(**972-618-3547**, www.txnaturalpediatrics.com)

Dear Parent,

Welcome! On behalf of our entire team, I would like to thank you for choosing Natural Pediatrics. Our goal is to help you raise a happy and healthy child with minimal medications.

**OUR PHILOSOPHY OF CARE**

By training, I am an American Board-Certified Pediatrician. But in my younger years I grew up with non-chemical alternative for common ailments. As a mom, I have tried to incorporate that for my kids and it has worked wonders. And finally, as I study natural & alternative medicines, I realize the beauty and wisdom of living closer to earth. Hence in my practice I integrate both…for acute ailments I follow American Academy of Pediatrics (AAP) recommendation but for simple and/or chronic conditions I suggest natural alternatives (such as diet and nutrition change, yoga, behavioral and parenting change) first.

A few folks associate the word "natural" exclusively with "no shots". While I am open to alternative schedules and working with the parents, I am foremost an advocate for the child and hence I **do** recommend vaccination. I strive to use only preservative-free vaccines where possible. The safety & benefit from these vaccines far outweigh the tragedies of not vaccinating which I have experienced firsthand which reinforces my belief, "Prevention is better than cure. "

In western training, we are raised to think that "health is the absence of symptoms and problems". But eastern sensibilities have educated me that "Health is state that allows one to use the full capabilities of their body, mind and intellect. Therefore, healthy living is a balanced state of well-being: physically, mentally, socially and spiritually." This implies that healing is not a "one-pill-fits-all", but a personalized experience for each child.

Having said that, we want you to know and feel that we are part of your extended family!

We don't just believe in being a "nice clinic" or just be "friendly". Our expectations are to have the friendliest service, cleanest & comfortable surroundings, providing holistic care, and a caring and patient doctor who addresses all your concerns. I say "We" because it's not something that I as a Doctor insist upon but something that all our clinic team work towards and expect of each other. We don't accept mediocrity.

However, we realize that sometimes things can go wrong, sometimes out of our control. When something is not right, no matter how insignificant you may think it is, we want to make it right! Please let us know! Should you experience any problems or issues that needs special attention please contact the Office Manager: planonaturalpediatrics@gmail.com.

***I am at your service!***

Cheers and Good health,

Dr. Lata Shridharan

# Patient Information Form

Preferred Pharmacy Name: _____Cross Streets:_____

**PATIENT INFORMATION**

Patient 1: Last Name_____ __First Name_____ Middle _____

Date of Birth_____/_____/_____ Male ( ) Female ( ) SSN #_____-_____-_____

Patient 2: Last Name_____ __First Name_____ Middle _____

Date of Birth_____/_____/_____ Male ( ) Female ( ) SSN #_____-_____-_____

Patient 3: Last Name_____ __First Name_____ Middle _____

Date of Birth_____/_____/_____ Male ( ) Female ( ) SSN #_____-_____-_____

Patient 4: Last Name_____ __First Name_____ Middle _____

Date of Birth_____/_____/_____ Male ( ) Female ( ) SSN #_____-_____-_____

Address_____Apt:_____

City_____ State _____ Zip _____

Phone Number_____ Relationship to child:_____

Ethnicity: __American Indian __Asian ___African American __Latino/Hispanic __White/Caucasian ___Other

