



•PATIENT INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) \_\_\_\_\_ SEX MALE / FEMALE DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

SIBLING (FIRST, MIDDLE, LAST) \_\_\_\_\_ SEX MALE / FEMALE DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

SIBLING (FIRST, MIDDLE, LAST) \_\_\_\_\_ SEX MALE / FEMALE DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ MOBILE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SOCIAL SECURITY NUMBER (SSN OPTIONAL): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME OF PHARMACY: \_\_\_\_\_ PHARMACY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

•PARENT/GUARDIAN INFORMATION

FATHER'S/GUARDIAN'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN CHILD): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ MOBILE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER CONTACT: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

MOTHER'S/GUARDIAN'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS (IF DIFFERENT THAN CHILD): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ MOBILE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER CONTACT: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

•EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

HOME NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

•INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ POLICY/ID NUMBER \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

GROUP/ACCOUNT NUMBER \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

CLAIM MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

INSURANCE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER RELATIONSHIP TO PATIENT: SELF / CHILD / SPOUSE

SECONDARY INSURANCE: \_\_\_\_\_ POLICY/ID NUMBER \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ (MM/DD/YYYY)

GROUP/ACCOUNT NUMBER \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

CLAIM MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

INSURANCE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER RELATIONSHIP TO PATIENT: SELF / CHILD / SPOUSE

• **PAYING INSURANCE BENEFITS**

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO MACARTHUR PEDIATRICS. THIS ASSIGNMENT IS FOR SERVICES RENDERED TO ME BY MACARTHUR PEDIATRICS THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY MYSELF IN WRITING. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THIS PAYMENT. I UNDERSTAND THAT FAILURE TO NOTIFY MACARTHUR PEDIATRICS OF ANY CHANGES OF INSURANCE COVERAGE WILL RESULT IN THE FINANCIAL OBLIGATION TO REST FULLY ON MYSELF REGARDLESS OF ANY CONTRACT BETWEEN THE INSURANCE COMPANY AND MACARTHUR FAMILY MEDICINE.

\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF BIRTH IN MM/DD/YYYY)

\_\_\_\_\_  
(SIGNATURE OF PATIENT/GUARDIAN)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF SIGNATURE IN MM/DD/YYYY)

• **HIPAA DISCLOSURE**

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT MACARTHUR PEDIATRICS, OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY MACARTHUR PEDIATRICS TO: A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY THROUGH MACARTHUR PEDIATRICS OR NETWORKING ORGANIZATIONS, AND D) CONSENT TO PROPERTY TRANSFER OF SPECIMEN (TISSUE OBTAINED DURING MEDICAL TESTING) TO MACARTHUR PEDIATRICS.

I HAVE BEEN INFORMED BY YOU OF 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 ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MY OFFICE OR BY CONTACTING THEM AT 3501 N. MACARTHUR BLVD., SUITE 450, IRVING, TX 75062. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF BIRTH IN MM/DD/YYYY)

\_\_\_\_\_  
(SIGNATURE OF PATIENT/GUARDIAN)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF SIGNATURE IN MM/DD/YYYY)

• **RELEASE OF INFORMATION**

\_\_\_\_\_ MACARTHUR PEDIATRICS MAY NOT DISCUSS CHILD'S HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.

\_\_\_\_\_ MACARTHUR PEDIATRICS MAY DISCUSS CHILD'S HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

•FINANCIAL POLICY PATIENT CONSENT FORM

MACARTHUR PEDIATRICS RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDER REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

- I. PAYMENT: PAYMENT IS EXPECTED AT THE TIME OF SERVICE. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a \$25.00 charge for returned checks. If not paid within sixty (60) days, MacArthur Pediatrics will begin various collection activities including, but not limited by submitting the past due account to a collection agency.
II. SELF PAYMENT (PRIVATE, CASH PAYMENT): If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional services.
III. MANAGED CARE: ALL MANAGED CARE (HM, PPM, etc.) CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.
IV. MEDICARE: MacArthur Pediatrics is a participating provider with the Medicare Program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.
V. CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of MacArthur Pediatrics.
VI. MINORS: If the patient is a minor, he/she must be accompanied by a Parent/Guardian/Appointed Agent for each office visit. If the patient is to be seen without the Parent/Legal Guardian, prior consent must be given in writing and signed by the Parent/Legal Guardian. Any appointed agent listed below may bring the minor to any appointment scheduled. We will maintain a copy of this consent within the minor's electronic health record.

