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 alternatives 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 the 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 vaccines'. 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 a 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 need special attention please contact the Office Manager at 972-618-3547 and appointment@txnaturalpediatrics.com.

We are at your service!

Cheers and Good health,

Dr. Lata Shridharan

Patient Information Form

Preferred Pharmacy Name: _____Cross Streets:_____

PATIENT INFORMATION

Child 1: Last Name_____First Name_____ Middle _____

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

Child 2: Last Name_____First Name_____ Middle _____

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

Child 3: Last Name_____First Name_____ Middle _____

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

Child's Home Address_____Apt:_____

City_____ State _____ Zip _____ Home Phone Number_____

Ethnicity: American Indian__ Asian__ African American__ Latino/Hispanic__ White/Caucasian___ Other___

Vaccination Status: Fully Vaccinated___ Partial vaccinated___ NO Vaccination___

PARENT/GUARDIAN INFORMATION

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

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

_____

_ City:_____ State _____ Zip _____ Cell Phone:

_____

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

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

_____Cell Phone: _____

INSURANCE/PAYMENT GUARANTOR

Person paying the bill_____ Relationship to Child _____

If different from above, Address: _____

Home Phone Number (if different from above) _____Cell _____

PRIMARY INSURANCE

Primary Policy holder's name_____ Insurance name _____

Type: PPO___ HMO___ EPO___ Other___ **Member** Id _____ **Group** Id _____

Insurance Phone # _____Policy holder's SSN_____-_____-_____ Policy Holder's DOB _____/____/_____

Primary Policy Holder Name: _____

EMERGENCY CONTACT INFORMATION - The person to call in case of emergency

Name _____ Relationship_____Cell_____

Name _____ Relationship_____Cell_____

___ 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.

___Natural Pediatrics has my permission to examine and administer treatment as deemed necessary to my child(ren). I agree that all services are rendered on a paid basis only. If my account is referred to the collection process, I will pay all fees including attorney fees. I authorize the release of information to my insurance if requested.

___I acknowledge that I have been provided information and instructions regarding : authorization for the release of information and/or medical records, Consent to Treatment authorization and financial authorization, Texas immunization registration IMMTRAC consent, Patient Consent for the Disclosure of Information, Natural Pediatrics Policy Information, Patient Rights and Responsibilities, Appointment Policy, Advanced Practice Nurse Consent for Treatment, Privacy and Release of Information Policy, E-mail communication consent, Patient Financial Responsibility and Billing Information, and Medical Record Policy and Fees. And I understand and consent to its terms & conditions.

Mother/Guardian's Signature: _____ Date: _____

Father/Guardian's Signature: _____ Date: _____

NATURAL PEDIATRICS FINANCIAL POLICY AND CONSENT FORM

Please read our Financial Policy and Patient Consent Form and initial where indicated. **Your initial by each item indicates your understanding and agreement.**

_____NO SHOW FEE: Natural Pediatrics will charge a $35.00 fee for failure to keep scheduled appointments. Please call our office 24 hours before a scheduled appointment to cancel or reschedule an appointment that you will not be able to keep. Appointments made and canceled on same day will also incur a No-Show fee. Please be aware that your insurance will not cover any no-show fees.

_____PATIENT RESPONSIBILITY: We will submit **ONLY** to the primary insurance plan that we participate with, however, we cannot guarantee payment. It is **your** responsibility to be familiar with your insurance benefits and confirm our participation. Any services that you receive that are not covered by your plan will be **your** responsibility. Submitting claims to secondary insurance (if any) for payment is **your** responsibility. Please call your insurance if you have any questions.

_____WELL CHILD VISITS: Many insurance carriers **do not** cover well child exams at 100% OR have no copay or deductible. Often during a well-child exam, other medical problems or conditions are found or discussed that are not covered under the well visit. When this occurs, rather than rescheduling the well child exam, your child's provider may convert the visit to a sick visit OR treat or manage the condition during the well child appointment. This includes addressing ongoing medical conditions if they exist. This additional encounter may be subject to your usual office visit charge, copay, or deductible.

_____GUARANTOR: We can only bill the parent that signed the financial responsibility paperwork. We are unable to bill anyone who is not listed as the guarantor on the account. It will be the responsibility of the parent to forward the bill to another party.

_____UPDATED INFORMATION: Please be certain you have updated all demographic and insurance information at every visit. We are only able to bill the insurance provided to us **at the time of service**. If you become aware that the incorrect insurance was billed or you have new insurance that was not provided, **you** must provide it within 15 days of the date of service. We may not be able to properly submit claims if the information is not provided to us in a timely manner. Payment for services rendered will then become patient responsibility.