**Mother's**/Guardian's Name: _____ Employer _____

SSN #_____-_____-_____ Birth date_____/_____/_____ Address: _____

_____

City:_____ State _____ Zip _____ Primary Phone: _____

**Father's**/Guardian's Name: _____ Employer _____

SSN #_____-_____-_____ Birth date_____/_____/_____ Address:_____

_____ _____

Home Phone: _____ Work: _____ Cell: _____

Preferred E-mail:_____

**EMERGENCY CONTACT**- In case of an emergency, who should we contact?

Name _____ Relationship _____Cell_____

Name _____ Relationship _____Cell_____

**INSURANCE/PAYMENT GUARANTOR**

Name of person responsible for paying the bill_____ Relationship to Child _____

If different from above, Address: _____

Home Phone Number (if different from above) _____Cell _____

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**PRIMARY INSURANCE**

Policyholder's name_____

Insurance name _____

**Policy holder's social security #_____-_____-_____ Policy Holder's DOB _____/_____/_____

**SECONDARY INSURANCE (If any)**

Policyholder's name _____Insurance name_____

**Policy holder's social security #_____-_____- _____ Policy Holder's DOB _____/_____/_____

**HOW DID YOU HEAR ABOUT US:** Please be specific so that we can thank them:

Name & Address: _____

Child's School's Name: _____

**I certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility and duty to inform Natural Pediatrics should any information contained on this form change in the future.**

Guardian Signature:

_____ Date: _____

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**Consent for Treatment/Authorization for the Use and Disclosure of Health Information, Understanding Patient Rights and Responsibilities, Understanding Appointment Policy, Understanding Medical Record Policy & Fees, Understanding Release of Information Policy, Understanding Natural Pediatrics' Billing Policy, Email Usage Consent and Understanding your financial responsibility.**

**I acknowledge that I have been provided information and instructions regarding**

- Consent to Treat;
- Patient Rights and Responsibilities;
- Appointment Policy
- Privacy / Release of Information Policy
- Education on Billing Issues
- E-mail consent
- Patient Financial Responsibility and Billing Information
- Medical Record Policy and Fees

**And I understand and consent to its terms & conditions.**

**Signature of Parent/Guardian: _____ Date_____**

**Name of Parent/Guardian: _____**

# AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of the medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed below.

**Patient Name:** _____ **Date of Birth:** _____

**Patient Name:** _____ **Date of Birth:** _____

(Last Name, First Name, MI)

**Release the following health information:**

___Complete Office Records ___ Laboratory Reports ___Immunization Records ___ Radiology Reports

___Hospitalization Reports _____ What Other?

---

**Name of entity/person from whom records are requested:**

_____ _____

Physician Name/ Health Care Facility City, State, Zip

_____ _____

Street Address Phone Number

- **Records to be Released To:**
  **Natural Pediatrics / Dr. Lata Shridharan,**
  **2440 Timber Ridge Dr, #101, Frisco, TX 75034.**
  **Phone/Fax: 972-618-3547**

**I understand written notice is necessary to cancel this request. Legal Authority is: ___ Parent of Minor _____Legal Guardian**

**Signature of Parent/Guardian:** _____ **Date**_____

*As it states, under the Texas Medical Practice Act, Chapter 159, Section 006, you will provide copies of patient medical files within 15 business days after receiving a written request.

**CONSENT for TREATMENT of a MINOR**

I, the Parent or Guardian of said patient, who is a minor, authorize NATURAL PEDIATRICS and all persons acting as agents thereof and all physicians to who said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to NATURAL PEDIATRICS.

**AUTHORIZATION AND RELEASE**

I authorize NATURAL PEDIATRICS to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to NATURAL PEDIATRICS insurance benefits otherwise payable to me.

**I UNDERSTAND THAT ONLY MEDICAL DOCUMENTATION ORIGINATING IN THE OFFICE WILL BE COPIED. RECORDS FROM AN OUTSIDE FACILITY ARE NOT THE PROPERTY OF THIS OFFICE AND WILL NOT BE DUPLICATED.**

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**
***IMMUNIZATION REGISTRY (ImmTrac)***
**MINOR CONSENT FORM**

ImmTrac
Texas Immunization Registry

*(Please print clearly)*

**Child's Last Name**

*For Clinic/Office Use*

**Child's First Name**

**Child's Middle Name**

**Child's Date of Birth** / / **Children under 18 years only.*

**Child's Gender:** ☐ Male ☐ Female

**Child's Address**

**Apartment #**

**Telephone**

**City**

**State**

**Zip Code**

**County**

**Mother's First Name**

**Mother's Maiden Name**

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

***The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.***

**Consent for Registration of Child and Release of Immunization Records to Authorized Entities**

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

**By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.**

**Parent, legal guardian or managing conservator:** _____
**Printed Name**

_____ _____
**Date** **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

**Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.**

**Questions?** (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
**Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347**

