Pediatric Sports and Spine Associates
2020 W. State Hwy 114, suite 110
Grapevine, TX 76051

•PATIENT INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) _____ **M** _____ **F** _____

ADDRESS: _____ **EMAIL:** _____

CITY: _____ **STATE:**_____ **ZIP CODE:** _____

Main Contact Number: (_____) _____- _____ ALTERNATE: (_____) _____- _____ WORK: (_____) _____- _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) SOCIAL SECURITY NUMBER (SSN OPTIONAL): _____-_____-_____

NAME OF PHARMACY: _____ **PHARMACY PHONE NUMBER: (_____) _____- _____**

REFERRING PHYSICIAN: _____ **PHONE NUMBER: (_____) _____- _____**

PRIMARY CARE PHYSICIAN: _____ **PHONE NUMBER: (_____) _____-_____**

•EMERGENCY CONTACT

Name: _____ **Relationship:** _____

HOME NUMBER: (_____) _____- _____ CELL: (_____) _____- _____ WORK: (_____) _____- _____

•INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **POLICY/ID NUMBER** _____

NAME OF POLICY HOLDER: _____ **DOB _____/_____/_____ (MM/DD/YYYY)**

GROUP/ACCOUNT NUMBER _____ **EMPLOYER:** _____

EMPLOYER ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

WORK NUMBER: (_____) _____- _____

SECONDARY INSURANCE: _____ **POLICY/ID NUMBER** _____

NAME OF POLICY HOLDER: _____ **DOB _____/_____/_____ (MM/DD/YYYY)**

GROUP/ACCOUNT NUMBER _____ **EMPLOYER:** _____

EMPLOYER ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

WORK NUMBER: (_____) _____- _____

•COMPLETE IF PATIENT IS A MINOR

FATHER'S/GUARDIAN'S NAME: _____ RELATIONSHIP: _____

EMPLOYER: _____ EMPLOYER CONTACT: (_____) _____- _____

MOTHER'S/GUARDIAN'S NAME: _____ RELATIONSHIP: _____

EMPLOYER: _____ EMPLOYER CONTACT: (_____) _____- _____

• PAYING INSURANCE BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO PEDIATRIC SPORTS AND SPINE ASSOCIATES. THIS ASSIGNMENT IS FOR SERVICES RENDERED TO ME BY PEDIATRIC SPORTS AND SPINE ASSOCIATES. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY MYSELF IN WRITING. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THIS PAYMENT. I UNDERSTAND THAT FAILURE TO NOTIFY PEDIATRIC SPORTS AND SPINE ASSOCIATES OF ANY CHANGES OR INSURANCE COVERAGE WILL RESULT IN THE FINANCIAL OBLIGATION TO REST FULLY ON ME REGARDLESS OF ANY CONTRACT BETWEEN THE INSURANCE COMPANY AND PEDIATRIC SPORTS AND SPINE ASSOCIATES.

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) **(DATE OF BIRTH IN MM/DD/YYYY)**

_____ _____/_____/_____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

• HIPAA DISCLOSURE

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT PEDIATRIC SPORTS ASSOCIATES, OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY PEDIATRIC SPORTS AND SPINE ASSOCIATES TO: A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSURANCE THROUGH PEDIATRIC SPORTS AND SPINE ASSOCIATES OR NETWORKING ORGANIZATIONS.
I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MY OFFICE OR BY CONTACTING THEM AT 2020 W. STATE HWY 114, SUITE 110, GRAPEVINE, TX. 76051. I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) **(DATE OF BIRTH IN MM/DD/YYYY)**

_____ _____/_____/_____

(SIGNATURE OF PATIENT/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

Pediatric Sports and Spine Associates

David S. Brown, M.D. Roderick Capelo, M.D. Renee Mathew, PA-C Lisa Darr, PA-C

•RELEASE OF INFORMATION

_____ PEDIATRIC SPORTS AND SPINE ASSOCIATES MAY NOT DISCUSS MY HEALTHCARE AND MAY NOT DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ANYONE.

_____ PEDIATRIC SPORTS AND SPINE ASSOCIATES MAY DISCUSS MY HEALTHCARE AND MAY DISCUSS AND/OR MAKE FINANCIAL ARRANGEMENTS WITH ONLY THE FOLLOWING INDIVIDUALS LISTED BELOW:

_____ PEDIATRIC SPORTS AND SPINE ASSOCIATES MAY LEAVE A MESSAGE ON MY PHONE: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

•FINANCIAL POLICY PATIENT CONSENT FORM

PEDIATRIC SPORTS AND SPINE ASSOCIATES RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDER REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

I. **PAYMENT: PAYMENT IS EXPECTED AT THE TIME OF SERVICE. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, Pediatric Sports and Spine will begin various collection activities including, but not limited by submitting the past due account to a collection agency.**

II. **SELF PAYMENT (PRIVATE, CASH PAYMENT): If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your surgery/procedure. We require an advance payment for professional services.**

III. **MANAGED CARE: ALL MANAGED CARE (HM, PPM, etc.) CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.**

IV. **CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Pediatric Sports and Spine Associates**

V. **SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. You agree to provide such information as outlined below. You agree to notify provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.**

Initial/Complete as applicable:

_____ I have NO SECONDARY INSURANCE COVERAGE

_____ I have SECONADARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM

Pediatric Sports and Spine firmly believes that a good patient/phyisican relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (817)865-6950.

_____ _____/_____/_____

PATIENT NAME (PLEASE PRINT) **(DATE OF BIRTH IN MM/DD/YYYY)**

_____ _____/_____/_____

(SIGNATURE OF INSURED/GUARDIAN) **(DATE OF SIGNATURE IN MM/DD/YYYY)**

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