\_\_\_  
(Physician or Facility Name)

\_\_\_\_\_  
Address City St Zip

\_\_\_\_\_  
Phone Number Fax Number

I hereby request that my child's complete records or specific information as listed below be released to:

All About Children Pediatrics  
Todd Burton, M.D., Kathleen Dollins M.D., Kelley Smith, M.D.,  
Holly Whitesell, PA-C., Jodi Lemeshev M.D.  
2217 Eldorado Parkway  
McKinney, TX 75070  
972-542-1444 Fax: 972-542-6967

\_\_\_\_\_  
Patient's Name Patient's Date of Birth

\_\_\_\_\_  
Parent's Signature Today's Date

\_\_\_\_\_  
Information Requested

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to the facility receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be re disclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

**Please note that the physician or facility you have requested records from have 15 days by law to send us these records.**



**Pediatric Health History**

Please answer the following as completely and accurately as possible. This information will aid us in the treatment of your child as well as answer any concerns you might have.

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: Male or Female (Circle One) Age: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
 Child's School: \_\_\_\_\_ Previous Physician: \_\_\_\_\_

**ALLERGIES** (Drug, Food, Other)

**MEDICATIONS**

Substance	Reaction	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Birth History:**

**Birth Weight:** \_\_\_\_\_ lbs. \_\_\_\_\_ oz. **Length:** \_\_\_\_\_ inches **Weeks Gestation:** \_\_\_\_\_ wks

Hospital: \_\_\_\_\_ Obstetrician: \_\_\_\_\_

Any problems with the pregnancy or delivery? Please explain: \_\_\_\_\_  
 \_\_\_\_\_

Are you breastfeeding? \_\_\_\_\_ If so, how many times a day and how long on each breast?  
 \_\_\_\_\_  
 \_\_\_\_\_

If bottle feeding, how many oz. per bottle and times per day? \_\_\_\_\_  
 \_\_\_\_\_

**General:**

Does your child have any serious illness or medical condition? Y or N Explain: \_\_\_\_\_  
 Has your child had any serious accidents? Y or N Explain: \_\_\_\_\_  
 Has your child had any surgery? Y or N Explain: \_\_\_\_\_  
 Has your child ever been hospitalized? Y or N Explain: \_\_\_\_\_

**Development:**

Are you concerned about your child's physical development? Y or N Explain: \_\_\_\_\_  
 Are you concerned about your child's emotional development? Y or N Explain: \_\_\_\_\_  
 Are you concerned about your child's attention span? Y or N Explain: \_\_\_\_\_

Other Concerns: \_\_\_\_\_

**Family History:**

Have any family members had the following:

Deafness	( ) Yes ( ) No	Relationship: _____	Comments: _____
Nasal Allergies	( ) Yes ( ) No	Relationship: _____	Comments: _____
Asthma	( ) Yes ( ) No	Relationship: _____	Comments: _____
Tuberculosis	( ) Yes ( ) No	Relationship: _____	Comments: _____
Heart Disease	( ) Yes ( ) No	Relationship: _____	Comments: _____
High Blood Pressure	( ) Yes ( ) No	Relationship: _____	Comments: _____
High Cholesterol	( ) Yes ( ) No	Relationship: _____	Comments: _____



Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relationship: _____	Comments: _____
Other pertinent family history: _____				

**Past History:**

Does your child have or has he/she ever had:

Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Nasal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Asthma, bronchiolitis, bronchitis, or Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Any heart problem or murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Urinary tract infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Bed-wetting (after age 5)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Chronic skin problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Thyroid or endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Other significant problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____

# A Note From Todd Burton, M.D.



Dear Families of All About Children Pediatrics,

We at AACP are aware and constantly trying to improve on wait time. Make no mistake, our #1 priority is providing good quality medical care to your children, and we will never compromise this! There are a number of potential factors which can affect time spent at the doctor's office...some totally out of our control and others that the collective "we" may be able to improve upon. Some of these you may or may not be aware of...

- **In-office emergencies:** lacerations, respiratory distress, severe allergic reactions, etc.
- **Emergency deliveries:** We attend emergency c-sections or other deliveries at Medical Center of McKinney and Presbyterian Hospital of Allen if there are complications or potential complications and the Obstetrician requests our presence.
- **Certain times of day:** The "after-school rush" tends to make for longer wait times.
- **Our policy of same day sick appointments:** While some physicians would view this as a luxury for parents, we feel strongly about it. If you know you want your children seen today, we will see them today even if every appointment is booked. We may inform you that all of our appointments are booked and we will have to double book you and work you in. We may also decide, together with you, over the phone on a course of treatment to get you through until the next day.
- **Staffing:** We have grown and changed staffing as the Practice population has changed. Part of that has been transitioning from some superb part-time staff to full-time staffing. Seeing the same faces everyday is important for you and your children, but it also allows us to grow, mature, and gel as a work group, which can and will improve the efficiency of the office. We also continue to grow in numbers as the need arises.
- **Being on time for appointments:** Because many times wait times have been long, too long in our opinion, we find it hard to be strict on this. But this is a key factor that can snowball over the day and add up to 45 minutes to an hour or more of delays by the end of the morning or afternoon sessions. We ask that you arrive on time or approximately 5 minutes early (15 minutes if first time patients) to fill out paperwork. Please realize that if you are more than 10 minutes late we have to cancel your appointment slot and "work you back in" or reschedule you. If we are going to improve on wait times, we must address all factors we can control. We realize emergencies happen, or sometimes just getting a new baby or 2-3 children to go anywhere is a chore, especially if they are sick and you are sleep-deprived! We simply ask that if you know that you will be late, please call and we can reschedule you and give your time slot to someone else.
- **Keeping your appointment to what it is scheduled for:** Many times, parents request to change a sick appointment to an overdue well exam, or want to discuss some other major issue/problem other than what the child is there for that day. As you can imagine, this will cause delays. It takes much more time for the staff to "prepare" for a well exam with measurements, graphing, history, etc., not to mention the time for the exam, discussion of development, and immunizations. Sometimes parents want us to see siblings who are not scheduled or even discuss siblings who aren't there.

**These last two points are important to remember and ones with which we would like to request your assistance. Please help us in our effort to serve you better as we are caring for your child and the children and families of this community.**

Thank you for your cooperation,  
Todd Burton, M.D.