TEXAS PEDIATRIC SPECIATLIES AND
FAMILY SLEEP CENTER
REGISTRATION FORM – PEDIATRIC

(Please Print)

Referring Physician:_____ Primary Care Physician:_____

Patient's **LEGAL** Last name: _____ First:_____Middle Initial: ____

Patient date of birth ____/____/_____ Patient Ethnicity: _____

Primary home street address:_____ Apt #: _____

City:_____ State: _____ Zip:_____Social Security#: _____-____-_____

Primary parent email address: _____

Home phone ( ) _____ Cell phone ( ) _____Employer phone ( )_____

Ok to leave a voicemail at the numbers listed? Yes/No If so, preferred # ( )_____

In case of an emergency, who should we notify:_____ Phone #_____
Relationship to patient:_____

Is this person authorized to make medical decisions? Yes/No If not, please provide a contact that is authorized to make medical decisions:

Name:_____Relationship to patient: _____

INSURANCE INFORMATION

Subscriber's Name:_____ Date of Birth: ____/____/_____

Subscriber's SS #:___-____-_____ Relationship to patient:_____

Employer: _____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

Secondary Insurance: YES / NO

Subscriber's Name:_____ Date of Birth: ____/____/_____

Employer: _____

Subscriber's SS#: ___-____-_____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Medical & Sleep Specialists or my insurance company to release any information required to process my claims.

_____ _____
Signature of Parent, Guardian or Responsible Party Date

_____ _____
Printed name of parent, guardian or responsible party Relationship to patient

CLINICAL RESEARCH INTEREST FORM

Road Runner Research
"Dedicated to Finding Solutions"

Being part of a clinical research trial is a great opportunity to contribute to the constantly evolving world of medicine and participate in innovative medical treatment. Your participation could help guide the future of medicine. By participating you *may* receive:

- **Free medical evaluations**
- **Free study medication**
- **Compensation for time and travel**
- **24/7 monitoring and access to study physician**

Although it is not guaranteed that you will experience benefits from participating in clinical trials, many subjects believe that there is a positive outcome due to their involvement in research studies.

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*Patient's Name:_______________________ *Patient's DOB:__________________ Male/Female

Parent/Guardian's Name (*if above person is under 18*): ____

*Patient/Parent Phone Number: ______________________________ Best Time to contacted: _________

Mailing address: ____

Patient/Parent E-mail Address: ____

**REQUIRED INFORMATION*

Please choose one:

☐ **I DO NOT WISH TO BE CONSIDERED FOR RESEARCH AT THIS TIME.**

☐ **I AM INTERESTED IN OBTAINING INFORMATION ABOUT STUDIES.**

May we add you and/or your child's information into the Road Runner Research database (information will not be provided to any additional research sites or companies) for any possible future trials/studies so that we may contact you? ☐ **Yes** ☐ **No** If no, no information **will not** be added to the Road Runner Research database.

PLEASE SELECT THE CONDITIONS YOU WOULD LIKE TO RECEIVE INFORMATION (Please check all that apply):

[ ] ***Spasticity (Cerebral Palsy)***
[ ] ***Chronic Pain***
[ ] ***Epilepsy/Seizures***
[ ] ***Autism***
[ ] ***Attention Deficit Disorder***
[ ] **OTHER(S):** ______________________________

[ ] ***Narcolepsy***
[ ] ***Migraines***
[ ] **Tourette Syndrome**
[ ] **Fragile X Syndrome**
[ ] **Insomnia**

[ ] **Major Depression**
[ ] **Down Syndrome**
[ ] **Bi-Polar Disorder**
[ ] **Asthma**
[ ] **Allergies**

______________________________________ ______________________

Self (if over 18)**/Parent/Guardian Signature** **Date**

Electronic Prescriptions

We subscribe to an electronic prescription service. Our physicians transmit e-prescriptions via a secured internet network directly to participating pharmacies. Please list your pharmacy name, address and phone number below. TMSS has the ability to download my pharmacy benefits and medication history through a secure internet network. This will allow your physician to prescribe medications covered by your health insurance plan and also prevent any medication allergies or duplicate prescriptions from being prescribed.

By signing below, I give my permission for TMSS to download this information from the above pharmacy. **This is an OPTIONAL service provided by TMSS. If you do not wish to participate, feel free not to sign below.**

Effective October 1, 2018

All refill requests will be processed through your patient portal. Please allow 24 to 72 hours to process. You can also contact your pharmacy and your pharmacy will contact our office. We will no longer process patient phone call refill requests.

If you do not have a patient portal account, please ask the receptionist for details.

Patient's Name:
_____

Name of Pharmacy:
_____

Pharmacy Address:
_____

Pharmacy Phone #: (_____) _____ - _____

_____ _____
Patient or Guardian Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice

By signing this form, you are granting consent to Texas Pediatric Specialties and Family Sleep Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information office at: 210-249-5020.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Name (Print): _____

Signature: _____

Date: _____

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this

Acknowledgement but did not because _____

_____

Signature of Privacy Officer

Consent to Leave Messages/Share Information with Family/ Friends

I understand that for Texas Pediatric Specialties & Family Sleep Center (TPS &FSC) to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to TPS & FSC.

