Patient Information

Name:_____ Date:_____
Last Name First Name Middle Name

Sex: Male Female Date of Birth: _____ Soc. Security # _____-_____-_____

Home Address: _____
Street City State ZIP code

Mailing Address: _____
Street City State ZIP code

Please fill in all fields, and check which is your preferred method of contact:

Primary Ph #_____ Mother's Mobile # _____ Father's Mobile #_____

Email Address: _____ Preferred Pharmacy: _____

Whom may we thank for referring you or how did you hear about us? _____

Billing Information

_____ _____
Mother/Guardian's Name Father/Guardian's Name

Address (if different than patient): _____ Address (if different than patient): _____

_____ _____

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

Employer: _____ Employer: _____

Date of Birth: _____ Drivers Lic. # _____ Date of Birth: _____ Drivers Lic #: _____

Social Security #:_____ Social Security #: _____

Insurance Information

(Must be filled out along with photocopy of card)

Insurance Type:

_____

Cardholder Name: _____ Employer: _____

Cardholder Date of Birth:_____ Cardholder Social Security #:_____

ID#: _____ Group #: _____

Emergency Contact

In the event of an emergency, whom should we contact? (Someone other than parent/guardian)

Name: _____ Relationship to patient: _____

Home Phone #: _____ Work Phone #: _____

Release And Assignment

Because your child is a minor, it becomes necessary that a signed permission be obtain from a parent/guardian before any and/or all necessary medical services can be started and accomplished at Head Pediatrics.

I authorize the release of any medical or other information required in the processing of claims. I authorize my insurance benefits to be paid directly to the health care provider.

My signature as parent/guardian affixed below authorizes the rendering of medical services. This consent shall remain in full force and effect until canceled by either party. I understand that I am financially responsible for all charges incurred as a result of medical services rendered.

_____ _____

(Signature of Parent/Guardian) (Date)

Date: _____
Person Filling Out This Form: _____ Relationship to Child:_____

Number of adults that live with child: _____ Number of Children that live with Child: _____

PLEASE CHECK THE BOXES WHERE CHILD'S BLOOD RELATIVES HAVE ANY OF THESE PROBLEMS

	Father	Mother	Brother(s)	Sister(s)	Father's Side	Mother's Side
Allergies (Asthma, Eczema, Hayfever)						
Birth Defects (Cleft Lip, Club Foot, Hip Dysplasia)						
Blood Disorders (Bleeding, Sickle Cell, Anemia)						
Bone/Joint Disorders (Arthritis, Gout)						
Cancer (Leukemia, Breast Cancer, Tumors)						
Cholesterol Problems						
Diabetes						
Eye Problems (Blindness, Lazy Eye, Crossing Eyes)						
Gastrointestinal Disorders (Ulcer, Chron's, Celiac)						
Genetic Disorders (Down Syndrome, CF)						
Heart Disease (Heart Attack, High Blood Pressure)						
Kidney Disease (Absent Kidney, Cystic Kidney)						
Lung Disorders (Asthma, Tuberculosis)						
Muscle Disorder (Multiple Sclerosis, Stiffness)						
Nervous Disorders (Migraines, Seizures, Epilepsy)						
Psychiatric Disorders (Depression, Suicide, Schizophrenia)						
Thyroid Problems						
Venereal Disease (Syphilis, Gonorrhea, HIV)						
Alcoholism, Drug Dependency						
Smoker						
Other:						

The following information is of value in the complete examination of your child. Answering is optional and of course confidential.

Are there any problems at home we should be made aware of? _____

Are parents divorced or separated? _____

Dr. Ryan Head, MD, FAAP

VACCINATION POLICY

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by Advisory Committee for Immunization Practices (ACIP) of the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults is one of the single most important health-promoting interventions we perform as health care providers and that you can perform as parents/caregivers.

