Pediatric & Adolescent Center of NW Houston, PA

Poonam Singh, MD ● Tonya Suffridge, MD ● Elizabeth Sanchez Fowler, MD ● Anuradha Venkatachalam, MD ● Bethany Rife, MD ● Alia Hussain, MD

455 School Street, Suite 26 ● Tomball, Texas 77375
19059 Champion Forest Drive, Suite 101 ● Spring, Texas 77379
14502 Cypress Mill Place Blvd, Suite 100 ● Cypress, Texas 77429
Phone (281) 374-9700 ● Fax (281) 370-8765
www.pedsofnwh.com

THIS SECTION REFERS TO THE PATIENT(s) ONLY

If more than one patient in the family with the same information, please list all the patient's names:

Last Name_____ First_____ Middle_____ DOB:_____ Sex ___

Last Name_____ First_____ Middle_____ DOB:_____ Sex ___

Last Name_____ First_____ Middle_____ DOB:_____ Sex ___

Street Address_____ City_____ State ____ Zip _____

Home Ph#_____ Work Ph#_____ Cell Ph# _____

Email address_____ Preferred method of contact _____

Race_____ Ethnicity_____ Language _____

Emergency Contact_____ Relation to patient_____ Ph# _____

If a MINOR, complete with PARENT'S / LEGAL GUARDIAN info

Mother's Name_____ D.O.B. _____

SS#_____ DL#_____ Email Address _____

Address (if different than above)_____ Ph# _____

Employer Name_____ Employer Ph# _____

Father's Name_____ D.O.B. _____

SS#_____ DL#_____ Email Address_____

Address (if different than above)_____ Ph# _____

Employer Name_____ Employer Ph# _____

INSURANCE INFORMATION

Primary Insurance Company_____ Customer Service # _____

Subscriber Name_____ D.O.B._____ Employer _____

Secondary Insurance Company_____ Subscriber Name_____ D.O.B. _____

ADDITIONAL INFORMATION

Name of siblings not listed above _____

How did you hear about us? _____

Preferred Pharmacy_____ Pharmacy Ph# or Address _____

I, the insured person for this account, do assign the collection of benefits to the Pediatric and Adolescent Center of NW Houston, PA (PACNWH). I give my permission to release medical information needed to process medical claims. I understand that PACNWH will attempt to collect payment from my insurance company, yet I am ultimately responsible for the payments on this account. Any balance unpaid by my insurance company after 60 days of filing can be billed to me for payment. I have been provided a copy of the office policies. I give consent to PACNWH to provide treatment to the above listed patient (s).

Signature of Patient/Legal Guardian_____ **Date**_____

PEDIATRIC & ADOLESCENT CENTER OF NW HOUSTON, PA
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PATIENT NAME:_____ DOB_____ DATE _____

ALLERGIES Please list any drug allergies _____

DAILY MEDICATIONS: _____

PAST MEDICAL HISTORY

1. Has patient been hospitalized or visited ER in past 12 months?_____Yes_____No

If yes, When_____Where_____Why _____

2. Please list any surgery(s) the patient has had with the date(s)?_____

3. Please check if the patient has been diagnosed with the following in the past?

_____ ADHD_____Allergies_____Anxiety_____Autism/Aspergers_____Ear Infections

_____Eczema_____Frequent Respiratory Infections_____Migraines_____Trouble in School

_____Seizures_____Sleep Disorders_____Staph Infections_____Urinary Tract Infections

Other _____

SOCIAL HISTORY

1. Please list the members of the household: _____
(Ex: mom, dad, 2 brothers)

2. Is patient exposed to pets? _____If so, what kind? _____

3. Is patient exposed to smoke? _____Yes_____No

4. Does patient attend daycare? _____Yes_____No Other _____

Age of Father _____ Age of Mother _____ Ages of Siblings _____

FAMILY HISTORY Please circle any of the following illness/problems that the *immediate* family has had.

Allergies	Bleeding Disorder	Eczema	High Cholesterol (mom or dad)
Asthma	Cancer	Seizures	Other _____
Autism	Diabetes	Thyroid Disease	_____

____Patient is Adopted. _____Unknown History –Patient is Adopted. Is patient aware of adoption? Y or N

BIRTH HISTORY (Please complete for patients under Age 1)

Delivery Method_____Hospital of Delivery _____

Birth Complications_____Prenatal Complications _____

Was labor difficult or prolonged? _____

Full Term or Premature (Weeks of Gestation_____) Birth Weight_____Length _____

Hepatitis B Vaccine given at Birth? Y or N Date:_____Newborn Hearing Screening: Pass or Fail ___

Any Newborn Issues: _____

Pediatric & Adolescent Center of NW Houston, PA

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (protected health information) by Pediatric & Adolescent Center of NW Houston PA in order to carry out treatment, payment, or health care operations. The patient should review Pediatric & Adolescent Center of NW Houston PA Notice of Privacy Practices for Protected Health information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

Pediatric & Adolescent Center of NW Houston PA reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Pediatric & Adolescent Center of NW Houston PA does change the terms of its Notice of Privacy Practices, the patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Pediatric & Adolescent Center of NW Houston PA is not required to agree to such requested restrictions; however, if Pediatric & Adolescent Center of NW Houston PA does agree to Patient requested restriction(s), such restrictions are then binding on Pediatric & Adolescent Center of NW Houston PA.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Pediatric & Adolescent Center of NW Houston PA in writing. The revocations shall be effective except to the extent that Pediatric & Adolescent Center has already taken action in reliance on the Consent.