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted.*
***DO NOT fax to ImmTrac. Retain this form in your client's record.***

# Patient Rights and Responsibilities

The staff of Natural Pediatrics is here for patients and their families. We strive continuously to offer a family-centered environment, and we are dedicated to providing our patients with quality healthcare. Consideration and respect for individuality and a trusted relationship between physician and family are among our primary objectives. The entire staff supports the following:

## Patient and Families' Rights

- Each patient/family has the right to receive the care necessary for his/her medical diagnosis, without discrimination on the basis of race, color, creed, sex, disability, sexual orientation or source of payment.
- Each patient/family has the right to be assured of confidential treatment of disclosures and health information in accordance with current state and federal (HIPAA) regulations.
- Each patient/family has a right to make decisions regarding medical care. As such, each patient/family has the right to be informed of alternative treatments and to choose among alternatives. Each patient/family has the right to accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences of those actions.
- Each patient/family has the right to be treated respectfully and considerately by others, to be addressed by his/her proper name, to be listened to when he/she has a problem or a question and to receive an appropriate response. We encourage each patient/family to share concerns, suggestions and comments with us at any time. If the patient/family has a complaint, this will not compromise the patient's future care. The procedure for filing a complaint is available at our office, through our website, on the Contact Us tab.
- Each patient/family has the right to unbiased and complete information concerning the patient's diagnosis and treatment in terms that are understandable.
- Each patient/family has the right to culturally competent services. We will make every attempt to be sensitive to the patient's/family's cultural and spiritual beliefs.
- Each patient/family has the right to notified in the event Natural Pediatrics deems that the continuation of care from our office is ineffective due to patient/family behavior that causes physical or mental harm to the patients or staff of Natural Pediatrics, or repeated abuses of the expectations of patients/families as outlined in the patient/family responsibility section of this posting. Each patient/family will be given an explanation of the reason(s) for the discharge and a referral to an alternate source of care with continued availability of care at Natural Pediatrics for a period of 30 days following such notification.
- Each patient/family has the right to appropriate assessment and management of pain and acute illness.
- Each patient/family has the right to be examined in private by the doctor or other health care giver, and patients/families have the right to talk to the doctor in private.
- Each parent/legal guardian has the right to look at the medical records of their child and get a copy for a reasonable fee.
- Each patient/family has the right to review policies related to payment, forms, prescription requests, after hour services, test reporting and office hours and will be given a brochure outlining these processes at or prior to their first appointment.

## Patient/Family Responsibilities

- It is the responsibility of the patient/family to update the patient's financial and/or insurance records on a regular basis. Failure to do so could result in suspension of services and/or the requirement for payment for services. Every attempt will be made to aid the patient/family in this process in order to prevent a lapse in the child's medical care.
- It is the responsibility of the guarantor of the patient's account to make arrangements for payment of services at the time services are rendered unless prior arrangements have been specifically made with the Billing Manager. This includes all co-payments, deductibles, and services rendered that are not covered by health insurance.
- It is the responsibility of the patient/family to keep appointments as scheduled and to notify the appointment desk if you are unable to do so **at least 24 hours** in advance so that time can be given to a patient who requires services.
- It is the responsibility of the patient/family to carry out treatment and obtain tests as requested by the physician and/or professional staff.
- It is the responsibility of the patient/family to notify Natural Pediatrics promptly of changes in address, phone numbers and/or legal guardianship.
- It is the responsibility of the legal guardian/parent to accept the responsibility for your actions if you refuse treatment for your child and/or do not follow your practitioner's instructions.
- It is the full responsibility of the family/patient to report unexpected changes in the patient's condition to your doctor, or nurse.
- It is the full responsibility of patients/families to be considerate of the rights of other patients and staff and assist in the control of noise and the number of accompanying visitors.