_____RECORDS FEE: There is a $25.00 charge for copies of medical records from NATURAL PEDIATRICS. If an 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.

_____FORMS FEE: Natural Pediatrics reserves the right to charge a minimum of $25 for the duplication of 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.

_____REFERRALS FEE Natural Pediatrics reserves the right to charge a minimum of $25 administration fee for any referrals. Payment is due when the referrals are made. We have a 5-to 15-day turnaround time for referrals, based on patient insurance.

_____BILLING FEE: All insurance co-pay and deductible amounts are **due in full at the time of service**. Your account will be charged a $25.00 billing fee if you do not pay your co-pay or deductible on the day of your visit.

_____REBILL FEE & COLLECTIONS FEE: Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due as soon as you receipt 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 or late payment fee. Any balance over 60 days will be forwarded to a collection agency. Please be aware that if there has been no attempt to settle a balance on a patient account after 60 days of which it becomes due, the account will be accessed a $35.00 collection fee and future appointments will be put on hold and the patient shall be discharged from the practice automatically.

_____NSF CHECKS: There will be a $35.00 fee for all checks returned to us for non-sufficient funds. Additionally, we will no longer accept checks and will request payments by cash or credit card.

Signature of Parent/Guardian: _____ Date_____

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 (Last, First) Name:_____**Date of Birth:** _____

Patient (Last, First) Name:_____**Date of Birth:** _____

Release the following health information: Complete 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, 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___ 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.

PATIENT HEALTH QUESTIONNAIRE

Child's Name:_____Date of Birth:_____

Pregnancy History:

During pregnancy, did mother: Use tobacco? ☐ Yes ☐No Drink alcohol? ☐ Yes ☐No

Use drugs or medications? ☐ Yes ☐No What?_____

Birth & Developmental History:

Birth weight: _____ lb _____oz. Was the baby circumcised? ☐Yes ☐ No Was the baby born at term? ☐ Yes ☐No ____weeks

Any complications before or after birth? ☐ Yes ☐No Explain _____

Was a NICU stay required? ☐ Yes ☐No Explain _____

Normal newborn screen at birth? ☐Yes ☐ No Normal hearing screen at birth? ☐Yes ☐ No

Rolling Over Age: _____ Walking Age: _____ Sitting Up Age: _____ Talking Age:_____

Previous Medical History: ☐None (asthma, recurrent UTI, seizure, anemia, depression, ear infections, murmur, OTHER)

_____

Are **Immunizations** up to date? ☐ Yes ☐No If no, are you willing to immunize? ☐ Yes ☐No (If yes, please past record copy)

Surgical History: ☐None (type of surgery and when)_____

Hospitalizations: ☐None (for what illness and when)_____

Allergic Reactions: ☐None Allergy to: (What)_____When_____

Allergy to: (What)_____When_____

What happened: ☐Rash ☐Difficulty Breathing ☐Vomiting ☐Facial Swelling ☐Other: _____

Medication History: ☐None (list on back if needed) Daily Medications: What _____ Dose:_____

What _____ Dose:_____ What _____ Dose:_____

As needed medication: What _____ Dose:_____ What _____ Dose:_____

Family Medical History: (provide history of child's: mother, father, siblings, grandmother, grandfather, uncle, aunt)

Asthma ☐ Yes ☐No Who: _____ Anemia ☐ Yes ☐No Who: _____

Cancer (before 55) ☐ Yes ☐No Who: _____ Heart disease (<55 yrs) ☐ Yes ☐No Who: _____

High Cholesterol ☐ Yes ☐No Who: _____ Stroke ☐ Yes ☐No Who: _____

Diabetes ☐ Yes ☐No Who: _____ Epilepsy or seizures ☐ Yes ☐No Who: _____

Substance Abuse ☐ Yes ☐No Who: _____ Mental Illness ☐ Yes ☐No Who: _____

Developmental Disorder ☐ Yes ☐No Who: _____ Thyroid Disease ☐ Yes ☐No Who: _____

Other _____

Travel History:

Has your child traveled outside the United States in the last 3 months? ☐ Yes ☐No

If so, where to and when? _____

Social History:

Pets in the home? ☐ Yes ☐ No If yes, what kind and how many? _____

Guns in home? ☐ Yes ☐ No Are they secured? ☐ Yes ☐ No

Smoke/Vape/Drug exposure? ☐ Yes ☐ No Pool at home? ☐ Yes ☐ No Trampoline at home? ☐ Yes ☐ No

Daycare? ☐ Yes ☐No How many days _____

Who lives in the home? ☐ Mom ☐ Dad ☐ Step-Mom ☐ Step-Dad ☐ Grandmother ☐ Grandfather Other _____

How many siblings? _____ Siblings ages _____ Are there any custody concerns? ☐Yes ☐ No Explain:_____

How long has your family lived in this area? _____ Where did you live before coming to this area? _____

Is there anything you would like us to know about your child? _____

School History:
School History: ☐None Name of school: _____ Current grade level: _____

Average grades this school year: ☐A ☐B ☐C ☐Failing School Problems: _____

Seen by Speech Therapist, Psychologist, or Special Teachers (if any) _____

Who was your last doctor?
Name: _____ Phone number: _____

Address: _____

___ 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.

Signature of Parent/Guardian: _____ Date_____

CONSENT FOR TREATMENT OF A MINOR AUTHORIZATION

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.

