PEDIATRIC DIAGNOSTIC SERVICES, PA
Ildiko G. Edenhoffer MD

Patient Registration / Forma de Registracion

Patient Last Name (Appellido): _____ **First (Primer Nombre):** _____
Address (Direccion): _____
City (Ciudad): _____ State (Estado): _____ Zip (Codigo Postal): _____
Phone Number (Telefono / casa): _____ Age (Edad): _____
Date of Birth (Fecha de Nacimiento): _____ Sex (Sexo) : Male / Female
Social Security # (Numero de Seguro Social): _____

Mother's or Legal Guardian's Name (Nombre de la Madre): _____
Address (Direccion) : _____
City (Cuidad): _____ State (Estado): ____ Zip (Codigo Postal): _____
Date of Birth (Fecha de Nacimiento):_____ SS# (Numero de Seguro): _____
Home Phone (Telefono / Casa): _____ Work Phone(Trabajo):_____
Cell Phone(Cellular): _____Occupation:_____ Employer(Empleador):_____
E-mail: _____ Pharmacy Name/Phone:_____
Emergency Contact (Contacto de Emergencia): _____Relation: _____
Emergency Phone (Telefono de Emergencia): _____

Father's or Legal Guardian#2 Name (Nombre de la Padre):_____
Address (Direccion) : _____
City (Ciudad) : _____ State (Estado): _____ Zip (Codigo): _____
Date of Birth (Fecha de Nacimiento): _____SS# (Numero de Seguro): _____
Home Ph (Telefono / Casa): _____Work Phone:(Trabajo):_____
Cell Ph(Cellular): _____ Occupation:_____ Employer(Emperador) _____
E-mail:_____

Primary Insurance (Nombre de Aseguranza): _____
Address (Direccion) : _____
Phone (Telefono): _____ Effective Date (Fecha de Efecto): _____
Policy Number (Numero de Poliza): _____Group (Grupo): _____
Name of Policy Holder (Nombre): _____ DOB (Fecha de Nacimiento): _____

Secondary Insurance (Nombre de Asegurado): _____
Address (Direction):_____Effective Date (Fecha de Efecto)_____
Phone Number (Telefono): _____Name of Policy Holder(Nombre):_____
Policy # (Numero de Poliza): _____ Group (Grupo):_____
Name of Policy Holder (Nombre) _____ DOB (Fecha de Nacimiento:_____

Please note: This registration form can only be filled out and signed by legal guardian or parent. ID is required.

Signature: _____Relationship to patient: _____**Date:** ____-_____-_____

PF-1000

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY BEFORE SIGNING THE CONSENT FORM.

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, diagnosing medical conditions and providing treatment. For example, the physician in the practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician or other specialists with information about your particular condition so that he or she can appropriately treat you for the other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health care professionals who may provide treatment or who may consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you may be received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed 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. However, your decision to revoke the authorization will not effect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the time and management of your medical condition. We may also send you some information describing other health related products and services that we believe might interest you.

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

The right to request restrictions on the use and disclosure of your protected health information
The right to receive confidential communications concerning your mm medical condition and treatment
The right to inspect and copy your protected health information
The right to amend or submit corrections to your protected health information
The right to receive an accounting of how and to whom your protected health information has been disclosed
The right to receive a printed copy of this notice

Practice Duties

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

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our private practices and policies. These changes in our policies and practices may be required changes in federal and state laws and regulations. Upon request we will provide you the most recent notice on any visit. The revised policies and practices will be applies to all health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by the Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your rights have been violated, you should call the matter to attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.
You may also send a letter outlining your concerns to the US Department of Health and Human Services.

Contact Person: Privacy Officer : Ildiko edenhoffer 9947 N MacAthur Blvd Irving, TX 75063 (972) 969- 4230

KID'S KLINIC
9947 N. MACARTHUR BLVD.
IRVING, TX 75063
(972) 969-4230

PF 2000 ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses of disclosures we make of your protected health information, and all of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing the consent.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Right to revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed on the Privacy Practice. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Our practice reserves the right to modify the practices outlined in the notice.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare questions.

Signature: _____ Date: _____

If a personal representative on the behalf of the patient signs this consent, please complete the following:

Personal Representative's Name: _____

Relationship to patient: _____

Kid's Klinic Financial Policy
12/1/12

Dear Parent,

Welcome to Kid's Klinic. Please take a few moments to review our Financial Policy. The following is a summary of our financial policy:

1. **Payment is expected at the time services are rendered.** This includes co-payments, coinsurance payments and deductibles. **Please do not ask us to waive co-payments**; it is considered a breach of the insurance contract and it can lead to denial of payment by the insurance company.
2. **We accept Cash, Money Orders and Credit cards**. **WE DO NOT ACCEPT CHECKS AT THIS TIME.**
3. **If your child is brought to the clinic by a relative or a friend, payment is still expected at the time of service**.
4. **In case of divorce or other changes in guardianship, please bring legal papers and inform our office about the responsible party for the payments**.
5. **Please inform our office of all billing address changes and changes of phone numbers at the time of check in**.
6. If you have insurance coverage, as a courtesy to you, **Kid's Klinic will bill your insurance company**, so you will not need to file your own claims. In order for us to be able to verify coverage and effectively submit charges we need you to **bring your proof of insurance to EACH and every visit**. This includes Medicaid or Medicaid type insurance papers as well. Specifically bring to our attention **any changes** (new card, new group number etc.)
7. **You are responsible for the outstanding balance, if:**
    - **at the time of your visit you are not covered by Insurance or Medicaid;**
    - **your coverage lapsed or had not been renewed.**
    - **you did not provide us with accurate information for example billing address, responsible party or insurance information etc. and when we re-bill with the correct information the claim now is outside of timely filing limits.**

