PEDIATRIC WOUND CARE AND LASER SPECIALISTS, PA

PATIENT INFORMATION

Please print clearly

Patient's Name _____ Date _____

Birthdate _____ Age _____ Sex: Male ☐ Female ☐ SSN _____

Address _____ Phone _____

City _____ State _____ Zip _____

Referring Doctor _____ Phone _____

Primary Doctor _____ Phone _____

Reason for visit _____ _____

Current Medications _____

Does the patient have any known drug allergies? N ☐ Y ☐ Name of drug(s) _____

Are immunizations up to date? Y ☐ N ☐ Pharmacy name & number_____

Parent/Guardian Name _____ Relationship to Patient _____

Work Phone _____ E-Mail Address _____ Cell Phone _____

EMERGENCY CONTACT Name _____ Phone _____

INSURANCE & BILLING INFORMATION

Name of individual responsible for this account _____

Name of Insurance Company to be Billed _____

Member ID Number _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Birthdate _____ Subscriber SSN _____

Subscriber Employer _____ Employer Phone _____

Subscriber Address (*if different from patient's)* _____

City _____ State _____ Zip _____

Do you have a secondary insurance? No ☐ Yes ☐

Name of secondary insurance company _____

Subscriber Name _____ Member ID number_____

Patient Name: _____ DOB: _____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I understand as part of my healthcare, Pediatric Wound Care and Laser Specialists, PA. originates and maintains health records describing my examination and test results, diagnoses, treatment and any plans for future care or treatment.

***I understand that this medical record serves as*:**
A basis for documenting my care and treatment.
A means of communicating to other healthcare professionals who contribute to my care.
A source of information to clarify billing.
A means by which a third party payer can verify that services billed were actually provided.
A tool for assessing the quality and competence of the care I received.

I understand that I have the right:
To object to the use of my health information for directory purposes.
To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my medical records:

_____

_____

☐ I have no restrictions to the use of my medical records as described above

_____ _____
Signature of Patient or Legal Representative/Parent Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMEMT

I acknowledge that the Notice of Privacy Practices has been provided to me and I understand my rights as a patient of this practice.

_____ _____
Signature of Legal Representative/Parent Date

Patient Name: _____ DOB: _____

Financial Policy

Your child has been referred to Dr. Amaya and colleagues for evaluation and treatment of a complex wound and/or a condition that would benefit from laser therapy. Our practice is committed to providing you with quality medical care and our professional fees have been determined through careful consideration. We believe these fees are reasonable and reflect the service and expertise provided by a medical specialist. In order to prevent any misunderstandings and to serve you better, we ask that all parents read and sign our Financial Policy. If you have any questions, please ask to speak to a representative from our business office.

As a courtesy, we will verify your insurance eligibility and benefits prior to or at your initial visit and any time you notify us of a change in your coverage. However, we cannot guarantee that the information we receive is accurate (at the time of verification or for later visits) or that the insurance company will process the claim in accordance with the information they provide. You as the holder of the insurance policy are ultimately responsible for knowing what your plan does and does not cover (such as an evaluation by a specialist) and the administrative rules (authorizations and referrals). You are also responsible for verifying that our physicians are participating in your insurance plan. Although our practice has made a determined effort to enroll in every insurance plan available in the Houston area, in some situations our physicians may not be contracted by your insurance plan and would file the claim as an out-of-network provider. Any amounts not covered by your plan, except for contractual fee discounts, are your responsibility.

Please read and initial each item below.

1. _____ **CO-PAYMENTS/COINSURANCE, DEDUCTIBLES AND BILLING FEES**. I understand that at the time of my appointment any copayments, deductibles or other fees that are required by my insurance will be paid in full. Cash, checks, Visa, and Mastercard are accepted. My insurance company will be advised that I have paid these fees.

2. _____ **BALANCE DUE PER THE EXPLANATION OF BENEFITS (EOB).** After my insurance plan has processed the insurance claim, any balance is due upon receipt of the bill from the office. Bills are submitted to patients on a monthly basis. If I disagree with the amounts due per the EOB, it is my responsibility to immediately contact our practice's billing office (281-412-2494) and my insurance plan for resolution of the problem. I understand that I may not withhold payment to Dr. Amaya and his colleagues pending resolution of insurance problems. If the insurance corrects the problem, I understand I will be promptly refunded any overpaid amounts.

3. _____ **INSURANCE COMPANY DENIAL OF PAYMENT.** If despite proper submission and coding of the claim, the insurance carrier denies payment to Dr. Amaya and colleagues based on a contractual non-covered benefit, I will be responsible for the entire balance and I will be billed directly. I understand that the office will not become involved in disputes between myself and my insurance company regarding deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges" other than to supply factual information when necessary. I understand I will be promptly refunded any amount the insurance carrier subsequently pays.

4. _____ **LAB TESTING**. I understand that as the policy holder, it is my responsibility to be aware of the coverage for lab testing. Although the office will ensure that I am sent to a contracted lab, specific tests may not be paid by my insurance. I am encouraged to verify that the requested labs are covered prior to performing these tests. All unpaid balances are the responsibilities of the policy holder.

5. _____ **ACCURATE INSURANCE INFORMATION** must be provided before my child is seen. Failure to provide correct insurance information may result in the entire bill being my own responsibility. Furthermore, your insurance company may on occasion request additional information directly from you. These include requests to verify if other insurance coverage exists, details of accidents/injuries etc. Failure to provide this information in a timely manner may result denial of payment and in the entire bill being my own responsibility.

6. _____ **UNACCOMPANIED MINORS**. An unaccompanied minor must have written authorization for medical treatment signed by a parent or guardian. As with any office visit, the parent or guardian is responsible for providing current insurance information for the patient and payment of copay, fees or balances.

Patient Name: _____ DOB: _____

7. _____ **FEE FOR SERVICE CHARGES.** In the event that my child loses or has no insurance coverage and I wish to initiate or continue treatment with Pediatric Wound Care and Laser Specialists, PA, arrangements will be made for me to pay a fee at the time of each office visit. These fees may vary based on the treatment and procedure performed. I will have the right to decline these procedures if desired.

8. _____ **COLLECTION AGENCY:** Unless prior payment arrangements have been agreed upon, I understand that if I allow my account balance to exceed 90 days, the account will be turned over to a collection agency and may be reported to the major credit bureaus.

9. _____ **RETURNED CHECKS** will incur a $25 fee. The check will be redeposited the first time it is returned from the bank. If it is returned a second time and additional $25 fee will be posted to the account and I will be asked to pay the entire balance by cash, money order or credit card within 10 days of notification of the problem.

If you have any questions regarding the above policies, please do not hesitate to ask. Please sign below to acknowledge your understanding of the entire policy and that you are provided a copy at your request.

_____ _____
Signature of Parent or Guarantor Date

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Pediatric Wound Care and Laser Specialists, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Pediatric Wound Care and Laser Specialists, PA may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent or Guarantor Date

MEDICAL RECORDS

Our office can gladly provide you with a copy of your child's medical records with a written request. These records will be made available to you within 2 -3 business days from the time of your request.

Medical records can ONLY be mailed or picked up at our main Memorial City location. The fee for this service is $15.00 and will be collected at the time of the initial request and prior to delivery of the records.

_____ _____
Signature of Parent or Guarantor Date