ADVANCED PRACTICE NURSE CONSENT FOR TREATMENT

This facility has on staff an advanced practice nurse to assist in the delivery of medical pediatric care.

An advanced practice nurse is not a physician. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my child's health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

AUTHORIZATION AND RELEASE OF INFORMATION AND/OR MEDICAL RECORDS

I consent and authorize Natural Pediatrics to release information contained in any financial or medical records, including but not limited to: diagnosis and treatment/continuity of care, information concerning communicable disease, drug or alcohol abuse, psychiatric diagnosis and treatment, medical history, lab results progress notes, and other related information to insurance companies and its agents, Medicaid or Medicare, or any other entity responsible for paying or processing payment, utilization management, or consulting and/or follow-up care.

Natural Pediatrics is hereby authorized to release any information or records and reports regarding patient care and health status as required by law or regulation.

Information may be transmitted by mail, facsimile, or other electronic medium.

I understand that I may revoke this authorization in writing at any time, except to the extent that action is already in progress.

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-WIDE IMMUNIZATION REGISTRATION IMMTRAC CONSENT

I agree that the record of giving each vaccine (past, present or future) can be given to the Texas Department of Health Immunization Tracking System, and to other health care providers, schools, or places that provide childcare.

I hereby authorize the Texas Immunization Registry to release such information concerning my child's immunizations to any public health district, local health department, child's healthcare providers, insurance companies, school or child care center, as well as the Texas Department of Human Services.

The above entries to re-release such information in order to promote the availability of accurate, complete and up-to-date immunization records to those entities and individuals who administer and promote immunizations.

I am aware that I may withdraw this consent at any time by contacting: The Texas Department of Health, Immunization Registry: 1100 West 49th Street, Austin, TX 78756

NOTICE TO PATIENT REGARDING USE OF A PROVIDER NOT IN NETWORK

If your physician has provided a list of specialists, it is important that you confirm with the specialist and your insurance company that the provider is in network with your insurance.

Please be aware that if you choose a provider that is out of network:

• The out of network hospital, facility or provider will not be restricted to seeking payment from your insurance.

• The out of network hospital, facility or provider may bill the patient for amounts other than deductibles, co-pays, co-insurance, and services not covered by your benefit plan. You may have higher out-of-pocket costs when using an out of network provider based on your benefit plan. Note that if you do not have out of network benefits under the terms of

your benefit plan and you receive services from an out of network provider, you may be responsible for the entire cost of the service.

• Your physician has NO affiliation or financial ownership interest in or with the out of network hospital, facility or provider.

• You may still choose an out of network provider knowing that all of the above applies.

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 needs.
• 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 an 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 a i n i n 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 & providers.

COMMUNICATION CONSENT

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL…CALL 911. Also, do not use email 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 SMS, patient portal, US postal mails or email. By signing this agreement, you authorize Natural Pediatrics to communicate with you through any of the aforementioned medium. Use the parent portal for any medical communication. This is a HIPAA requirement.

RISKS OF UNPROTECTED EMAILS/SMS

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 email 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 email address.
• E-mail can be used to introduce viruses into computer systems.

HOW WE WILL USE E-MAIL/SMS

• We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representatives of established patients.
• We will use email to communicate with you only about non-sensitive and non-urgent issues such as:
    o Questions about prescriptions,
    o Routine follow-up questions,
    o Appointment scheduling, and/or
    o Billing questions.
• Your e-mail messages may be forwarded to another office staff member as necessary for appropriate handling.
• 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 email. 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 the telephone.
• Include your and your child's name and phone number in the body of the message.
• If your email 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 email.
• Inform us of changes in your email address.

CONSENT

I, the parent or legal guardian of the child, want to communicate with the Natural Pediatrics doctor and the office staff by email. I understand the risks of communicating by email, 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 email 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 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 the 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.

PATIENT EDUCATION ON BILLING ISSUES

As your healthcare 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 and are 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.

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 coinsurance 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 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 canceled 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 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', its 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 Immunodeficiency 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 by 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.