Pediatric & Adolescent Center of NW Houston PA may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that Pediatric & Adolescent Center of NW Houston PA is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, Pediatric & Adolescent Center of NW Houston PA has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that Pediatric & Adolescent Center of NW Houston PA is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name of Patient/Guardian Relationship to Patient

Pediatric & Adolescent Center of NW Houston, PA

HIPAA PATIENT QUESTIONNAIRE

_____ _____
Patient Name Date of Birth

_____ _____
Parent/Guardian Name DL Number

1. Please list other persons, if any, whom we may inform about your general medical condition and your diagnosis:

_____ _____

_____ _____

2. Please list other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

_____ _____

_____ _____

3. Please list other persons, if any, with whom we may discuss your billing information (including patient balances).

_____ _____

_____ _____

4. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voice mail?

YES _____ NO _____

5. Can confidential messages be left at your place of work voice mail? YES _____ NO _____

I voluntarily give my permission to the health care providers of Pediatric & Adolescent Center of NW Houston, PA to provide medical services as they deem necessary to the above mentioned patient. I understand by signing this form, I am authorizing them to treat my child for as long as I seek care from Pediatric & Adolescent Center of NW Houston, PA, or until I withdraw my consent in writing.

_____ _____
Signature of Parent / Guardian Print Name

_____ _____
Relationship to Patient Date

Pediatric & Adolescent Center of NW Houston, PA
Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please review our policy carefully.

Appointments

1. We value the time we have set aside to spend with you. If you are unable to keep your appointment, please notify us 24 hours in advance so that we may give another patient the opportunity for that appointment. We reserve the right to charge for missed or late cancelled appointments. This fee will not be covered by your insurance. Failure to comply with our cancellation policy may result in dismissal from our practice.
2. If you are more than 15 minutes late for your appointment, we will do our best to accommodate you. On certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and we appreciate your understanding in advance.
4. All patients must complete the patient information forms prior to seeing the doctor and present a current insurance card. To protect your child's record, you must provide a driver's license or photo ID.
5. Services performed on a Saturday, Federal Holiday, and after "normal business" hours along with Work In or Walk In appointments may be billed an additional fee.

Financial Policy

1. Our office participates in a variety of insurance plans. If we do not participate with your insurance plan, or your child does not have insurance, payment in full is expected at the time of service. We do offer a discount to "Self-Pay" patients. Self-pay patients are expected to pay in *full* at the times services are rendered.
2. According to your insurance plan contract, you are responsible for any and all co-payments, deductibles, and co-insurances. Copayments and estimated deductibles / co-insurances are due at the time of service.
3. If our office is unable to verify your insurance coverage at the time of service, you will be financially responsible for the visit at the time services are rendered.
4. It is your responsibility to keep us updated with the correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and responsible to submit the charges to the correct plan for reimbursement.
5. If your insurance company is an HMO or POS policy it may require you to choose a primary care provider (PCP). You will need to choose a physician from our practice. If we are not the designated PCP, you will be considered self-pay and financially responsible for the visit in full.
6. Our office verifies your coverage as a courtesy but there is no guarantee until the claim is processed. It is your responsibility to understand your benefit plan with regards to, for instance, covered services and participating laboratories. For example:
    a. Not all plans cover annual physicals, sports physicals, or hearing screenings. If these are not covered, you will be responsible for payment.
    b. Some insurances limit the number of allowable well visits per year and/or have a dollar maximum of benefits payable for well child services. If this benefit is exceeded, your insurance company will not pay and you will be responsible for payment.
    c. Some insurance companies consider visits for ADD or ADHD as mental health and will not cover the claim for services rendered by a medical physician. In this case, you will be responsible for payment.
7. Your insurance company may request that you supply information to them directly in order to process claims (i.e. coordination of benefits, pre-existing information). It is your responsibility to comply with these requests in a timely manner.
8. In cases of divorce and /or separation, the person bringing the child in for treatment will be held responsible for the payment due at the time of service. For past due balances, the person requesting treatment is responsible for the balance on the account. We will be happy to provide a receipt if you need to seek reimbursement from another party.
9. All prior balances must be paid before your appointment.
10. We accept cash, check, Visa, and MasterCard. A $30 fee will be assessed for any checks returned for insufficient funds.
11. Statements are sent out monthly. Your remittance is due within 10 business days upon receipt of the bill. Any accounts with balances over 90 days with no activity can be turned over for collections and you and your immediate family members may also be discharged from the practice.