Appointed Agents (optional):

Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

VII. CLINICAL RESEARCH: MacArthur Pediatrics participates in clinical research studies, and MacArthur Pediatrics Physicians are compensated (receive money) by the study sponsors to perform research trials. You hereby authorize MacArthur Pediatrics to access your medical information for the purpose of evaluating your eligibility to partake in such clinical research studies. You also agree to be contacted by MacArthur Family Medicine regarding the possibility of being enrolled in such a research study. You are UNDER NO OBLIGATION to enroll in any study. Study participation is voluntary and refusal to participate will in no way involve penalty or loss of benefits to which you are otherwise entitled. Refusal to participate in a research study will not affect your continuing care with a MacArthur Pediatrics Physician. Participation in a research study will not interrupt your regular care with a MacArthur Pediatrics Physician.

VIII. SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. You agree to provide such information as outlined below. You agree to notify provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.

Initial/Complete as applicable:

\_\_\_\_\_ I have NO SECONDARY INSURANCE COVERAGE

\_\_\_\_\_ I have SECONADARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM

MacArthur Pediatrics firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (972) 786-0330.

\_\_\_\_\_  
PATIENT NAME (PLEASE PRINT)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF BIRTH IN MM/DD/YYYY)

\_\_\_\_\_  
SIGNATURE OF INSURED/GUARDIAN

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(DATE OF SIGNATURE IN MM/DD/YYYY)

**•MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Child's Health History**

Who lives in the household with your child? \_\_\_\_\_

Was the baby born at term? If no, how many weeks? \_\_\_\_\_

Were there any prenatal or neonatal complications? \_\_\_\_\_

Was the delivery: \_\_\_\_\_ Vaginal \_\_\_\_\_ Cesarean If Cesarean, why? \_\_\_\_\_

Was a NICU stay required? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, for how long? \_\_\_\_\_

Allergies to medications (explain) \_\_\_\_\_

Adverse reactions following Immunizations (explain) \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Surgeries \_\_\_\_\_

Emergency Room Visits \_\_\_\_\_

Does your child seem to be developing normally? \_\_\_\_\_

Does your child hear well? \_\_\_\_\_

Does your child see well? \_\_\_\_\_

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

Age when toilet trained \_\_\_\_\_

Does your child have any current problems? \_\_\_\_\_

Do you have any concerns about your child? \_\_\_\_\_

Has your child ever had any of the following? If yes, please list age.

Condition	No	Yes	Age
Allergies			
Anemia			
Asthma			
Bleeding			
Cancer			
Chicken Pox			
Constipation, Chronic			
Convulsions			
Developmental Delay			
Diabetes			
Diarrhea, Chronic			
Ear or Hearing Problems			
Eye or Vision Problems			
Fractures or Concussions			
Heart Problems			
High Blood Pressure			
Liver or Kidney Problems			
Leukemia			
Measles			
Meningitis			
Metabolic or Genetic Problems			
Obesity			
Pneumonia			
Psychiatric Illness			
Recurrent Skin Problems			
Scarlet Fever			
Sickle Cell			
Thyroid Problems			
Tonsillitis			
Whooping Cough			
Other			

•MEDICAL HISTORY (Cont.)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Family History**

Age of child's mother at delivery: \_\_\_\_\_ Father: \_\_\_\_\_ Siblings: \_\_\_\_\_

Health Problems of child's parents: \_\_\_\_\_

Health Problems of child's siblings: \_\_\_\_\_

*(Complete applicable information for all age patients)*

**C. List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.**

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, T.B.			
Birth Defects			
Blood Disease			
Bone/Muscle Disease			
Cancer (specify)			
Childhood Hearing Loss			
Cystic Fibrosis			
Diabetes ( ) Adult ( ) Juvenile			
Drug/Alcohol Abuse			
Epilepsy			
Eye/Ear Disorders			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Nerve Disorder (Epilepsy, C. P.)			
Obesity			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			

***This concludes the new patient paperwork; please return to the front desk to submit your information.***

3501 N. MacArthur Blvd., Ste. 450 Irving, TX 75062 • Main: (972) 786-0330 • Fax (866) 630-6348 • [www.macarthurmc.com](http://www.macarthurmc.com)

Susan Powell, M.D.

Rachana Dixit, M.D.

Melisa DeMassi, DNP

Cassandra Wright, DNP