Child Neurology Consultants of Austin

**Welcome to our Practice!**

**PATIENT INFORMATION** (PLEASE PRINT)

Full Name: ______________________ DOB: __________ Preferred Name: ______________

Address: ______________________ City: ______________ St: _____ Zip: ______

Main Contact Phone: ______________ (check one) ☐ Cell ☐ Home ☐ Work

Alternate Phone: ______________ (check one) ☐ Cell ☐ Home ☐ Work ☐ Other ______________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Race: ______________ Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other ______________

Who referred you to us? ______________ Pediatrician / PCP: ______________

**PREFERED PHARMACY:** (Name/location/phone#) ______________________

**EMERGENCY CONTACT**

Name: ______________ Phone Number: ______________ Relationship: ______________

**PRIMARY INSURANCE** (*all information is required if insurance card has not been provided, otherwise complete the bold fields only*)

**Insurance Company:** ______________ Insurance Address: ______________

Subscriber/Member ID #: ______________ Group #: ______________

**Policy Holder/Guarantor:** ______________ ______________ ______
Last First M.I.

**Relationship to Patient:** ______________ **Date of Birth:** ______________

**ADDITIONAL INSURANCE** (if applicable)

**Insurance Company:** ______________ Insurance Address: ______________

Subscriber/Member ID #: ______________ Group #: ______________

**Policy Holder/Guarantor:** ______________ ______________ ______
Last First M.I.

**Relationship to Patient:** ______________ **Date of Birth:** ______________

## Authorization and Acknowledgement

I hereby state that the above information is true and correct to the best of my knowledge. I authorize Child Neurology Consultants of Austin to release any information acquired in the course of my treatment to my insurance company, physicians, institutions or third party payers, as required for certain claims filed.

______________________ ______________________ ______________
**Signature of Patient or Guardian** Printed Name Date

# Consent for Treatment

I hereby voluntarily consent for treatment. I permit the facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by facility personnel under the instructions, orders or direction of such physician(s).

If my physician deems necessary, I consent to the photographing or videotaping, including body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the facility.

*The undersigned certifies that he/she has read the forgoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent execute the above.*

**Signature of Patient or Guardian:** ______________________________ **Date:** ____________

**Relationship to Patient:** ______________________________________ (i.e., Self, Parent)

Patient Name: ______________________________ Date of Birth: __________ (Please Print)

# Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Child Neurology Consultants of Austin and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

**(Circle one) YES NO**

**Notice of Privacy Practice:**

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form (Rev. 06/16) for review and a personal copy to keep will be provided upon request.

**Signature of Patient or Guardian:** ______________________________ **Today's Date:** __________

**Relationship to Patient:** ______________________________________ (i.e., Self, Parent)

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## Personal Health Information Release (PHI)

This information must be completed and updated every 6 months by the patient or guardian

This release authorizes Child Neurology Consultants of Austin to discuss medical information regarding my care, condition, treatment or diagnosis with the following:

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** ____________________________________________

☐ **Parent(s) (*Specify Name of Parent(s)*):** ____________________________________________

☐ **Other *(Please specify)*:** ____________________________________________

**How may we contact you with automated messaging?**

| | | | |
|---|---|---|---|
| Health Notifications | ☐ Phone | ☐ Email | ☐ Text |
| Appointments | ☐ Phone | ☐ Email | ☐ Text |
| Announcements | ☐ Phone | ☐ Email | ☐ Text |
| Billing | ☐ Phone | ☐ Email | ☐ Text |

**When contacting you with results such as labs, x-rays, etc., please mark one or all desired:**

☐ Home Phone: ____________________ May we leave a detailed message: **YES / NO**

☐ Work Phone: ____________________ May we leave a detailed message: **YES / NO**

☐ Cell Phone: ____________________ May we leave a detailed message: **YES / NO**

**The following people may pick up medication samples and/or prescriptions on my behalf:**

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** ____________________________________________

☐ **Parent(s) (*Specify Name of Parent(s)*):** ____________________________________________

☐ **Other *(Please specify)*:** ____________________________________________

**Signature of Patient or Parent/Guardian:** ______________________________ **Today's Date:** __________

**Relationship to Patient:** ______________________________________ (i.e., Self, Parent)

Patient Name: ______________________________ Date of Birth: __________ (Please Print)

# OFFICE POLICIES

We strongly feel all patients deserve the very best medical care that we can provide. We have prepared this material to acquaint you with our office and financial policies.

