Morning Star Pediatrics

Patient Demographics

Today's Date: _____

Patient Last Name:_____

Patient Middle Name: _____

Patient First Name: _____

DOB:_____

Gender: ☐ Male ☐ Female

Address:_____

City:_____ Zip:_____

Home Phone:_____

How did you hear about Morning Star Pediatrics?

_____

☐ **Race(s): (check one)**

☐ American Indian or Alaskan Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

Declined to Answer

☐ **Ethnicity: (check one)**

☐ Unknown

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Declined to Answer

Other Children in Family:

Name: _____DOB_____

Name: _____DOB_____

Name: _____DOB_____

Contact Information:

Parent/Guardian #1: (Person you want notified first for all issues)

First Name:_____

Last Name: _____

DOB:_____

Employer:_____

SSN:_____

Resides with Patient: ☐ Yes ☐ No

Address: Same as Patient ☐

If different: _____

City: _____Zip:_____

Home phone:_____

Cell phone:_____

Work phone:_____

Home email:_____

Preferred Contact Methods—please indicate how you would like to be notified for these issues by selecting home phone, cell phone, text to cell, home email.

Medical issues:_____

Reminders:_____

Recalls:_____

Billing Statements:_____

General Notices:_____

Patient portal:_____

Morning Star Pediatrics

Patient Demographics

Parent/Guardian #2:

First Name:_____

Last Name:_____

DOB:_____

Employer: _____

SSN: _____

Resides with patient: ☐ Yes ☐ No

Address: ☐ Same as Patient

If different: _____

City: _____ Zip:_____

Language:_____

Home phone:_____

Work phone:_____

Cell phone:_____

Email:_____

Preferred Contact Methods—please indicate how you would like to be notified for these issues by selecting home phone, cell phone, text to cell, home email.

Medical issues:_____

Reminders:_____

Recalls:_____

Billing Statements:_____

General Notices:_____

Patient portal:_____

Primary Insurance Information:

Provider:_____

Guarantor Information:

Last Name:_____

First Name:_____

Sex: ☐ Male ☐ Female

Birth date:_____

Subscriber ID:_____

Group Number:_____

Secondary Insurance Information:

Provider:_____

Guarantor Information:

Last Name:_____

First Name:_____

Sex: ☐ Male ☐ Female

Birth date:_____

Subscriber ID:_____

Group Number:_____

Morning Star Pediatrics

Acknowledgement of Privacy Practices:

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Responsible Party

_____

Date

Except for life threatening emergencies, we are not able to treat your minor child unless he or she is accompanied to our office by a parent, legal guardian, or designated adult. In order to designate an adult to bring your child into our office for medical care in your absence, you must have the following form completed, signed, and on file for each designated adult for each of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form, or a signed note from a parent may need to be rescheduled.

Alternate Caregiver Consent Form:

I authorize the following individuals to bring my children to their appointments:

Name: _____ Relationship to child:_____

Name: _____ Relationship to child:_____

Name: _____ Relationship to child:_____

I attest that the above named individuals are all 18 years of age or older as of this date. I authorize the above named individuals to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccines, procedures, and hospitalizations. This practice may relay any medical information about my child necessary for the above named individuals to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver, and that under most circumstances, a follow up call to me personally should not be necessary.

I agree to hold Morning Star Pediatrics and its staff harmless for any disagreement between the above named individuals and myself regarding treatment decisions.

Morning Star Pediatrics

I attest that I am the parent or legal guardian of the above named children and that I have legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

_____

Signature of Parent/Legal guardian **Date**

_____ _____

Name of parent/legal guardian (PRINT) **Phone contact for parent/legal guardian**

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier, including Medicaid, private insurance, and any other medical/health plan, to issue payment to Morning Star Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

Authorization of Release Information

I hereby authorize Morning Star Pediatrics to release any information necessary to insurance carriers regarding my illness and treatments, process insurance claims generated in the course of examination or treatment, and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Morningstar Pediatrics on behalf of myself and/or dependents, and understand by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Printed Name of the Patient

_____

Signature of Patient or Responsible Party if a Minor

Morning Star Pediatrics

Office and Financial Policies

To reduce confusion between our patients and practice, we have established the following office and financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of the following policies as an essential element of your care and treatment.

