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

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FAX 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

CEDAR PARK
1301 Medical Parkway, Suite 310
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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. **Test results will not be discussed over the phone.**
2. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
3. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
4. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Pediatrix Urology of Central Texas at 512-472-6134.
6. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services and that Pediatrix Urology of Central Texas HIPAA notice of privacy practices is available on www.childrensurology.com.
7. I understand I have received information to file a complaint or that I can access it on www.childrensurology.com.
8. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. **Insurance:**
      i. I understand that health plan payment policies for telemedicine visits vary. I am responsible for any co-payments and/or deductibles.
      ii. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. **Self-Pay:**
      i. I understand that New Patients may be billed a fee of $175 and Established Patients may be billed a fee of $150 if insurance does not cover my telemedicine visit.
9. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

_____ _____
*Patient Name *Date of Birth (DOB)

_____ _____
*Parent/Guardian Printed Name *Parent/Guardian Signature

_____ _____
*Relationship to Patient *Date

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Telemedicine Patient Intake Form

Patient Name: *_____ DOB: *_____

Primary Care Physician (PCP): *_____

Last visit with PCP: *_____ Reason:* _____

Estimated Height: *_____ Ft. ***_____** In. **Estimated Weight: *_____** Lbs.

Current Medications: * _____

_____

Allergies: *_____

Preferred Pharmacy: *_____

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Parent/Guardian Name (Printed): *_____

Parent/Guardian Signature: *_____

Relationship to Patient: *_____ 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? _____

_____

What Pharmacy do you use? *_____

Location of Pharmacy: *_____

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:

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

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 ___	

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

NAME OF PATIENT *_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF A MINOR *_____ **DATE** *_____

*Required Field

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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.

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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