**Please Initial**

***All Patients***

_______ A $25.00 reservation fee will be required when scheduling future appointments after two (2) NO-SHOW appointments. Please call 24 hours prior to your appointment time if you are unable to make it.

_______ A $25.00 charge will be assessed on all **returned** checks.

_______ I understand that if I fail to pay amounts owed the clinic has the right to secure an outside collection agency and/or attorney to collect unpaid debt. I understand that any unpaid debt will be reported to credit-reporting agencies. I further understand that I will be responsible for any additional charges or fees incurred by securing the collection agency or attorney ~ including reasonable attorney's fees.

_______ I understand that I am responsible for updating my information (i.e., insurance, address, phone numbers) with the clinic in order for them to be able to contact me for future appointments, refunds, etc. I understand I can do this by contacting the office directly or on the Patient Portal.

_______ I understand that there is a fee for copies of my medical records. I also understand that I may use the online patient portal to receive copies of part of my medical record instead.

***Insurance Patients***

_______ All co-pays are due when you check-in for your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

***Self-Pay (cash pay patients or in the event there is a lapse in insurance)***

_______ I have **NO** insurance coverage. I understand that I am responsible for payment of services rendered to myself or my dependents **<u>at the time of service</u>** (unless prior arrangements have been made and approved through the office manager.)

_______ I understand that as a self-pay patient I will receive a 20% discount for medical services provided. I also understand that if I pay I pay in full at the time of service there will be an additional 10% off medical services. (This equals 28% off medical fees.) If I do not pay in full at the time I check out, the additional discount will not be given.

***Medicare Patients***

_______ I authorize any holder of medical or other information about myself to be released to the Social Security Administration and Health Care Financial Administration, or its intermediaries or carriers, any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withhold this information.) Regulations pertaining to Medicare assignments or benefits also apply.

# WAIVER OF LIABILITY

There may be certain services that are not adequately covered by your insurance company. If the provider feels that the service is medically necessary and your insurance company denies payment, it will be your responsibility to pay for that service.

I have read and understand the payment policies listed above and agree to the terms provided.

**Signature of Patient or Guardian:** ________________________________ **Date:** _______________

**Relationship to Patient:** _____________________________________ (i.e., Self, Parent)

Patient Name: ______________________________ Date of Birth: __________ (Please Print)

# ELECTRONIC PRESCRIBING NOTICE

**What is electronic prescribing? Why does your provider E-Prescribe?**
E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Your provider participated in E-Prescribing because he/she cares about your health and well-being and E-Prescribing has multiple safety benefits.

**How does E-Prescribing work?**
Instead of writing out your prescription on a piece of paper, your provider enters it directly into the computer. Your prescription travels from your provider's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure and closed network, so your prescription information is not sent over the open Internet or as e-mail. Your E-Prescription arrives at the pharmacist's computer faster and may help to save you time. The E-Prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept E-Prescriptions, your provider can print your prescriptions for you.

**Privacy**
The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared for treatment, payment, and healthcare operations. E-Prescriptions meet this requirement.

# PATIENT CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

**Patient/Guardian Signature:** ______________________________ **Today's Date:** ________________

**Relationship to Patient:** ______________________________(i.e., Self, Parent)

**Witness Signature:** ______________________________

Patient Name: ______________________________ Date of Birth: __________ (Please Print)

# Terms and Conditions of Use for Patient Portal

**The Patient Portal allows you online access to information such as lab results and billing information; as well as having the ability to request appointments and communicate with the physician and staff. An e-mail directing you on how to register for this service will be sent to the email address provided below. You also have the right to refuse access to this service.**

**Patient Consent and Agreement:**

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for **non-emergency** purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. *If I refuse to sign at this time, I understand that I may change that decision in the future and can contact Child Neurology Consultants of Austin to obtain access to the Portal.*
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

*******PLEASE CHOOSE AN ACCESS OPTION BELOW, SIGN AND DATE*******

<table>
<tr><td colspan="2">Patient Signature<br><br>**X**</td><td>Date</td></tr>
<tr><td>☐ Patient Refused Access to the Portal</td><td colspan="2">☐ Patient Allows Access to the Portal<br><br>Please provide the email address for your individual access to the patient portal. Each portal account requires a separate email address.<br><br>EMAIL: ______________________________<br>PLEASE PRINT</td></tr>
<tr><td colspan="2">Clinical Staff Signature (witness to refusal)</td><td>Date</td></tr>
</table>

Patient Name: ______________________________ Date of Birth: __________ (Please Print)