Pediatric & Adolescent Center of NW Houston, PA

Phone: (281) 374-9700 Fax: (281) 370-8765
www.pedsofnwh.com

Please print clearly and complete all sections of form.

PATIENT INFORMATION

Last Name _____ First _____ Middle _____ DOB _____ Sex _____

Last Name _____ First _____ Middle _____ DOB _____ Sex _____

Last Name _____ First _____ Middle _____ DOB _____ Sex _____

Last Name _____ First _____ Middle _____ DOB _____ Sex _____

Race: □ Asian □ Black/African American □ Native Hawaiian or other Pacific Islander □ White □ American Indian/Alaska Native
Ethnicity: □ Hispanic □ Not Hispanic
Language: □ English □ Spanish □ _____
How did you find out about us: □ Another Patient/Word of mouth □ Insurance □ Hospital □ Social Media □ Other _____

Address: _____ Apt _____ City/State/Zip _____

Pharmacy: _____ Street Intersection _____

Mother's Name _____ Date of Birth _____ SSN _____-_____-_____

Father's Name _____ Date of Birth _____ SSN _____-_____-_____

Child lives with both parents: □ Yes □ No. If not, Child's Custody: □ Mother □ Father □ Other _____

Mother's Phone: _____ Father's Phone: _____ Other: _____

Preferred Method of contact (this is where texts messages should be sent): □ Mother □ Father □ Other _____

Mother's Address (if different from above): _____ City/St/Zip _____

Father's Address (if different from above): _____ City/St/Zip _____

Email address: _____

EMERGENCY CONTACT (other than parent)

Name: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company _____ Customer Service # _____

Subscriber Name _____ DOB _____ Relation to patient _____

Secondary Insurance Company _____ Customer Service # _____

CONSENT AND FINANCIAL RESPONSIBLITY

CONSENT
By signing below, I consent to be evaluated and treated by my provider(s) at Pediatric & Adolescent Center of NW Houston, PA. I consent to services, treatment and diagnostic procedures including but not limited to medications, laboratory tests and other studies as ordered by my provider.

FINANCIAL RESPONSIBILITY
By signing below, you understand that you are financially responsible for all charges pertaining to your care. If you have medical insurance, we will bill it for the services we provide. By signing below, you agree that you have insurance coverage as above and assign directly to Pediatric & Adolescent Center of NW Houston, PA all medical benefits, if any, otherwise payable to you for services rendered. You hereby authorize Pediatric & Adolescent Center of NW Houston, PA to release all information necessary to secure the payment of benefits or process your insurance claims. However, please understand that insurance is a contract between you and/or your employer and your insurance carrier. If we provide services that are required by medical standards of care and in case the insurance does not pay for them, these charges are your responsibility. It is also your responsibility to advise us of any updates or changes to your insurance. Most insurances require that claims be filed not more than 60 days after service and delays in filing due to incorrect insurance information may lead to non-payment of such claims. In such cases, the unpaid charges will become your responsibility. Copays and estimated deductible rates are due at the time of service. After your insurance company has paid on your claim, if there is any unpaid balance, we will send a statement of charges to you. Your insurance company may also send you an Explanation of Benefits (EOB). The balance on your account is due immediately once responsibility has been determined by the EOB or by our statement. I have been provided a copy of the full office policy.

Signature of Parent/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? Yes No If yes, 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 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 and Financial Policy

Date last revised: March 5, 2026

Our goal is to provide excellent care for your child while maintaining a respectful and positive relationship with every family in our practice. Providing our office and financial policies in advance helps ensure clear communication and efficient service. We appreciate you taking the time to review the following information carefully. **Initial on indicated lines.**

Communication

Our office utilizes the Healow portal for communication with patients. All messages and questions to providers and staff – including medical questions, referral inquiries, refill requests, labs and imaging questions, or billing questions – must be sent through the patient portal. Providers and staff will respond through the portal.

Parents also have access to shot records, growth charts, referrals, future appointments, patient statements, and other information to view and print via the portal. Printing is only available through the online portal.

Important: If a staff member must initiate a message due to refusal to utilize portal, a fee of $10 will be applied per message initiated.