As the topic vaccinations continue to be debated, we here at Head Pediatrics believe that vaccines are vital and necessary. With that said, ***we will not accept patients that refuse or wish to delay vaccines, except for those who have a medical indication.*** Infants and children with certain medical conditions, such as leukemia, are very susceptible to these preventable diseases. Unvaccinated individuals may be harboring these illnesses, and though not outwardly sick, may pass them along to these at-risk patients in our clinic. We take the tremendous responsibility of caring for your child very seriously. This is also why vaccinations are very serious to us. We feel if we would allow children to skip or delay vaccinations it would ultimately be a disservice to your child with potentially disastrous results. This care we have for your child is the ultimate reason we require vaccinations.

I have read and understand the above vaccination policy. I agree to adhere to it and understand that should I choose to not keep my child(ren) current on their vaccinations, I will be asked to secure the services of another physician.

_____

Patient name

_____ _____

Signature of parent/guardian Date

_____ _____

Printed name of parent/guardian Relationship to patient

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Dr. Ryan Head, MD, FAAP

OFFICE POLICY & PROCEDURES

In order for each and every appointment to go as smoothly as possible and so that we can be sure that all of our patients get the same care and attention, we have implemented the following policies and procedures. Please read over them carefully.

1. **PLEASE ARRIVE FOR YOUR APPOINTMENT ON TIME.** If a patient is more than 15 minutes late for a scheduled appointment, they will need to be rescheduled to the next available appointment, which may or may not be the same day. Additionally, arriving for your appointment early will not guarantee that you will be seen earlier than your scheduled time. Dr. Head will typically see patients in the order they are scheduled, not in the order that they arrive.
2. **DO NOT LEAVE YOUR CHILDREN UNATTENDED.** Children under the age of 12 will need to have a parent/guardian/caregiver with them at all times. If you bring more than one child with you and only one is being seen, please make arrangements for either someone to come with you or otherwise care for them during the appointment time. Children 17 and under will require a parent or guardian with them for any procedures done in the office.
3. **WE DO NOT ACCEPT ANY HMO PLANS.** If you obtain health insurance coverage through an HMO plan, we will be happy to continue care on a self-pay basis.
4. **PRESCRIPTION REFILL REQUESTS REQUIRE A MINIMUM OF 48 HOURS NOTICE**. Any prescription refills not made in conjunction with an appointment will need to be requested at least 48 hours in advance. Please DO NOT wait until the medication is empty and keep weekends and holidays in mind. There will also be a fee for this service (please refer to our financial policy).
5. **IT IS YOUR RESPONSIBILITY TO KNOW WHAT FACILITIES ARE APPROVED BY YOUR INSURANCE PLAN.** In the event that it is necessary for a patient to be referred to an outside laboratory, imaging center, hospital, or other facility, it is up to the insured/responsible party to know if that facility is covered by your insurance. If you are not sure, you may contact the facility directly or request a provider directory from your insurance plan or human resources office.
6. **WALK-IN PATIENTS WILL BE SEEN ON AN URGENT BASIS ONLY.** We will not see a walk-in patient for routine care. If you come into the office for a routine follow-up, vaccination, etc. without an appointment, one will be scheduled for you at that time, which may or may not be on the same day.
7. **IT WILL BE YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGE IN HEALTH STATUS OR VISITS OUTSIDE OF OUR OFFICE THAT MAY PERTAIN TO THE PATIENT'S CARE.** If your child has a visit with another provider or goes to the emergency room or urgent care, it is your responsibility to bring this to our attention and to make sure that the other provider or facility forwards any records or results related to that visit.

(Continued on back)

