GALAXY PEDIATRICS

556 BLUEBIRD LN, RED OAK, TX 75154 PHONE: 972-617-6660 FAX: 469-218-0070

Date _____ Referred by _____

Patient Last Name _____ First Name _____ MI _____

Date of Birth _____ Gender (Male) _____ (Female) _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Email _____

Mother's Name _____ Last Name _____

Date of Birth _____ Driver License # _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Occupation _____

Work Phone _____ Cell Phone _____

Father's Name _____ Last Name _____

Date of Birth _____ Driver License # _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Occupation _____

Work Phone _____ Cell Phone _____

Patient lives with: _____

List all children under age 18:

Name _____ Gender: M / F Date of birth _____

Name _____ Gender: M / F Date of birth _____

Name _____ Gender: M / F Date of birth _____

Name _____ Gender: M / F Date of birth _____

EMERGENCY CONTACT (**Must be Completed**) Not living with you:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Phone (s) _____

Explanation of Payment Policy

We accept cash, check, debit card payment and credit cards (Visa, MasterCard, Discover or American Express). Payment for services is due and payable at the time the services are rendered.

All payments on unmet deductibles and co-pays are due in full at the time of service. If outdated or invalid information has been given to our office, payment in full is the responsibility of the parent/guarantor.

All insurance benefits from claims filed by GALAXY PEDIATRICS. prior to payment in full are assigned to his practice. In the event the insurance is cancelled, the services provided are not covered, or covered only in part, the undersigned is responsible for full payment for services rendered.

I, the undersigned, realize that all medical charges incurred by my dependent child for services rendered by GALAXY PEDIATRICS. are my financial responsibility and all fees necessary to collect my account are payable by me. I also, agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the fee charged by the agency.

Signature _____ Patient's Name _____

Date _____

Authorization for Treatment

I authorize the Physicians of GALAXY PEDIATRICS., or anyone they designate, to treat (Patient's Name): _____ as considered necessary in my absence.

Signature _____ Date _____

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FINANCIAL POLICY

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relation ship. Everyone is treated equally and fairly.

INSURANCE: Payment for services are due at the same time services are rendered, except as outlined below. "Payment" means deductibles, co-insurance and co-pays for participating insurance companies. We accept cash, checks, Master Card, Visa, Discover and American Express. Outstanding balances are due within 30 days, unless prior arrangements have been made with our billing department. **All personal balances over 90 days will be sent to a collection agency.** Even though we verify coverage, insurance plan vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to know your insurance policy benefits. NOT EMERGENT APPOINTMENTS, i.e. physicals, well child checks, etc. will have to be rescheduled if there are outstanding balances or co-pay is not paid at the same time of service. If you are experiencing financial difficulty, please let us know.

BILLING: We can provide you with an itemized statement each time your child receives services. A $ 10.00 rebilling fee will be charged to you if payment is not made at the time services or if you do not furnish us with correct insurance information. A $ 25.00 fee will be charged for all returned checks, and future payments need to be made by cash, money order or credit card.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of you account. Charges remaining unpaid ninety (90) days after the date of service are considered delinquent and will be sent to a collection agency.

IF WE DO PARTICIPATE WITH YOU INSURANCE COMPANY, all services performed in our office and at the hospital will be submitted to your insurance. Do not file your own claim, by contract, we have to do it. All co-pays are due at time of service. Deductibles and co-insurance are your responsibility and will be billed to you by our office as instructed by your insurance's explanation of benefits. Therefore, any balances

not covered by insurance and allowed by contract become the responsibility of the patient. Again, payment for services is due at the time of services.

MISSED APPOINTMENTS / LATE CANCELATIONS: Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge for late, cancelled or missed appointments. Cancellations are requested 24 hours prior to the appointment.

MEDICAL RECORDS: Please note they will charge you a fee for this service. A chart summary and/or shot record will be provided by our office for a nominal fee.

FORMS AND FEES: There is a $ 10.00 fee for the review and completion of school/day care forms not provided to us at the time of the well child exam. Please, complete all demographics and medical history portion before giving the form to our staff.

REFERRALS: If your insurance plan requires a written referral in order for your child to see a specialist, or for procedures and/or, lab test, you must allow us five business days to complete the appropriate form(s) prior to obtaining services. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first. It is important that if questions arise, you contact your insurance company directly for final guidance and clarification.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTANS THE FINANCIAL POLICY SET FORTH BY GALAXY PEDIATRICS. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTIONS IN ADDITION TH THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME.

Signature of Parent and/or Responsible Person: _____

Date: _____ Witness: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA,) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may ne involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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AVISO DE RECONOCIMIENTO DE LAS PRÁCTICAS DE PRIVACIDAD

Entiendo que según la ley de portabilidad y rendición de cuentas de seguro médico de 1996 (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi protegida información médica. Entiendo que esta información puede y será usado para:

- Planificar y dirigir el tratamiento y seguimiento entre todos los proveedores médicos y/o organizaciones dde salud que puedan estar envueltos en el tratamiento médico, directa o indirectamente.
-Obtener el pago por servicios médicos prestados.
-Realizar las operaciones normales de la salud tales como evaluaciones de calidad y certificaciones para los médicos y esta organización.

He recibido, leído y entiendo su aviso de privacidad que contiene una descripción más completa de los usos y revelaciones de mi información de salud. Entiendo que esta organización tiene el derecho de cambiar este aviso de prácticas de privacidad de vez en cuando y que puedo contactar esta organización en cualquier momento a la dirección anterior para obtener una copia actualizada del aviso de prácticas de privacidad. Entiendo que puedo pedir por escrito que se restrinja el cómo mi información privada es usada o divulgada para llevar a cabo operaciones de tratamiento, pago o cuidado de la salud. También entiendo no es requisto que esta organizacion acepte dichas restricciones, pero en caso de aceptarlas, está obligada a regirse por ellas.

Patient's Name (Nombre del Paciente) _____

Name of Parent or Guardian (Nombre Padre, madre o encargado) _____

Signature Parent or Guardian (Firma padre, madre o encargado) _____

Date (fecha) _____

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Family & Patient's Past History

Patient's Name _____ Date of Birth _____

Health problems of Patient's parents: _____

Health Problems of Patient's siblings: _____

Use this list below to identify any illnesses that run in the family or that are in the past history of the patient. Feel free to add any other illnesses not included in the list.

Condition	**No**	If yes for ***FAMILIY MEMBER,*** identify relationship.	If yes for **PATIENT**, indicate age when diagnosed or appearance of first symptoms.
Allergies			
Anemia			
Asthma, Emphysema			
Birth Defects			
Blood Disease			
Bone / Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Chicken Pox Disease			
Diabetes ( ) Adult / ( ) Juvenile			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Hearth Disease			
High Blood Pressure			
Hyperactivity			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Never Disorder (Epilepsy, C.P.)			
Obesity			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			

Complete and explain when applicable FOR THE PATIENT ONLY

Hospitalizations or surgeries?_____

Any adverse reaction to medications?_____

Any adverse reaction to immunizations?_____

Does your child hear/see well?_____

Does your child seem to be developing normally?_____

Is your child's speech understandable most of the time?_____

Does your child have any current problems? _____