New Patient Packet

Child or Children's Full Names:

_____Sex: M F DOB: _____/_____/_____

Siblings Name_____ Sex: M F DOB: _____/_____/_____

Siblings Name_____ Sex: M F DOB: _____/_____/_____

Siblings Name_____ Sex: M F DOB: _____/_____/_____

Address_____

City_____ State_____ Zip_____

Who referred patients? _____

***All patients must be fully vaccinated and adhere to regular vaccine schedule.**

***If the New Patients are not newborn, immunizations must be provided at the very least a day before the patient's first well child appointment.**

Race (circle all that apply): American Indian or Alaska Native; Asian; Black or African-American; Native Hawaiian or Other Pacific Islander; White; Other Race; Recipient Refused

Ethnicity (circle only one): Hispanic or Latino; Not Hispanic or Latino; Recipient Refused

Religion: _____

Parent's Full Name _____ Date of Birth _____

Parent's Home Address (if different from above) _____

Parent's EMAIL _____

Cell Phone # _____ SSN# _____-_____-_____

Driver's License # _____ State _____ Exp. Date _____

Parent's Full Name _____ Date of Birth _____

Parent's Home Address (if different from above) _____

Parent's EMAIL _____

Cell Phone # _____ SSN# _____-_____-_____

Driver's License # _____ State _____ Exp. Date _____

Would you like to sign up for **MyChart** and have access to your children's medical records online?

☐ Yes ☐ No

Preferred Pharmacy: (Brand name & 2 major cross roads)

_____

Did you call your insurance company or go online to make sure Dr. Matthew Simon or Dr. Tiffany Lieu was in network with you insurance?

☐ Yes ☐ No

We MUST have a copy of your insurance card.

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number _____ Copay _____

Patient's Relationship to Subscriber: (Circle One) Self Child

Subscriber's full name _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone # _____ Alternate Phone # _____

Date of Birth _____/_____/_____ SSN# _____ - _____ - _____

Please sign to verify that all information above is correct and valid.

_____
Name of Child or Children

_____
Date

X _____
Signature of Parent or Guardian

PAST MEDICAL HISTORY

Child's Name _____

Place of Birth _____ Birth Weight _____

Pregnancy and Birth Problems _____

Prior Hospitalizations _____

Prior Surgeries _____

Chronic Medical Problems _____

Food or Medication Allergies _____

FAMILY HEALTH PROBLEMS: IDENTIFY PROBLEM AND RELATIONSHIP TO CHILD

☐ **No former conditions presented in family history**

Description	Problem	Relationship to Child
SKIN (Dermatitis, Birthmarks, Etc)		
EYE, EAR, NOSE, THROAT (Visual, Hearing, Infections, Allergies, Cleft Lip)		
LUNGS (Asthma, Tuberculosis, Emphysema, Reactive Airways Disease)		
IMMUNOLOGIC (Receiving Chemotherapy or Steroids, AIDS)		
HEART (Heart Disease, Stroke, High Blood Pressure, High Cholesterol)		
BLOOD DISORDERS (Anemia, Sickle Cell Disease)		
STOMACH (Ulcers, Pyloric Stenosis, Liver Disease, Diarrhea, Constipation)		
KIDNEY (Urinary Tract Infections, Renal Failure)		
ENDOCRINE (Thyroid Disease, Diabetes)		
BONE/MUSCLE (Dislocated Hip, Arthritis, Scoliosis)		
NERVOUS (Headaches, Seizures, Learning Problems, Mental Illness, Mental Retardation)		
OTHER (Cancer, Obesity, Cystic Fibrosis, Birth Defects, Alcoholism)		

PAYMENT POLICY

1. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim. Please bring your insurance card to every visit and notify us of any new changes.

2. All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience, we accept MasterCard, Visa, Discover and American Express. You may make credit card payments via the phone. Hot check writers will be charged a $30 fee and may be referred to the Dallas County District Attorney's office and/or sent to our collection agency.

3. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days, we will require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.

4. Please be aware that some of the services you receive may not be covered by your insurance company. You will be responsible for payment of all charges for services not covered by your insurance company.