8. **IT WILL BE YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FROM A PREVIOUS PROVIDER IF YOUR INSURANCE CARRIER REQUIRES ONE.** If your insurance requires a referral authorization for a patient to be seen by a specialist, it will be your responsibility to not only be aware of that requirement but also to obtain that referral AT LEAST THREE (3) BUSINESS DAYS PRIOR TO arriving for your scheduled appointment.
9. **IT WILL BE YOUR RESPONSIBILITY TO KEEP US UP-TO-DATE WITH CURRENT CONTACT INFORMATION.** Please let us know as soon as possible when any changes in personal or business phone numbers or physical and mailing addresses are made. We need to be able to get in touch with you for appointment reminders, test results, billing questions, etc., in a timely manner.
10. **PLEASE LET US KNOW IMMEDIATELY IF THERE ARE ANY CHANGES THAT COULD EFFECT PATIENT CARE OR WELL BEING.** Changes at home, school, etc., that could effect a patient's care or well being should be brought to our attention as soon as possible. Changes in living conditions, academic difficulties, changes in appetite or mood, or even the death of a loved one or pet can effect a patient's health. Please make us aware of any change, so that we can address or be sensitive to new issues as needed.

I have read and understand the above office policies and agree to adhere to them.

_____

Patient name

_____ _____

Signature of parent/guardian Date

_____ _____

Printed name of parent/guardian Relationship to patient

head
PEDIATRICS

Dr. Ryan Head, MD, FAAP

FINANCIAL POLICIES

At Head Pediatrics we are committed to treating all of our patients with the highest quality of care and respect. In order to make sure that your account is handled in the most efficient manner and to get the maximum benefit from your insurance carrier or to avoid any discrepancies in billing, we have implemented the following policies and are providing a copy of them to our patients' parents, guardians, and/or responsible parties. It is important that you have a clear understanding of, and cooperate with, these policies. All questions concerning your billing should be directed to our billing office at (800) 893-3557. Their hours are Monday through Friday, 7:30am to 5:30pm CST. Also, please keep in mind that none of the fees addressed in this financial policy are covered by insurance except for co-pays, co-insurances, etc., that might be covered if you have a secondary insurance or Medicaid.

1. **PAYMENT WILL BE DUE IN FULL AT THE TIME OF SERVICE.** Any fees, co-pays, co-insurance percentages, or deductible amounts will be due the day the patient(s) is seen.
2. **WHOEVER BRINGS THE PATIENT IN IS RESPONSIBLE FOR PAYMENT.** Grandparents, aunts, uncles, caregivers, etc., will be expected to bring payment in with them. In the case of court-ordered custody arrangements, whichever parent brings the child in will be responsible for full payment at the time of service. It will not be Head Pediatrics' responsibility to bill the other party nor will we intervene to determine how responsibility of payment will be split.
3. **CURRENT & CORRECT INSURANCE INFORMATION MUST BE PROVIDED PRIOR TO YOUR APPOINTMENT.** If there is a change in the patient's insurance, please let us know as soon as possible so we can verify benefits. Ideally, we should be notified prior to the appointment. If we are not notified prior to the next scheduled appointment, be prepared for a delay in being seen or even being rescheduled. If we are not notified of any insurance changes in a timely manner, this could possibly result in you being responsible for all charges. Most insurance companies have filing deadlines, some as short as 90 days. If you have not given us correct information and a claim does not get paid due to the time limit expiring, this will be come YOUR financial responsibility.
4. **A NO CALL/NO SHOW MISSED APPOINEMENT WILL RESULT IN A $25.00 FEE.** We realize that there are unexpected events or unforeseen circumstances that necessitate missing an appointment. However, please have the courtesy of notifying our office at least three hours prior to your appointment time so that we might adjust our schedule accordingly. The first two appointments missed in this manner will be assessed a $25.00 fee that MUST BE PAID PRIOR TO the next scheduled appointment. If a third appointment is missed in this manner, your family will be asked to secure the services of another physician within 30 days.

(Continued on back)