Last Revised: 4.2.2019

12. Overpayments will be refunded to the responsible party within 30 days of the request.
13. If you have any questions about your insurance or your bill, we are happy to help. However, specific coverage issues should be directed to your insurance company. You may contact the member services phone number on the insurance card.
14. If parent changes mind about an injection after it is ordered and drawn up the parent will be financially responsible for the cost. The insurance will not cover it.
15. We do not file claims to automobile insurance. If your visit is a result of an automobile accident, you will be required to pay self pay. We will provide a receipt so that you may seek reimbursement.

Referrals

1. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2. It is your responsibility to know if a selected specialist or provider participates in your plan.

Forms

1. We may charge for shot records, school forms, camp forms, Family and Medical Leave Act forms, and any other forms to be completed by the physician. Payment is due when the forms are dropped off and we request a 5 day turnaround time. (*Please ask the nurse to update your personal shot record at each well child visit)*
2. Typically a fee will be charged for medical letters requested to be written by the physician. This can vary depending on the nature of the letter.

Transfer of Records

We provide records for visits rendered by our physicians only. For any previous records, you must request from previous providers. A fee of $25.00 for the first 20 pages and $0.50 for each additional page will be assessed for a copy of your medical records. A release of information must be signed. Please allow up to 15 business days for transfer of records.

Prescription Refills

For medication refills, we require 48 hours' notice. For controlled substance, we require 3-5 business days and appointment is required every 3 months.

Starting January 1, 2020 we will no longer see unvaccinated patients. We will continue to provide care for patients on alternate immunization schedule and unimmunized patients wanting to catch up on immunizations. We will continue to provide science backed information to help parents make an informed decision. Parents are encouraged to call their primary pediatrician and discuss their concerns on this matter. We care deeply for all our patients and wish to continue taking care of them to the best of our ability.

Signature of Understanding: I have read and understand the above stated office and financial policy.

Patient Name _____ Patient Date of Birth _____

Name of Parent / Guardian _____ Relationship _____

Parent / Guardian Signature/ Responsible Party _____ Date _____

Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Pediatric & Adolescent Center of NW Houston, PA, for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims benefits.

Parent / Guardian Signature/ Responsible Party _____ Date _____

Last Revised: 11.22.2019

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE

(For families who are ongoing patients of Pediatric & Adolescent Center of NW Houston)

I appoint_____, who is my child(ren)'s
(Name of Proxy Caretaker)

_____, as my proxy decision maker for
(Specify Proxy Caretaker's Relation to the children)

consenting to non-urgent medical care for my children listed below. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Child(ren) Information:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____

_____

_____

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

_____

_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my children at the following telephone number(s). If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

_____	_____
Parent's Name	Parent's Name
_____	_____
Daytime phone	Daytime phone
_____	_____
Evening phone	Evening phone
_____	_____
Cell phone	Cell phone

_____ _____
Signature of Parent Date

_____ _____
Signature of Proxy Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ **Date of Birth** _____

Social Security#_____ **Date(s) of service. If all dates of service, write "all"** _____

Please select which location will be receiving/releasing medical records:

( ) Pediatric & Adolescent Center of NW Houston, PA
455 School Street Suite 26
Tomball, TX 77375

( ) Pediatric & Adolescent Center of NW Houston, PA
19059 Champions Forest Dr. Suite 101
Spring, TX 77379

( ) Pediatric & Adolescent Center of NW Houston, PA
14502 Cypress Mill Place Blvd, Ste 100
Cypress, TX 77429

*****If medical records do not exceed 25 pages, you may fax records to (281) 370-8765*****

_____I authorize the above named organization to release my medical records to:

_____ I authorize the above named organization to receive records from:

_____
Person or Organization

_____
Address

_____
Phone Fax (if applicable)

This information is being released for the following purposes:
( ) Continued Care ( ) Attorney / Litigation ( ) Insurance ( ) Disability ( ) Other _____

INFORMATION TO BE RELEASED:
[ ] **All** Medical Records [ ] Consultation/History and Physical Exam [ ] Billing Records [ ] Progress/Visit Notes [ ] Immunization Record
[ ] Radiology Reports [ ] Diagnostics / Labs [ ] Other (Specify)_____

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV; behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time in writing and will present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. This authorization expires 180 days from the date of my signature unless specified in writing here: _____
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- **To the party receiving this information**: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____ _____
Signature of Patient or Legal Representative Print Name Date

_____
Relationship to Patient (If Legal Representative)

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APPOINTMENT NO SHOW POLICY

Starting March 1st, 2018 our office will be enforcing a $40 no show/late cancellation fee. The fee is charged to the patient, not the insurance company, and is due on or before the patient's next office visit. In order to avoid this fee, please call our office at least 24 hours in advance to cancel or reschedule your well child/med evaluation appointment and at least an hour before your sick visit appointment.

If you are late for a Well child/Physical Exam, the appointment may have to be rescheduled.

Child(ren) Information:

_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:

_____	_____
Parent/Guardian Printed Name	Relationship to Patient
_____	_____
Parent/Guardian Signature	Date