Office and After Hours Services:

Our office hours are 8:30 a.m. to 4:30 p.m. on Monday and Friday, 8:30 a.m. to 5:00 p.m. on Tuesday and Thursday, and 8:30 to 12:30 on Wednesday. The phone line will be open during normal business hours for patients. Dr. Thomas is available for after-hours emergencies every day, including holidays. If you are considering an emergency room visit or are concerned that your child's health condition cannot wait until the morning, please call our office number, 214-383-0434, and select option #4. Your call will be directed to Dr. Thomas through the answering service. Be sure to leave your child's first and last name, date of birth, name of caller, and a call back number. If you do not hear from Dr. Thomas within 30 minutes, please place your call again. Please remember this service is for EMERGENCIES only, not medical questions.

Appointments:

Patients are seen by appointment only. Each child needing examination by Dr. Thomas should have an individual appointment. We reserve only a certain number of Well Examinations per day. Well Examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the Well Examination; however, Dr. Thomas can see your child for his/her illness during the scheduled appointment time.

Well Child Examinations:

Any issues discussed other than preventative care is not part of a well child exam or routine physical (i.e. ADHD, allergies, asthma, infections, developmental delays, referrals, and maintenance prescriptions). If addressed during a wellness exam, additional charges will be billed, which may result in additional co-pays, deductibles, or co-insurance.

Telephone Calls:

Our medical assistants are always available during business hours to serve your needs. You can ask to leave a message with any questions that you may have. All messages received prior to 3:00 p.m. will be returned on that business day; however, depending on the daily schedule, calls may not be returned until the end of the day and will be returned in order of urgency. Calls received after 3:00 p.m. will be returned the next business day. If you feel your child needs to be seen by the physician, speak with someone in the front office to schedule an appointment, as the schedule fills quickly. In general, antibiotics will not be prescribed over the phone. In case of an emergency, call 911 or take your child to the nearest hospital emergency room.

Morning Star Pediatrics

Medication Refills:

Patients on medication for ADD/ADHD require a follow up office visit every 3 months. Medication Refills for ADD/ADHD will be provided only if follow up visits are kept. Parents/Guardians must call the office to request a refill 48 hours in advance. Prescriptions are available for pick up in the office or may be mailed to your home address on record. Controlled substance medications must be picked up by a parent or guardian and filled at the pharmacy within 21 days of the date written. By law, ADD/ADHD medications cannot be called in or faxed to any pharmacy. Requests for medications to treat stable, chronic medical conditions (i.e., asthma, allergies) can be requested as long as the patient is established and has been seen for the condition within the last 6 months.

No-Show and Late Arrivals:

Please arrive on time for your appointment. If you are more than 15 minutes late, rescheduling may be necessary; however, if time allows, we will try to work you in. Appointments must be canceled at least 24 hours prior. In the event you fail to arrive at the scheduled appointment, the visit will be noted as a No Show. During a calendar year, if one appointment is missed, a letter will be sent reminding you of our No Show policy. If a second appointment is missed, a $25.00 fee will be billed to your account. If a third No Show occurs, the practice reserves the right to place the patient on probationary status or dismissed from the practice. Note that this policy is per family.

Medical Records:

Medical Records requested by the patient for the purpose of transfer of care will be provided to another physician at no charge with a completed medical records release form. As a privilege to patients, parents requiring medical records for personal use may access and print all records via the patient portal. If you request the office provide a copy of your child's medical record for personal records or use, there will be a $25.00 fee assessed.

Payment:

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept cash, checks, and all major credit cards. Any returned checks will result in a $35 service charge.

Insurance:

Insurance is your responsibility. You must present a valid insurance card at every visit. You are responsible for updating the office of new or terminated coverage. In the event that we cannot verify your benefits or a claim is denied due to terminated coverage, we will expect payment in full.

Morning Star Pediatrics

Payment and Collection Policies:

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement. Insurance companies require you pay the authorized copayment at the time of service. Deductibles and fees for non covered services are due at the time of service. Statements will be sent for any remaining balance after your plan pays its share. Payment is due upon receipt. If you are unable to pay the balance, please contact our office to set up a payment plan. Credits due to patients that are in the amount of $20 or more will be refunded in a check form. If the refund is less than $20, your account will be credited.

Non-covered Services:

Your health insurance company may not pay for services listed below. Health Insurance does not necessarily pay for all of your health care costs. Non-covered services may be billed in addition to your visit and may be subject to a separate deductible. If your doctor recommends that you receive a service, the fact that insurance may not pay for a particular service does not mean that you should not receive it.

- Use of local anesthetic prior to vaccines
- Cauterization of umbilical cord
- Cerumen (wax) removal
- Intramuscular admin of antibiotic
- Sure Sight
- Foreign body removal
- Wart removal
- Hearing or vision screen

Newborns:

It is imperative that you add your child to your insurance policy within 30 days. Please do this as soon as possible to avoid any unpaid claims. We file all hospital claims; any balance due is your responsibility and is due upon receipt of a statement from our office.