- It is the responsibility of the patient/family to keep Natural Pediatrics advised of medical treatment rendered by other providers and to assist in communication and transferring information on such treatment so we can better coordinate and provide continuity of care to the child.
- It is responsibility of the family to be aware at all times of your child and of his/her location and to manage and control any children that you bring with you to the clinic for their safety and the safety of others.

## APPOINTMENT POLICY

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.
- **Schedule an appointment by calling 972-618-3547.** Walk-in patients are offered the first available appointment only if available.
- **Schedule same-day appointments for ill visits.** Appointments are used on a first-available appointment basis. Late appointments are typically reserved for same day sick patients.
- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your child's visit.
- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment.
- **Late arrivals (>15 minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge of $25 for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment may *or may not* be on the day the appointment was missed.
- **The no-show charge will be waived if you contact the office 24 hrs before your appointment.** Remember that appointments canceled more than 24 business hours prior to when they were scheduled do *not* incur a no-show fee. We do this so that a needy child can be seen in the slot.
- **Appointments for additional children should be made by phone prior to coming to the office.** A $25 charge is applied for the add-on appointments. If you would like another child to be seen, please schedule appointments for *both* children *by phone* prior to coming to the office. If you have 3 or more kids, we may schedule the kids on different days/slots to give individualized attention to each child's need.
- **Turn off cell phones in the office and examination rooms.**
- **For the safety of allergic patients, please do not bring food or drinks into the clinic. Also, no smoking, drugs/medications, firearms are permitted in the clinic.**

**After-hours Call Service**

- Please limit after-hour calls to urgent medical issues and emergencies. Please refer to our patient information packet for answers to common illness questions (Web site). For refills, appointment requests, and other non-urgent matters, you may leave a message or call the office during regular hours. A charge of $25 may be applied for after-hours calls that do not lead to an office or emergency department visit. When leaving a message, please speak slowly. Be sure to leave a callback number. Disable your call block feature. Follow the doctor's instructions.

## MEDICAL RECORDS

- There is a $25.00 charge for copies of medical records from NATURAL PEDIATRICS. If affidavit is required, the additional fee is $15. These fees are set by the Texas State Board of Medical Examiners as published in the Texas Register. This fee must be paid prior to the release of the records. Please allow two weeks to process your request. All original medical records are property of NATURAL PEDIATRICS and only copies will be given.
- School Forms, Camp Forms, Day Care Forms, etc. - Please allow 48-72 hours to process these forms

## RELEASE OF INFORMATION POLICY

Natural Pediatrics' has a legal and ethical responsibility to preserve the confidentiality of patient information that we retain in our medical records. To comply with the Health Insurance Portability and Accountability Act of 1996, we are required to have patients sign a written release of information form before providing our patient records to other individuals or agencies.

- We do not provide copies of records to persons on a walk-in basis. *Natural Pediatrics' requires a formal request for medical records be made in advance and there may be a turn-around time of 48 hours or more, depending on size of the medical record.*
- In order to reduce the potential liability associated with the faxing of medical records and the risk of violating patient

confidentiality, Natural Pediatrics' is only able to send patient records to other healthcare facilities and providers.

## PATIENT EDUCATION ON BILLING ISSUES

As your health care provider, we are obligated to follow those regulations in how we report services provided to you. Additionally, every insurance plan may have different rules that vary from insurer to insurer and may even vary between plans of the same insurer.

