PEGASUS PEDIATRICS

1020 Townsend Ave.
San Antonio, TX 78209

Patient History Form

Child's Name:	Date of Birth:	E-mail Address:
Are there any vaccines you do not plan to give your child (excepting HPV and Influenza)? Yes / No Are you planning on an alternate vaccine schedule that you have not discussed with our physician? Yes / No		

If you answered yes to either question above, please see the front desk now.

Race Ethnicity:	[] White, Non-Hispanic [] Black, Non-Hispanic [] Hispanic [] Asian [] Native American
	[] Native Hawaiian and Other Pacific Islander [] Other:

PAST MEDICAL HISTORY

Birth Hospital:	Pregnancy Problems?	[] N	[] Y	Problem in the nursery	[] N	[] Y
Birth Weight:	Labor/delivery Prob?	[] N	[] Y	Baby home with Mom	[] N	[] Y
Discharge Weight:	---- with Mother	[] N	[] Y	Breast Fed?	[] N	[] Y
Discharge Date:	---- with Baby	[] N	[] Y	How Long?		
Hepatitis B Vaccine given in Hospital?		[] N	[] Y			
Pregnancy Duration:						
Did either parent have Developmental Hip Dysplasia (dislocated hip in infancy)? **Y N**						
Did your baby have a breech presentation during the 3rd Trimester? **Y N**						
Problems with your child in first few months of life?						
Chronic illnesses/injuries (asthma for example)?						
Hospitalizations/Surgeries?						
Behavior Issues?						
School Issues?						
Interests/ Activities:						
Location of previous pediatric care:						

Allergic to any medications?	[] No	[] Yes	List
Adverse reaction to medication?	[] No	[] Yes	List
Allergic to any foods?	[] No	[] Yes	List
Other allergies?	[] No	[] Yes	List

MEDICATIONS

List all medications your child currently takes including prescription medications, over-the-counter medications and herbal remedies **(please include dose if known)**

SOCIAL HISTORY

Mother's First Name:	Age:	Occupation:
Father's First Name:	Age:	Occupation"
Parents Married? [] Yes [] No		Parents living together? [] Yes [] No
Child's Daytime caregiver?		
Please list Name/Relationship of everyone living in your home:		

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Name:

FAMILY HISTORY

Please check if there is a family history of the medical problems noted below

(mother, father siblings, grandparents, aunts, uncles and cousins)

Problem	Relationship to child	Problem	Relationship to child
[] ADD		[] Eczema	
[] Alcohol Abuse		[] Heart Disease	
[] Allergy		[] High BP	
[] Asthma		[] Kidney	
[] Birth Defects		[] Mental Illness	
[] Cancer		[] Obesity	
[] Skin Cancer		[] School Problems	
[] Cholesterol High		[] Seizures	
[] Development		[] Stomach/Bowel	
[] Diabetes		[] Thyroid	
[] Drug Abuse			

Any other medical condition that "runs in the family"?

DEVELOPMENT/ BEHAVIOR

Problems with eating?	[] N [] Y	Problems in School?	[] N [] Y
Problems with sleeping?	[] N [] Y	Problems with peers/siblings?	[] N [] Y
Problems with elimination?	[] N [] Y	Problems with toilet training?	[] N [] Y
Problems with temper?	[] N [] Y	Problems with behavior?	[] N [] Y
At what age did your child sit alone?		At what age did your child speak words?	
At what age did your child walk?			
Do you have any concerns about your child's development?			

SAFETY/ ENVIRONMENT

Does your child always wear a seat belt?	[] N [] Y	Are there any smokers in the house?	[] N [] Y
Does you child always wear a helmet?	[] N [] Y	Does your home contain lead paint?	[] N [] Y
Do you have working smoke detectors	[] N [] Y	Do you have firearms in the house?	[] N [] Y
Do you have a carbon monoxide detector?	[] N [] Y	If yes, is ammunitions stored separately?	[] N [] Y

TUBERCULOSIS SCREEN

Has your child had a chronic cough?	[] N [] Y
Has your child lived with or spent time with anyone who was positive for tuberculosis?	[] N [] Y
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis?	[] N [] Y
Has anyone in your household come to the United States from another country?	[] N [] Y
Has you child lived with or spent time with adults who were homeless, lived in a shelter?	[] N [] Y
Has your child lived with or spent time with adults who have AIDS or are infected with HIV	[] N [] Y
Has your child lived with or spent time with adults who used intravenous drugs or street drugs?	[] N [] Y
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home, or mental institution?	[] N [] Y

If you child has had a positive skin test for tuberculosis in the past, inform your child's health care provider. Your child will not need another test.

OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH PHYSICIAN

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

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FINANCIAL POLICY

Thank you for selecting *Pegasus Pediatrics* as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, VISA, MasterCard, and Discover.

1. Your insurance policy is a contract between you, (your employer), and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges."

   We are, however, contracted with most managed care plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

2. *Co-payments as well as, unmet deductible amounts are due at the time of treatment and are the responsibility of the designated person bringing the child to the office.* All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions.

3. Co-Payments not paid at the time of service are subject to a $10 processing fee. All balances more than 60 days past due are subject to a penalty of $10 per month to cover the cost of sending additional statements.