I have read and understand the office and financial policies 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.

_____

Printed Name of Patient

_____

Signature of Patient or Responsible Party if a Minor **Date**

Morning Star Pediatrics

Past Medical History

Name:_____ DOB:_____

Birth History:

Child was born:

Date:_____ Term:_____ Premature:_____ Weight:_____

Child was born by:

☐ Vaginal ☐ Caesarian Section (why?)_____

Right after birth:

☐ Baby was healthy and went home in a few days

☐ Baby had some mild problems:_____

☐ Baby stayed in NICU for a long time

Birth Order:

☐ First ☐ Second ☐ Third ☐ Fourth _____

Hospitalizations or Surgery:

1. Age:_____

   Problem:_____

2. Age:_____

   Problem:_____

3. Age:_____

   Problem:_____

List of current medications and date started:

_____

_____

_____

Allergies:

None

Drug/Reaction:_____

Food/Reaction:_____

Preferred Pharmacy:

1. Name:_____ Location:_____ Phone:_____

2. Name:_____ Location:_____ Phone:_____

Morning Star Pediatrics

Medical History:

Please indicate in the below box if your child has ever had the following:

Head:
- Skull Fracture ☐
- Concussion ☐
- Pressure in the brain ☐

Eyes:
- Difficulty seeing ☐
- Eyes crossing ☐
- Patching ☐
- Glasses (Corrective Lenses) ☐

Ears:
- Frequent Infection ☐
- Ear Drainage ☐
- (Not associated with PE tubes)

Nose:
- Frequent sneezing or rubbing ☐

Throat:
- Frequent strep throat ☐

Neck:
- Enlarged glands ☐
- Enlarged Thyroid ☐

Heart:
- Heart murmur ☐
- Blue Spells ☐
- Irregular heart beat ☐

Lungs:
- Pneumonia ☐
- Tuberculosis ☐
- Asthma ☐
- Wheezing ☐
- Nebulizer or Inhaler use ☐

Abdomen:
- Yellow Jaundice ☐
- Blood bowel movements ☐
- frequent abdominal pain ☐
- Frequent diarrhea ☐
- Constipation ☐
- Bowel movement accidents ☐
- Gastro Esophageal Reflux ☐

Urinary Tract:
- Pain, frequency, or burning ☐
- Nighttime wetting ☐
- Daytime wetting ☐
- Repeated infections ☐
- Blood in urine ☐
- swelling of eyes or ankles ☐
- Diagnoses of GU Reflux ☐
- If yes, Grade_____

Blood:
- Anemia ☐
- Excessive bruising ☐
- Blood disorders ☐

Extremities:
- Weakness, limp, or paralysis ☐
- Joint Swelling ☐

Neurological:
- Frequent severe headaches ☐
- Convulsions or fits ☐
- Fainting or black-out spells ☐
- Delayed milestones- Physical, Occupation, or Speech ☐

Family History:

For each problem, please state relationship to patient:

Allergies_____

Asthma_____

Attention Difficulties_____

Birth Defects_____

Bleeding Disorders_____

Ear Problems_____

Eye Problems_____

Diabetes_____

Heart Disease_____

High Blood Pressure_____

High Cholesterol_____

Heart Attack before 50 years of age_____

Morning Star Pediatrics

Authorization for Release of Medical Information

Please request medical information FROM:

_____

Name of Physician

_____

Street Address City, State Zip Code

_____

Phone Number Fax Number

I hereby authorize the above stated person/facility to release medical records TO:

Morning Star Pediatrics
940 Ridgeview Dr., Suite 130
Allen, TX 75013
Phone: 214-383-0434
Fax: 214-383-3178

Records to be released (check all that apply):

- ☐ All Medical Records (Immunization record, Lab Reports, Radiology Reports)
- ☐ Medical Records within 90 days from last visit
- ☐ Lab and Radiology Reports
- ☐ New Born Screen
- ☐ Discharge Summary
- ☐ Immunization Record

I understand that my medical records may include information regarding testing, diagnosis, and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, and other communicable disease. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the discloser or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that my medical record may contain reports, tests results, and notes that 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 that has been written in the record.

I will not hold Morning Star Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I have read the above forgoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I understand that I may revoke this authorization in writing at any time to the extent that Morning Star Pediatrics has already resided on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I further understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. This consent will expire 90 days after the date of signature.

Release Records Regarding:

_____

Signature of Parent/Legal Guardian Printed Name Date

_____

Patient #1 Name Patient DOB Phone Number

_____

Patient #2 Name Patient DOB

_____

Patient #3 Name Patient DOB