Appointments

1. We value the time we have reserved for your children's appointment. If you are unable to keep your appointment, please notify our office at least **24 hours in advance** so that we can offer the time to another patient. A **$40.00 no-show or late cancellation fee** will be charged if this notice is not provided. This fee is the responsibility of the patient and **cannot be billed to insurance**. Payment is due before or at the patient's next office visit.
2. Each child must have a **separate scheduled appointment.** If multiple children in the family need to be seen, please schedule an appointment for each child so that adequate time can be reserved.
3. Patients who arrive late may be asked to reschedule their appointment to avoid delays for other patients. Missed appointments due to late arrival are considered a no-show and will be subject to the no-show fee.
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. Minors must have a parent/guardian accompany them to all appointments.
6. If someone other than the patient's parent/guardian will be bringing patient to an appointment, we must have a Proxy Consent on file with parent/guardian signature authorizing this person to bring patient to appointment and consent to medical treatment.
7. Services provided outside of regular business hours, or schedule as urgent work-in appointments **may be billed according to applicable insurance guidelines and fee schedules.**
8. Our practice has a Pediatric Nurse Practitioner on staff. She is trained to provide preventative care and management of common acute and chronic pediatric problems under the supervision of a board-certified pediatrician. Patients consent to see a Nurse Practitioner when they schedule an appointment with her. Patients may refuse to see the Nurse Practitioner and request an appointment with the Pediatrician.

After-Hours and Emergency Policy

1. Our office provides after-hours call service for an additional fee that is billed to your insurance. You are responsible for any portions assigned by your insurance company. Any calls that require the physician to be contacted will incur a separate fee of $25.00 that will be billed directly to the patient.
2. Our after-hours phone service is intended for **urgent medical concerns that cannot wait until the next business day.** For life-threatening emergencies, please call **911** or go to the nearest emergency room. Prescription refill requests, appointment scheduling, school forms, and non-urgent questions should be addressed during normal business hours or through the patient portal.

Pediatric & Adolescent Center of NW Houston, PA
Office and Financial Policy

Date last revised: March 5, 2026

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 time services are rendered.
2. According to your insurance plan contract, you are responsible for all co-payments, deductibles, and co-insurances. Copayments and estimated deductibles / co-insurances are due at the time of service.
3. If a new or ongoing medical concern is addressed during a preventive (well child) visit, **an additional office visit charge may be billed** in accordance with insurance coding guidelines. This may result in **additional copayments, deductibles, or coinsurance** depending on your insurance plan.
4. 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.
5. 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 for submitting the charges to the correct plan for reimbursement.
6. 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.
7. If your insurance requires a referral or authorization to see a specialist, please find one contracted with your insurance company that you would like to see then submit the information via portal message for staff to proceed with referral. Referrals can take up to 5 business days so please notify us in advance. Our staff does not find specialists for patients due to the many variables involved. If we have to redo the referral (parent changes the specialist before referral is expired or lets the referral expire without seeing the specialist) or if we have to do an urgent referral within 48 hours there will be a $40 fee due to the amount of time it takes to complete this process. If a fee is charged this will be the patient's responsibility, not billed to the insurance company and due prior on or before the patient's next office visit.
8. 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, the services covered and participating laboratories. For example:
    a. Not all plans cover annual physical, sports physical, or hearing screenings. If these are not covered, you will be responsible for payment.
    b. Some insurances limit the number of allowable 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.
9. 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. Failure to do so may result in denial of claims which would then be the patients' responsibility.
10. For families with separate households, the parent or guardian presenting the child for care is responsible for all copayments, deductibles, and outstanding balances at the time of service.
    Payment arrangements between parents are the responsibility of the parents. Our office cannot mediate, communicate payment requests between parties, or become involved in custody or divorce matters. Receipts will gladly be provided for reimbursement as needed.
11. All prior balances must be paid before your appointment. The balance on your account is due immediately once responsibility has been determined by the EOB or by our statement.

Pediatric & Adolescent Center of NW Houston, PA
Office and Financial Policy

Date last revised: March 5, 2026

12. We accept cash, check, Visa, and MasterCard. A $30 fee will be assessed for any checks returned for insufficient funds.
13. Statements are sent electronically on a biweekly basis. Your remittance is due immediately upon receipt of the bill. Any patient balance not paid within 30 days of the original statement date will be considered **past due.** A **$25.00 late fee** will be assessed to accounts with balances that remain unpaid more than 30 days after the original statement date. We encourage families to contact our billing department promptly if there are any questions about a statement or if payment arrangements are needed. Billing should be contacted through your child's portal or by email to billing@pedsofnwh.com.
14. Overpayments will be refunded within thirty (30) days of a request. Refunds will be issued to the original method of payment when possible. Payments made by credit/debit will be credited back to the same card. For all other payment types, a valid credit/debit card will be required to process the refund.
15. 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.
16. Once an injection or vaccine has been prepared, it **cannot be returned to stock.** If a parent or guardian declines the injection after preparation, the **cost of the medication will be the patient's responsibility**, as insurance will not cover the charge.