Consent for Leaving Messages:

I give consent to TPS & FSC to leave a message on my voicemail/answering machine about my child's lab results. I understand that "sensitive information as noted below will be excluded.

☐ Yes ☐ No

Consent for shared information with Family & Friends:

The Name(s) listed below are family members or friends to whom I grant permission for my child's health care provider and their representatives at TPS & FSC to verbally discuss their care using their best judgement and grant them permission to disclose health information that is relevant to their care.

☐ Yes ☐ No

Under the HIPPA Privacy Law we are permitted, and we may make a professional judgement that certain disclosures are in your best interest even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my/my child's protected healthcare information will be provided without my signature on a release of Information Form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check the specific boxes for my provider or his/her designee to release any "sensitive" information.

- Medical Conditions
- Mental Health/ Psychiatric disorders (including Depression)
- Chemical Dependency (Drug and/or alcohol abuse/treatment)
- Pregnancy Information

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

Patient's Name (Please Print): _____ DOB: _____

Patient or Parent\Guardian Signature: _____ DOB: _____

AUTHORIZATION FOR MEDICAL TREATMENT of a MINOR

CHILD: _____ DOB: _____

I _____ _____ _____
Legal Custody/Guardian Address (Street, City, Zip Code) Phone Number

declare I have legal custody and am the guardian of the child mentioned above. I give the following permission:

- To attend appointments with mentioned child at Texas Pediatric Specialties and Family Sleep Center
- To receive medical information for the mentioned child
- To authorize medical treatment or medical procedures for the mentioned child

_____

_____ _____ _____
Full Name (ID must be presented at DOS) Address (Street, City, Zip Code) Phone Number

_____ _____ _____
Full Name (ID must be presented at DOS) Address (Street, City, Zip Code) Phone Number

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____

Date: _____

Our Financial and Office Policies

Thank you for choosing Texas Pediatric Specialties and Family Sleep Center as your healthcare provider. We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial and office policies and complete the patient information form prior to seeing the physician. As you read, please initial beside each topic to indicate your understanding of our policies.

_____1**. Demographic Information**- Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future).

_____2.**Copay** -All co-pays, deductibles, and/or co-insurances are due at the time of service.

_____ 3. **Balances**- If you have balance on your account we will ask for payment. We accept cash, check, Visa and MasterCard. We allow 90 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 90 days, the account will be referred to collections. If your account is sent to collections, you will incur **ALL** fees associated. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

_____4**. Insurance Verification**-We verify insurance benefits as a courtesy to our patients. Not all services are a covered benefit in your medical plan. Please contact your insurance company if you have questions regarding your health care coverage. Texas Pediatric Specialties and Family Sleep Center provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy. Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract**.**

_____ 5. **Referrals**-If your appointment requires a referral from you primary care physician, that referral will need to be on file with our office before the appointment day. Please contact your primary care physician to ensure this referral is sent to our office in time for the upcoming appointment. If you are seen without a referral on file and the insurance company does not pay, you will be responsible for all charges.

★ _____6. **No Show Fee**-

- If you are more than 20 minutes late for your appointment, it is considered a **(No-Show**). A $50.00fee will be applied.
- Appointments not canceled with a **24 hour notice** will be subject to a charge of $50.00.
- After **3 "no show"** appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician. Should the physician choose not to terminate the relationship, we reserve the right to charge a $50.00 deposit for any future appointments. This deposit can be applied to any copay, co-insurance or deductible due at time of service or the deposit will cover the cost of the no show fee.

_____7. **Returned Checks**-Any personal check that is returned due to insufficient funds will be subject to a $35.00 charge in addition to the amount of the check. After one instance of a returned check, all further payments will be required to be in the form of credit card, cash or money order only.

_____8. **Medical Records**-There is a $25.00 fee for the first 20 pages and $.50 thereafter for copies of medical records not requested by another physician. The patient, parent or guardian must complete an authorization to disclose health information.

____9.**FMLA**- There is a $25.00 fee to complete any FMLA paperwork. Please allow 7-10 business days for completion.

_____10. **Prescription Refills**-ALL prescription refills are transmitted via e- prescriptions via a secured internet network directly to participating pharmacies. You can have your pharmacy submit the refill request electronically or they may fax the request. We DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication to ask your pharmacy for a refill. **We require 5 business days to respond to a refill request. Please note that we do not process refill requests on the weekends or holidays.** The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescriptions refilled.

_____11. **Triplicate prescriptions** (Triplicate prescriptions are for Schedule II controlled substances): All expired Triplicate prescriptions that are not filled must be returned to our office. Triplicate prescriptions must be filled within 21 days. There is a $5 fee for each triplicate prescription that is picked-up in a timely manner and a $25 fee for expired triplicate prescriptions (i.e. not picked-up in a timely manner). Triplicate prescriptions can be mailed certified for a fee of $25.00 in addition to the regular $5.00 refill fee.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES

_____ ____/____/_____

Signature of patient (or responsible party) **Date**

_____ _____

Printed name of patient (or responsible party) **Witness**