8. **If you have HMO please make sure that the PROVIDER NAME on your card has been changed to Ildiko Edenhoffer MD. The insurance will deny payment if it has not been changed PRIOR TO THE VISIT and in that case you will be responsible to pay in full for the charges occurred.**

9. **We recommend that you check your benefits with your Insurance Company PRIOR TO THE VISIT to avoid unpleasant surprises.** Many Insurance companies limit the amount they will pay for some services, like yearly physicals and well child visits or part of services given at the time of the check up, like vision and hearing checks, or certain laboratory testing. Please check if you have "well visit reimbursement frequency or limitations".**In all cases, you are expected to pay for amounts your insurance company deems fair, but which do not exceed the contracted reimbursement limits.**

10. **We highly recommend that your child receive all "Well Child Check-ups" and all of the recommended childhood immunizations. However, if you know that your insurance company does not cover these services or part of these services, you have the option to receive this service from us on cash pay and receive free vaccinations provided by the state (TVFC Vaccines) or visit our State Health Department for immunizations. No child should go un-immunized!**
11. **If you have multiple coverage, make sure you let us know which insurance is the primary insurance. If you have multiple coverage that includes Medicaid, Medicaid always considered secondary. We have to bill the primary carrier first, so please bring your primary insurance information with you.** Not having this information will result of the denial of the claim, which delays us receiving the payments and you might be found responsible for the charges occurred.
12. **If for reasons that you failed to give us accurate information and we have not received payment from the insurance company in 45 DAYS you will be expected to pay the balance in full. You may want to resubmit the claims so you receive reimbursement.** We will be glad to provide you with the necessary information for re-submitting claims.
13. **We will bill you** (and a letter will be sent to the address you provided) **for your portion of the charges that is left after we have received payment from the insurance company. You have 30 DAYS to pay your balance, after 30 days it is considered overdue. (**As mentioned above if at that point you pay in full at the window you will receive a 5% discount.) **After the 30 days your balance is overdue and a "late fee" of $5 will be added to your balance to cover the expenses of billing you again. At that point a second letter will be sent to notify you. Patients with outstanding balances of grater then 60 DAYS overdue must make arrangements for payment prior to scheduling a visit and if balances go unpaid for 90 days your account will be sent for collections.** We realize that people have financial difficulties.
14. **Your insurance company might deny payment for the following reasons**:
    -There is a preexisting illness or condition that they do not cover.
    -You have not met your full calendar year deductible.
    -The type of medical services requested are not covered.
    -The insurance was not in effect at the time of service.
    -You have other insurance that needs to be filed first.
    -You have exceeded the dollar/visit amount allowed.
    -You did not have a referral number for your visit.
    -You have failed to change the name of the PCP on the card.

If your insurance company denies your claim for any reason it is your responsibility to pay the bill in full by no later then 60 days. We will be glad to give you the information that is needed to fight the claim further, but for our clinic to operate efficiently we cannot take further financial responsibility for it.

Following the recommendations above will help you avoid unnecessary charges and help us provide high quality care to your child. Your child's health is priority at our clinic and we would like to provide you with the best possible care. Should you have any questions please contact our Office Manager at 972 969-4230 ext. 107.

NO SHOW/ CACELLATION POLICY
12-1-12

Dear Parent,

Your child's health is very important to us. Keeping appointment with the physician is essential for your child's health. Missed appointments are potentially harmful for your child, as well as interrupts the smooth operation of the practice and it also hurts other children as well since if we would have known that you miss and you cancel your appointment we could have allowed others to be seen at that time.

It takes time and energy from the staff to get ready for your child's appointment: verifying insurance, making phone calls to verify appointment, getting the chart ready, reviewing previous visits, immunization status, previous results and sometimes more…

Considering the above, we feel that a fee imposed when appointments are missed without notice to us is reasonable. There will be a stepwise approach in charging for missed appointments without notice to us: **there will be a $30.00 fee added to your account with the first "no show", $50.00 for the second "no show".**

Please note that further "No Show" for appointments is considered disrespect to our staff and to other patients and at the third occasion you will be asked to find another provider.

Please note that to reinstate good standing, **you will be required to fully pay all "no show" charges before you child can be scheduled for an appointment.**

Please remember to call in advance to cancel your appointment so you will not be charged a "No Show Fee".

Thank you for your understanding and cooperation.

Kid's Klinic Staff

Patient's Name:_____ DOB:____-____-____

Acknowledgement of Receipt of Kid's Klinic Financial Policy

I have read the policy and I understand my financial obligations. I understand that this office as a curtsey to me will file an insurance claim on my behalf. I assign the payments of such insurance claim to Pediatric Diagnostic Services PA/ DBA Kid's Klinic.

Both Kid's Klinic and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail payment, deductions and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services for which payments were not rendered by my insurance company, as applicable by state and federal law.

_____ ____-____-_____ _____
Signature of Responsible Party Date Relationship to Patient

Acknowledgement of Receipt of Kid's Klinic No Show Policy

I have read and understand my responsibilities regarding appointments. I understand that if I decided that I do not need the appointment any more or cannot make it to the appointment I need to call and cancel at least 4 hours in advance to avoid Charges and the other consequences that are spelled out in the policy.

I agree to call and cancel 4 hours in advance in those cases. I understand that I will be fully responsible for the charges if I do not keep this agreement. I understand that the payment of these charges is due prior to my next appointment.

_____ ____-____-_____ _____
Signature of Responsible Party Date Relationship to Patient