Forms

1. We may charge for some forms including Family Medical Leave Act paperwork 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.
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 medical records for a fee. If you would like a printed copy the fee is $25.00 for the first 20 pages and $0.50 for each additional page. If you would like a copy of medical records on a CD/USB flash drive, we charge a flat fee of $25.00.
A release of information must be signed and 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.

Behavior/Respect Policy

Our practice is committed to maintaining a respectful and safe environment for patients, families, and staff. Abusive, threatening, or inappropriate behavior toward staff or providers will not be tolerated and may result in dismissal from the practice.

Dismissal from Practice

Our practice reserves the right to dismiss a patient for reasons including, but not limited to repeated missed appointments, failure to follow office policies, abusive behavior toward staff, or nonpayment of outstanding balances. When possible, patients will be provided with written notice and access to emergency care for 30 days while alternative care is arranged

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Pediatric & Adolescent Center of NW Houston, PA
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Signature of Understanding: Signing below indicates that you have read, understand, and agree to the policies outlined above.

Child(ren) Information:

_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Name:	DOB:
_____	_____
Parent/Guardian Printed Name	Relationship to Patient
_____	_____
Parent/Guardian Signature	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 _____

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"** _____

Pediatric & Adolescent Center of NW Houston, P.A.
www.pedsofnwh.com
455 School Street, Ste 26
Tomball, TX 77375
P: 281-374-9700 F: 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)

Pediatric & Adolescent Center of NW Houston, PA

Phone (281) 374-9700 • Fax (281) 370-8765
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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE

This consent form is required if anyone other than a parent or legal guardian brings your child to the office. This includes, but is not limited to, stepparents, grandparents, adult siblings, aunts, uncles, nannies, or family friends.

Patient Information

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Proxy Information

Name of Proxy: _____ Relation to Child: _____

Name of Proxy: _____ Relation to Child: _____

Scope of Consent

The above-named individual is authorized to:

- Accompany my child to office visits.
- Consent to routine, non-urgent medical care and treatment (e.g., physical exams, immunizations, diagnostic tests, prescriptions).
- Receive information regarding my child's care during the visit.

This authorization does not permit consent for:

- Emergency or life-threatening medical care.
- Surgical procedures
- Decisions regarding mental health treatment.

Duration of Consent

This consent is valid from the date of my signature below. I may revoke this authorization at any time in writing.

Acknowledgement

I understand that by signing this form, I am granting the above proxy the right to make healthcare decisions on behalf of my child(ren) in my absence for non-urgent care.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Proxy Date

Pediatric & Adolescent Center
of Northwest Houston

Immunization Policy Agreement

In order to initiate and maintain a patient-physician relationship within our practice, parents and guardians are required to review, agree to, and sign this Immunization Policy Agreement. A signed agreement is mandatory for establishing and continuing care in our office.

Our office follows the immunization guidelines and schedule recommended by the American Academy of Pediatrics, which emphasize the importance of routine wellness and timely vaccinations for all children.

The immunization schedule provided below outlines the recommended schedule of vaccines only and does not represent a complete schedule of all wellness visits in which vaccines are not administered. By signing this form, you acknowledge and agree to adhere to the vaccination schedule as outlined.

Our practice does not accommodate alternative or selective vaccination schedules, including the omission or refusal of individual vaccines. Refusal of recommended vaccines will result in dismissal from the practice.

Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

Wellness Visit by Age	**Vaccines Given**
2 Months	Vaxelis (Hep B, Dtap, Polio, Hib), PCV, Rotavirus
4 Months	Vaxelis (Hep B, Dtap, Polio, Hib), PCV, Rotavirus
6 Months	Vaxelis (Hep B, Dtap, Polio, Hib), PCV, Rotavirus
12 Months	MMR, Varicella
15 Months	Dtap, PCV, Hib
18 Months	Hep A
24 Months	Hep A
4 Years	MMR, Varicella, Quadracel (Dtap, Polio)
10 Years	*HPV
11 Years	Tdap, Menquadfi, *HPV
16 Years	Menquadfi, Trumenba

*HPV series (2 doses) can be started as early as age 9, but should be completed by the age of 13.
**HPV, Influenza, and COVID vaccines are recommended but optional, and are not subject to dismissal.

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