5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment. If you do not give adequate notice, you may be charged $25.00.

6. Self-pay families will receive a prompt pay discount, which is due at the time of service.

7. Families with higher balances or extreme circumstances may contact our office to discuss a payment plan.

8. Statements are sent monthly. To save on postage, we do not bill for balances less than $5.00. Credits will be applied to your next visit.

Child or Children's Names

X _____ _____

Signature of Parent/Guardian **Date**

Text, Voice, and Automated Messaging Consent

I authorize Children's Health Mobile Messaging to sent communications by text message Voice and automated calls to the cell phone number I provide. I acknowledge that message and standard data rates and fees will apply, message frequency rates may vary, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify the patient's health care needs. Children's Health Mobile Messaging privacy policy and SMS terms of service are available at childrens.com/footer/policies-procedures. Text HELP to 77444 for mobile messaging assistance, or text STOP to 77444 to opt out of Children's Health Mobile Messaging.

Note: Recipients of text, voice, and / or automated messaging may opt-out at any time. Reminders are included on how to opt-out upon initial text and annually thereafter.

Child or Children's names:_____

_____

Parent Guardian Signature:_____

Date: _____/_____/____

CONSENT TO TREAT

I give consent for diagnosis and treatment to Park Cities Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available upon request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request.

CARE EVERYWHERE CONSENT

Care Everywhere is a way to receive and send medical records electronically with other facilities that have the same medical records program. By signing below you authorize Park Cities Pediatrics to receive/send medical records when they are available or needed.

☐ I do **NOT** want to participate in Care Everywhere

ASSIGNMENT OF BENEFITS

I hereby assign Park Cities Pediatrics all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Park Cities Pediatrics and I will be responsible for any charges accrued and not paid by the insurance company. I am responsible for all co-pays, deductibles, co-insurance and non-covered services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my child's medical information by Park Cities Pediatrics to any consulting physician, hospital, and third-party payers such as insurance companies, government agencies, self insurance employer or utilization review organization.

This document remains in effect unless revoked in writing.

_____

Child or Children's Names

X _____ _____

Signature of Parent/Guardian **Date**

HIPAA INFORMATION FORM

Matthew L. Simon, MD
Tiffany J. Lieu, MD
8215 Westchester Dr Suite 150 Dallas, Texas 75225
Phone: 214-361-7185 Fax: 214-373-4841

PATIENT'S NAME: _____ **DATE OF BIRTH:** ____/____/____

Brother or Sister's Name_____ Sex: M F DOB: ____/____/____

Brother or Sister's Name_____ Sex: M F DOB: ____/____/____

Brother or Sister's Name_____ Sex: M F DOB: ____/____/____

(CHECK THE BOX THAT APPLIES)

( ) **I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASE TO THE FOLLOWING:** THIS FORM'S PURPOSE IS TO DESIGNATE ANYONE BESIDES THOSE THAT ARE LISTED IN THE PARENT 1 AND PARENT 2 SECTION AS PERSONS WITH ACCESS TO YOUR CHILDREN'S MEDICAL INFORMATION. IF THERE IS NOT ANYONE THAT YOU WOULD LIKE TO DESIGNATE PLEASE CHECK THE SECOND BOX.

1. _____
2. _____
3. _____

( ) **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**

SIGNED: _____ **DATE:** _____

You are able to sign in advance to witnessing. The act of the signee turning in the paperwork is evident.

WITNESSED: _____ **DATE:** _____

****THIS RELEASE WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ **Date of Birth:** _____

City, state, zip: _____ **Phone number:** _____

I, the undersigned, authorize/request the below named medical office / doctor to release my medical records.

_____

Name of physician / office / clinic / hospital

Phone number _____ Fax number or email _____

Please release my medical records to the following:

Matthew L. Simon, M.D.; Tiffany J. Lieu, M.D.
Park Cities Pediatrics, PA
8215 Westchester Dr. Ste. 150
Dallas, TX. 75225
(Phone) 214-361-7185 (Fax) 214-373-4841

This request and authorization applies to:

☐ All medical records

☐ Immunization Records

☐ Other: _____

Parent/Guardian Signature: _____ Date Signed: _____