AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

CEDAR PARK
1301 Medical Parkway, Suite 310
Cedar Park, TX 78613

PHONE: 512-472-6134
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General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guarantee has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education. **Test results will not be discussed over the phone.**

I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to "patient," "me," and "my" in this document means: *_______________________________ (name of patient).

Electronic Medical Records

Your child's records are shared with their primary care provider to allow and promote continuity of care. Your child's records will not be released to anyone else without your express consent.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows heath care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/ patient relationship exists.

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting.

I acknowledge that I have received a HIPAA Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact us at 512-472-6134.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Name of Patient: * ____

Patient's Date of Birth (MM/DD/YYYY): * ___________________________

Signature of Patient (or responsible party if a minor): *____

Date: * ___________________________

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Past Medical History

Patient Name: * ______________________________

Date of Birth: * ______________________________

Medications

Current medications: * ______________________________

Allergies

List all known allergies (medications, foods, or environmental): * ______________________________

Previous Hospitalization(s): *Symptom & Date*

* ______________________________

Previous Surgeries: *Procedure & Date*

* ______________________________

Has your child had any blood transfusions? **No** ____ **Yes** ____

Has your child been circumcised? **No** ____ **Yes** ____ When? ______________________

Medical Conditions/Problems

*Please list any other known medical issues:

____

Reason for today's visit: * ______________________________

Has your child had any lab test or x-rays for this problem? **No** ___ **Yes** ___

If YES which test, when and where were they performed? ______________________________

____

Pharmacy Name: * ______________________ Pharmacy Address: * ______________________

Questions for Prenatal Only

When is your Due Date? ______________________ Who will be the Baby's PCP? ______________________

Who is your Obstetrician? ______________________ Which Hospital will you deliver? ______________________

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Past Medical History

Social History

Parent 1 occupation: * ________________________________

Parent 2 occupation: ________________________________

Please list names and ages of siblings:

____

____

____

Who lives in the Household? ____________________________

Child's daytime activities

Home **No** ____ **Yes** ___
Daycare **No** ____ **Yes** ___
Recreation/Sports **No** ____ **Yes** ___

List sports: ____

Birth History

Illness during the pregnancy of this child:

No ___ **Yes** ___ Explain: ____________________________

Medications taken during pregnancy:

No ___ **Yes** ___ Explain: ____________________________

Delivery: **Full Term** ____

Pre-Term ____ # of weeks ________________

Late: _____

Problems during delivery:

No ___ **Yes** ___ Explain: ________________________

____

Family history

Please list any family members (parent, sibling, grandparent, or other relatives) who have had any of the following medical conditions:

Condition	No	Yes	If yes, relation:
Bleeding Disorder	No ____	Yes ____	If yes, relation: ____________
Anesthesia Complication	No ____	Yes ____	If yes, relation: ____________
Kidney Failure	No ____	Yes ____	If yes, relation: ____________
Kidney Stones	No ____	Yes ____	If yes, relation: ____________
UTI	No ____	Yes ____	If yes, relation: ____________
Hydronephrosis "extra urine in kidney"	No ____	Yes ____	If yes, relation: ____________
Hypospadias "urine opening too low"	No ____	Yes ____	If yes, relation: ____________
Diabetes	No ____	Yes ____	If yes, relation: ____________
Hypertension	No ____	Yes ____	If yes, relation: ____________
Vesicoureteral Reflux	No ____	Yes ____	If yes, relation: ____________
Other	No ____	Yes ____	If yes, relation: ____________

Patient Past Medical History

Condition	No	Yes
Ear/Eye Problems	No ___	Yes ___
Seizures	No ___	Yes ___
Heart Problems/Murmurs	No ___	Yes ___
Pneumonia	No ___	Yes ___
Diarrhea/Constipation	No ___	Yes ___
Frequent Nosebleeds/Bruising	No ___	Yes ___
Anesthesia Problems	No ___	Yes ___
Diabetes	No ___	Yes ___
Developmental Problems	No ___	Yes ___
Psychiatric Problems	No ___	Yes ___
Nose/Sinus/Throat Problems	No ___	Yes ___
Headaches/Dizziness	No ___	Yes ___
Asthma/Bronchitis	No ___	Yes ___
Stomach Problems	No ___	Yes ___
Bleeding/Clotting Problems	No ___	Yes ___
Sickle Cell disease Trait G6PD	No ___	Yes ___
Cancers	No ___	Yes ___
Behavioral/Emotional Problems	No ___	Yes ___
School Problems	No ___	Yes ___
Muscle/Bone Problems	No ___	Yes ___

Name of Patient: * ________________________________

Signature of Patient (or responsible party if a minor): * ________________________________

Date: * ____________________

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Patient Information

Patient

Last Name: * ______________________ First Name: * ______________________ Nickname: ______________________

Date of Birth: * ______________________ Patient SSN: ______________________ Gender: * Male ____ Female ____ Non-binary ____

Race: American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or other Pacific Islander ___ White ___

Other: ______________________ Decline: ____

Ethnicity: Hispanic/Latin ___ Not Hispanic/Latin ___ Other: ______________________ Decline: ____

Who referred you? (Please CHECK one) FAMILY ___ FRIEND ___ PHYSICIAN REFERRAL ___ WEBSITE ___

Person referring you: ______________________ Primary Care Doctor: * ______________________ Phone: * ______________

In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient.