5. **IN THE EVENT THAT DR. HEAD ADDRESSES AN ISSUE AFTER HOURS VIA TELEPHONE, THERE WILL BE A FEE.** All after hours telephone calls will be $25.00, payable at the next appointment.
6. **THERE WILL BE A FEE FOR PRESCRIPTIONS THAT ARE NOT WRITTEN OR FILLED IN CONJUNCTION WITH AN APPOINTMENT.** Please make sure that all medication needs are addressed during your scheduled appointment, otherwise there will be a $5.00 fee.
7. **EACH PATIENT WILL BE ALLOWED ONE FREE FORM FILLED OUT PER CALENDAR YEAR, BUT THERE WILL BE A FEE ASSESSED FOR ANY ADDITIONAL FORMS FILLED OUT AND THAT FEE WILL BE DUE WHEN THE FORM(S) IS DROPPED OFF IN OUR OFFICE.** Forms for sports, camp, school, etc., will require payment to be completed, as they do take time. There is a five-day turn around time and the fee will be $5.00. If you need the forms sooner than five days, there will be an additional $10 rush fee. Keep in mind that at certain times of the year (beginning of the school year, beginning of various sports seasons, etc.) our office will get a larger influx of forms requests, so please don't wait until the last minute to bring them to us.
8. **THERE WILL BE A FEE FOR RETURNED CHECKS.** In the event a payment is rejected by your financial institution due to insufficient funds or for any other reason, there will be a $30.00 fee **IN ADDITION TO** the original amount of the payment.

I understand and agree to the terms and conditions of the above financial policies for Head Pediatrics and I have asked any questions and requested any clarification necessary for me to comfortably agree.

_____

Patient name

_____ _____

Signature of parent/guardian Date

_____ _____

Printed name of parent/guardian Relationship to patient

Dr. Ryan Head, MD, FAAP

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We most follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect May 26, 2015, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We are permitted to use and disclose your medical information to those involved in your treatment.

Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you.

Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification or (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information for marketing communications without your written authorization.

Public Health, Abuse or Neglect, and Health Oversight: We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. Texas law requires physicians to report child abuse or neglect.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors: We may release medical information to organ procurement organizations if you are a donor. We may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

National Security and Law Enforcement Agencies: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: Unless you specify otherwise, in writing, we may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request a copy of

your records by contacting our Medical Records office. You may request access to review your records by sending us a letter to the address at the end of this Notice. Federal and Texas State Laws permit us to charge a reasonable cost based fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before May 26, 2015. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required t agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

(Continued on back)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Attention: Privacy Officer Telephone: (936) 305-5050

Address: 2714 N University Drive, Suite 100 Nacogdoches, TX 75965

Head Pediatrics

Acknowledgement of Review of Notice of Privacy Practices

*****You may refuse to sign this acknowledgement*****

*****You may request a copy of the Notice of Privacy Practices*****

I, _____ [name of parent/guardian], have reviewed/received a copy of this office's Notice of Privacy Practices. Please list all current patients this acknowledgement applies to [patient's name(s)]:

_____

_____ _____

Signature of parent/guardian Date

_____ _____

Printed name of parent/guardian Relationship to patient

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (please specify)

Standard Authorization of Use and Disclosure of Protected Health Information

Information to be Used or Disclosed

The information covered by this authorization includes:

- Operative/Procedure Report
  Dated_____
- Pathology Report
  Dated_____
- Office Notes
  Dated_____
- Insurance Information
  Dated_____

Other:_____

_____

_____

Patient Information

Patient's Name: _____

Address: _____

Telephone Number: _____

Date of Birth:_____ SS#:_____

I, the undersigned, AUTHORIZE to release my medical records, including but not limited to a report of my diagnosis, treatment, prognosis and recommendations as well as data pertinent to any treatment I receive during the time that I was a patient, to:

Provider/Etc.. Name: Ryan E Head, MD, FAAP

Address: 2714 N. University Drive, Suite 100

Nacogdoches, TX 75965

Phone/Fax 936-305-5050 / 936-305-5151

This authorization covers dates of patient care from _____ to _____. I, the undersigned, understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire six months from the date of signature.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Signature of Witness Date

Released by:_____ _____

Date

Mode of Release: Mail Fax Given to Patient

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Ryan Head, MD, FAAP

The following person(s), aside from parents/legal guardians, are authorized to access my child's medical information and have permission to bring my child to appointments and make medical decisions on my behalf.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Name: _____ Date: _____
(Please print)

Parent/Guardian's Name: _____
(Please print)

Parent/Guardian's Signature: _____