MacArthur PEDIATRICS

NEW PATIENT PACKET - NEWBORN

•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, IRIVING, 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 Family Medicine.**

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 Family Medicine Physicians are compensated (receive money) by the study sponsors to perform research trials. You hereby authorize MacArthur Family Medicine 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 Family Medicine Physician. Participation in a research study will not interrupt your regular care with a MacArthur Pediatrics Provider.**

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: _____

A. Mother's Prenatal History

Number of pregnancies _____ Number of living children _____ Name of Obstetrician _____

Did you have any of the following health problems during your pregnancy?

Bleeding: ____ Yes ____ No High Blood Pressure: ____ Yes ____ No Surgery: ____ Yes ____ No Anemia: ____ Yes ____ No

Infections: ____ Yes ____ No Accidents: ____ Yes ____ No Swelling: ____ Yes ____ No Other: _____

Were any of the following used or taken during your pregnancy? Medications _____ Cigarettes _____ Alcohol_____ Drugs_____

B. Birth History

Where was your child born? _____ Number of weeks pregnant: _____

Was labor induced? ____ Yes ____ No Hours of labor: _____ Was this a multiple birth: _____

Medications: _____ Type of delivery: ☐ Vaginal ☐ Forceps ☐ Cesarean

Problems or complications during labor or delivery: _____

Child's Birth Weight: _____ Length: _____ APGAR Score: _____

Type of feeding: Breast _____ Formula _____ Both_____

Did the child have problems in the hospital? (check all that apply) Breathing _____ Color _____ Feeding ____ Temperature _____ Other _____

Allergies to any medications: _____

Is newborn taking any medications? ____ Yes ____ No

Did the child go home with you? ____ Yes ____ No If no, when? _____ Discharge weight: _____

C. Family History

Age of child's mother at delivery: _____ Father: _____ Siblings: _____

Health Problems of child's parents: _____

Health Problems of child's siblings: _____

D. 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)			
Cystic Fibrosis			
Diabetes ( ) Adult ( ) Juvenile			
Drug/Alcohol Abuse			
Eye/Ear Disorders			
Heart Disease			
High Blood Pressure			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Nerve Disorder (Epilepsy, C. P.)			
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.

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