NAME: * ______________________ **RELATIONSHIP: *** ______________________

NAME: ______________________ **RELATIONSHIP:** ______________________

Parent 1

Last Name: * ______________________ First Name: * ______________________ DOB: * ______________ Social Security #: * ______________

Street Address:* ______________________ City: * ______________ State: * ____ Zip: * __________

Cell Phone: * ______________ Secondary Phone: * ______________ Email: * ______________________

*Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Parent 2

Last Name: ______________________ First Name ______________________ DOB: ______________ Social Security #: ______________

Street Address: ______________________ City: ______________ State: _______ Zip: _________

Cell Phone: ______________ Secondary Phone: ______________ Email: ______________________

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Emergency Contact

Last Name: * ______________________ First Name: * ______________________ Relation: * ______________________

Cell Phone: * ______________________ Secondary Phone: * ______________________

Primary Insurance

Policy Holder

Last Name: * ______________________ First Name: * ______________________ Policy Holder's Birth Date: * ______________

Insurance Provider: * ______________________ Insurance ID Number: * ______________________ Group Number: * ______________

Provider Phone Number (from insurance card): * ______________ Policy Holder's SSN: * ______________ Relation to Patient: * ____________

Secondary Insurance

Policy Holder

Last Name: ______________________ First Name: ______________________ Policy Holder's Birth Date: ______________

Insurance Provider: ______________________ Insurance ID Number: ______________________ Group Number: ______________

Provider Phone Number (from insurance card): ______________ Policy Holder's SSN: ______________ Relation to Patient: ____________

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER(S) - (Check all that apply)

___ **HOME TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WORK TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **MOBILE TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WRITTEN COMMUNICATION**
- ___ OK to mail to home address

___ **PATIENT PORTAL**

Email: * ____

PLEASE INITIAL

***____ I acknowledge I have reviewed the HIPAA Notice of Privacy Practices policy at childrensurology.com. This can be found at: childrensurology.com/Patient Information/Forms & Information/HIPAA Notice of Privacy Practices.

I hereby give authorization for payment of insurance benefits to be made directly to Pediatrix Urology of Central Texas for services rendered.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

Name of Patient: * ____

Signature of Patient (or responsible party if a minor): * ______________________________ Date: * _______________

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PATIENT FINANCIAL POLICY

PATIENT NAME: *____ **PATIENT DATE OF BIRTH:*** ____________________

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. For your convenience we accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

INSURANCE (PLEASE INITIAL)

*____Insurance plans subject to a deductible will be charged $150 at Check-In and the balance collected at Check-Out.

*____I acknowledge that I have disclosed all insurance coverages. My primary insurance will not pay the claim(s) if they suspect other insurance coverage.

*____We have contracted with many insurers and health plans to accept assignment of benefits. This means we will bill those plans and will only require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service.

*____ It is the responsibility of the guarantor to know the benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **IF YOU DO NOT HAVE A CURRENT REFERRAL OR AUTHORIZATION ON FILE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.**

*____ In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

*____ Surgery deposits are due 10 business days prior to surgery. If for any reason surgery needs to be canceled it must be done 10 business days prior to the surgery date or a **$150 cancellation fee** may be charged to the parents.

SELF-PAY PATIENTS

*____ If you do not have insurance you will be considered a self-pay patient. Before seeing the doctor you need to make a deposit of **$150.** If the ENTIRE account is paid in FULL we will apply a 30% discount to your account. If you are unable to pay the entire account in full you will not receive the 30% discount. You will also need to make payment arrangements at CHECK-OUT with a credit card to pay the balance in full within **3 months.**

*____ We use a billing service. For any billing questions call 512-600-0125 for assistance.

*____ Telemedicine fees are $175 for new patients and $150 for established patients.

We accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

ESTIMATES

*____ Upon request, our staff provides an estimate of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider.

FEES

*____I understand that in the opinion of our Providers, the services or items that I have requested to be provided to me at Pediatrix Urology of Central Texas may not be covered under my insurance as being reasonable and medically necessary for my care. I understand my health insurance plan determines the medical necessity of the services or items I request and receive. If my plan determines these services and/or items are not reasonable and medically necessary for my care, I am responsible for payment for the services or items I received.

*____I understand lab work is sent to a reference lab. Pediatrix Urology of Central Texas will provide the reference lab your insurance information necessary to submit a claim. Any charges incurred are my responsibility to pay.

*____**FEES FOR FORM COMPLETION:**
I understand I will be responsible for paying **$25** for forms completed by my physician or staff (Example: Disability forms, FMLA forms, etc.). There is a **$50** fee for Immigration forms/ letters.

*____**FEES FOR "NO SHOW":**
I understand that a **$60** "no show" fee may be assessed for appointments that I do not keep.

I understand that a **$150** "no show" fee may be assessed for in-office procedure appointments and surgical center procedures that I do not keep.

Medicaid Members: No shows will be reported to your health plan.

*____**FEE FOR MEDICAL RECORDS: $25**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

NAME OF PATIENT*____

SIGNATURE OF PATIENT
OR RESPONSIBLE PARTY IF A MINOR *____ DATE*____________________

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Policy for Divorced or Separated Parents

Pediatrix Urology of Central Texas providers and staff are dedicated to our patients and to providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, and psychological health. We are not party to or involved in any legal issues involving divorce, separation or custody agreements. Please read and sign the following so that we may provide care to your child(ren).

1. The physicians, nurses, medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments and office procedures **PRIOR** to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Pediatrix Urology of Central Texas must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treatment" form that authorizes any named individuals (grandparents, nannies etc.) to bring your child to our practice, be present during the visit, and consent to treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. We reserve the right to charge an administrative fee for copying records should the requests become excessive.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless required by law, or tolerate appointment scheduling/canceling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collections process will be due at the next time of service.
8. Should the issues that come between parents become disruptive to our clinic or there is non-compliance with this policy, we may immediately terminate the patient/provider relationship. Your PCP will be notified.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Please List Children - Name and Date of Birth (DOB):

Child's Name	DOB	Child's Name	DOB
Child's Name	DOB	Child's Name	DOB

Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date
Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date