- Your financial responsibility is determined by the rules of your insurance company, which we are obligated to follow.
- Please double check that your physician is "IN NETWORK" in your plan. Also make sure that we are your doctor is set as the primary PCP with your insurance company. Not checking may trigger higher "OUT of network" cost for you by your plan.
- All physicians/providers must report services using codes to tell the insurance company what was done and why. It is not uncommon for patients in the course of a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventive services at the same visit. Both services must be reported to the insurance company and may result in an additional co-payment or charge as per the insurer's plan rules, which we are obligated to follow.
- There are many different insurance companies and plans; addressing a problem may trigger a co-payment or additional charges to your account.
- If you have questions, first check with your insurance plan. If our business office can help, please call them at 972-618-3547
- Natural Pediatrics will conduct credit and collections procedures in accordance with the law.

## E-MAIL CONSENT

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL…CALL 911. Also, do not use e-mail for urgent problems. If you have an urgent problem, call our office 972-618-3547 or go to an urgent care facility.

Natural Pediatrics offers our patients the opportunity to communicate by e-mail. **Use the parent portal for any medical communication**. **This is a HIPAA requirement**.

**RISKS OF UNPROTECTED EMAILS**

Communication by e-mail has a number of risks which include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in paper and electronic files.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- E-mail can be received by unintended recipients.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail senders can easily type in the wrong e-mail address.
- E-mail can be used to introduce viruses into computer systems.

**HOW WE WILL USE E-MAIL**

1. We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
2. We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as:
    - Questions about prescriptions,
    - Routine follow-up questions,
    - Appointment scheduling, and/or
    - Billing questions.
3. Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
4. We will not disclose your e-mails to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permit uses of your health information and your rights regarding privacy matters.

GUIDELINES FOR E-MAIL COMMUNICATION

- Include the general topic of the message in the "subject" line of your e-mail. For example, "advice," "prescription," "appointment" or "billing question."

- The e-mail message should not be time-sensitive. While we try to respond to e-mail messages daily, it may take up to three (3 to 7) working days for us to respond to your message. Urgent messages or needs should be relayed to us using telephone.
- Include your and your child's name and phone number in the body of the message.
- If your e-mail requires a response from us, and you have not heard back from us within three (3) working days, call our office to follow-up to determine if we received your e-mail.
- Inform us of changes in your email address.

**CONSENT**

I, the parent or legal guardian of the child, want to communicate with Natural Pediatrics doctor and the office staff by e-mail. I understand the risks of communicating by e-mail, in particular the privacy risks explained in this form. I understand that Natural Pediatrics cannot guarantee the security and confidentiality of e-mail communication. Natural Pediatrics will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct. I understand that I may also communicate with Natural Pediatrics by telephone or during a scheduled appointment, and that e-mail is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new issues or any sensitive medical information. I understand that Natural Pediatrics may periodically send information via email that may be relevant or useful for my child's health. I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

## PATIENT FINANCIAL RESPONSIBILITIES AND BILLING INFORMATION

As your partner in healthcare, it is important that we provide the following information to avoid any misunderstanding or disagreement concerning payment for professional services. If you have special financial needs, we are willing to work with you.

- As a Parent/Guardian, it is in your best interest to know and understand your insurance plan benefits and all plan provisions that may affect your financial responsibility (i.e., benefits, deductibles, co-insurance, co-payments, selection of PCP, etc.).
- It is your responsibility to provide Natural Pediatrics with current and valid insurance information. You are responsible for notifying our office of any changes in your child's insurance at time of appointment check-in.
- The parent/guardian is responsible for bringing the child's insurance card and a driver's license or valid photo ID to each visit.
- Natural Pediatrics is required to collect your co-payment at the time of service as part of our agreement with your insurance company. All other payments, including deductibles and co-insurance are due and payable at the time of service.
- It is your duty to ensure that the physician you are seeing is on file with the insurance as your Primary Care Provider (PCP). Insurance will not cover charges if these do not match, and you will be considered a private pay patient.
- Self-pay patients are required to pay a deposit at check-in. If the balance of the visit is paid at check-out, the patient will receive the Natural Pediatrics prompt pay discount. If the balance is not paid at check-out, the patient will be balance billed at the standard Natural Pediatrics' rate for all services rendered.
- If your account has an outstanding balance, you will be required to pay in full, or establish and make the first payment toward a scheduled payment plan. Otherwise, your appointment may be cancelled or rescheduled.
- It is your responsibility to provide us with your current billing address and telephone number; and to notify Natural Pediatrics of any changes at time of appointment check-in.
- Natural Pediatrics' reserves the right to charge a minimum of $25 for the duplication of medical records and completion of camp and school forms.
- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
- If you have no insurance, payment for an office visit is to be paid at the time of the visit.
- Co-payments are due at time of service. A $25.00 processing fee (or service fee) will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
- If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $25.00 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remains on file. There are addenda to this financial policy, which are signed separately.