4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay within 60 days, you will be responsible for payment.

5. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party.

6. Please note that all cancellations must be made at least 24 hours in advance, which allows us to care for other patients in need of our services. If you fail to cancel your appointment, you may be charged a $25 service fee which will not be covered by your insurance plan.

7. There will be a $25 NSF charge on all returned checks.

8. Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the Office Manager.

9. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our Office Manager, so that we can assist you in management of your account with a payment plan.

   I give permission to *Pegasus Pediatrics* to convert any paper check or check by phone to an electronic transaction.

   Again, thank you for choosing *Pegasus Pediatrics*. We appreciate the opportunity to serve you.

Parent/Guardian Name:_____ Child's Name:_____

Signature: _____ Date:_____

1020 Townsend Ave, San Antonio, Texas 78209 Phone 210-370-3061 Fax 210-370-3064

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Release Information To:
Benjamin L. Smith MD.
Pegasus Pediatrics
1020 Townsend Ave .
San Antonio, Texas 78209
Phone: 210-370-3061
Fax: 210-370-3064

From:
Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

Information to Release:

☐ Complete Medical Record
☐ Immunization Record
☐ Other _____

Reason for Release of Information:

☐ Change of Physician
☐ Personal Use
☐ Attorney / Legal
☐ Change of Insurance Please specify your new carrier _____
☐ Other _____

Informed Consent for Release of Confidential Information.

I understand that I may revoke this consent in writing at anytime except to the extent action has already been taken.
I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment and test results.
I understand that the information released is for the specific purpose stated above.
I understand that my medical records may contain reports only a physician can interpret.
I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
I will not hold Pegasus Pediatrics and Adolescents liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of patient or legal representative Date

_____
Relationship to patient

PEGASUS PEDIATRICS

Patient Registration Form

Thank you for choosing Pegasus Pediatrics for the care of your children. Please assist us in collecting the appropriate demographic information about your family to assist us in filing your insurance claims efficiently.

Child's Name: _____ DOB _____ M F

How were you referred to our office? [ ] Friend / Family / Coworker _____
[ ] Internet [ ] Phonebook [ ] Insurance Company[ ] MD _____
[ ] Other _____

Sibling's Names: First and Last

_____DOB _____ M F
_____DOB _____ M F
_____DOB _____ M F
_____DOB _____ M F

Child's Address

_____

Apt #: _____ City: _____ St: _____ Zip: _____

Home Phone Number: _____Parents: Married ___ Divorced ___
Separated ___ Single ___ Child lives with: Mother ___ Father ___ Other :
Name: _____ Relationship: _____

Mother _____	**Father _____**
Employer _____	**Employer _____**
License # _____	**License # _____**
Cell # _____	**Cell # _____**
Work # _____	**Work # _____**
E-Mail _____	**E-Mail _____**

[ ] Self-Pay [ ] Insurance coverage

PRIMARY INSURANCE

_____

Claims mailing address

_____

Member ID # _____ Group # _____

SS # _____ Employer _____

Insured Parent _____DOB _____

Person responsible for payment of account
Name_____

Address_____

Apt #: _____ **City:** _____ **St:** _____ **Zip:**_____

Phone # _____**Email**_____

Relationship to Child _____

Are all of the children listed above covered by the same policy? Y N

SECONDARY INSURANCE

_____

Claims mailing address_____

Member ID # _____ **Group #**_____

SS # _____ **Employer**_____

Insured Parent _____ **DOB**_____

Office Use:
Reviewed by _____ ***Ins verified by*** _____ ***Updated by*** _____

Emergency Contact Information (someone other than parents)

Name: _____ **Relationship** _____**Phone #**_____
Name: _____ **Relationship** _____**Phone #**_____

Please list the person(s) that you authorize to accompany and give consent for treatment to the child at appointment time, other than a parent or step-parent. If at any time you wish to terminate this authorization you must notify our office in writing of necessary changes.

Name _____ **Relationship** _____

Name _____ **Relationship**_____

Name _____ **Relationship** _____

I understand that if any of the above information changes that it is my responsibility to provide Pegasus Pediatrics with a written update of information indicating all necessary changes.

I understand that my primary insurance company will be billed for me but that all co-pays, co-insurance, non-covered items and deductible amounts are due at the time of service. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment of the charges until the dispute has been resolved and the insurance company makes payment on the charges in question. Lastly, I authorize insurance benefits to be paid directly to the physician and the release of any medical records that may be required by the insurance company in order to pay out those benefits. This assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original. In event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees and all courts costs.

Signature _____ **Date** _____
Relationship to patient [ ] Mother [ ] Father [ ] Other _____

PEGASUS PEDIATRICS

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information. **PLEASE REVIEW CAREFULLY.**

Uses and Disclosures

Treatment.
Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments.
Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations.
Your health information may be used as necessary to support the daily activities of Pegasus Pediatrics. As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal.
Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization.
Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information.
Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights.

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Pegasus Pediatrics Practice Responsibilities.

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices.

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information.

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or
medical reasons to deny the request.

For more information about HIPAA:

US Department of Health & Human Services
202-619-0257 Toll Free: 1-877-696-6775

Child's Name:_____

Parent/Guardian Name:_____

Signature: _____

Date:_____