- We require 24-hour notice for canceling any appointments. There is a $25.00 charge for weekday appointments and $40.00 charge for Saturday appointments if they are not canceled OR if 24-hour notice is not given.
- A $25.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- We charge $25.00 per child to copy or transfer medical records.
- If your child has school, camp, or sport forms to be completed, there is a $10 charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms.
- Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
- Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

## CONSENT FOR TREATMENT AND AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

- I hereby voluntarily authorize employees and agents of Natural Pediatrics (including physicians, physician assistants, and nurse practitioners and other employees and staff members) to render medical evaluations, procedures, tests and care to the patient. I understand that that a physician assistant/nurse practitioner is not a doctor but is a graduate of a certified training program and is licensed by the state of Texas Board. Under the supervision of a physician, a physician assistant/nurse practitioner can diagnose, treat and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. The duration of this consent is indefinite and continues until revoked in writing.
- I authorize Natural Pediatrics', it agents, directors and employees, to release medical information to third party payers, (whether private or governmental), schools, camps, daycare facilities, non-profit organizations, and sporting groups. This information may be disclosed from my child's medical records, financial records, and may include laboratory and other reports. This authorization specifically includes information concerning communicable diseases, including Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Virus (AIDS), genetic information, drug / alcohol abuse and psychiatric care. I also request release of payment information by or to Natural Pediatrics' by or to third party payers, whether required for payment or by coordination of benefits.
- Furthermore, I irrevocably assign any benefits available to me to Natural Pediatrics', and I authorize payment of those benefits directly to this provider. I authorize Natural Pediatrics' to appeal any denial under my appeal rights provision. This authorization and assignment is irrevocable unless in writing by me, from the moment I formalize it herein and that any action/appeal made by Natural Pediatrics' shall have the same weight as if it had been filed be me personally. I also fully understand, despite authorization and/or assignment, that pre-certification, pre-authorization, second opinions and instituting suit shall remain the sole responsibility of the patient, patient family, legal guardian, representative or agent. This Assignment does not relieve me of my liability or responsibility for charges and payment.
- It is agreed and understood that I, as the designated party, am responsible for the total charges for services rendered and for any portion of my bill not paid or covered by insurance within 60 days of date of service except to the extent limited or prohibited by law, Natural Pediatrics' policies or contractual agreements with third party payors. The amounts are due upon request and payable to Natural Pediatrics'. I agree that if the account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. I also hereby acknowledge that I have been informed of my right to receive an itemized bill within 60 days from the date of service and that I may receive information about charges for which I will be or am responsible by calling 972-618-3547. Natural Pediatrics' does not establish charge accounts for payments.
- I certify that the information given by me/my child/my ward in applying for payment under Title XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical or other information about me/my child/my ward to release to the Social Security Administration or intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefit be made on my/my child/my ward's behalf for these parties as well.
- Unless revoked, I understand that this authorization will not expire.
- I have been offered a copy of Natural Pediatrics' Notice of Privacy Practices in accordance with HIPAA as well as a copy of Natural Pediatrics' Release of Information Policy, and I understand that I may direct any questions/concerns to the Privacy Officer at 972-618-3547.