Champions Pediatric Associates

Compassionate Care for Kidz

Champions Pediatric Associates

Patient Registration Form

ID#: ___________

Patient Last Name	First Name	Int.	Birthdate	Sex

Primary Address	City	State	Zip Code

Primary Phone Number ( ) -	☐ Home ☐ Cell ☐ Work
Day Phone Number ( ) -	☐ Home ☐ Cell ☐ Work
Mobile Phone Number ( ) -	Email Address
Emergency Contact Name	Relationship to patient

Emergency Contact Phone Number ( ) _	Primary Language:	Secondary Language:

Ethnicity ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Answer ☐ Unknown

Race
☐ American Indian/Alaskan Native ☐ Black /African American ☐ Asian ☐ White ☐ Hawaiian / Pacific Islander ☐ Decline to Answer

Preferred Champions Pediatric Location	Who may we Thank for your referral?
☐ SPRING ☐ TOMBALL	☐ Newsletter ☐ Internet ☐ Friend ☐ Hospital / Clinic / Doctor ☐ Other

Preferred Pharmacy and Phone Number	Referre's Name	Referre's phone Number

How would you like to be contacted for each of the following:

For Medical Issues	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Appointment Reminders	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Recalls	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Billing Statements	☐ Home Address	☐ Email		
General Notices	☐ Home Address	☐ Email		

Parent / Guardian Contact Information - Mother

Mother Last Name	Maiden Name	First Name	Int.	Nickname

Social Security #	Date of Birth	Primary Language	Home Email

Street Address	City	State	Zip Code

Does the child live at the above mentioned address ? ☐ YES ☐ NO	Occupation
Employer	Work Email
Primary Phone Number ( ) -	Work Phone Number ( ) -
Cell Phone Number ( ) -	Fax ( ) -

Registrar: ________________________________ Date:____________________

 ID#:____________

How would you like to be contacted for each of the following:

For Medical Issues	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Appointment Reminders	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Recalls	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Billing Statements	☐ Home Address	☐ Email		
General Notices	☐ Home Address	☐ Email		

Parent / Guardian Contact Information - Father

Father Last Name	First Name	Int.	Sr., Jr., II, III ect.	Nickname

Social Security #	Date of Birth	Primary Language	Home Email

Street Address	City	State	Zip Code

Does the child live at the above mentioned address ? ☐ YES ☐ NO

Occupation

Employer

Work Email

Primary Phone Number ( ) -

Work Phone Number ( ) -

Cell Phone Number ( ) -

Fax ( ) -

How would you like to be contacted for each of the following:

For Medical Issues	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Appointment Reminders	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Recalls	☐ Home Phone	☐ Cell Phone	☐ Work Phone	☐ Email
Billing Statements	☐ Home Address	☐ Email		
General Notices	☐ Home Address	☐ Email		

Insurance Information - Primary

Guarantor Last Name	First Name	Int.	Sex ☐ Male ☐ Female

Date of Birth

Patient Relationship to Guarantor ☐ Child ☐ Spouse ☐ Self ☐ Other: ____________________

Insurance Carrier

Medicaid ☐ TMHP ☐ Managed Care Plan

Telephone # ( ) -

Subscriber ID	Group#	Group Name
PCP Copay $	Well Visit Copay$	Deductible Amount $

Insurance Information - Secondary

Guarantor Last Name	First Name	Int.	Sex ☐ Male ☐ Female

Date of Birth

Patient Relationship to Guarantor ☐ Child ☐ Spouse ☐ Self ☐ Other: ____________________

Insurance Carrier

Medicaid ☐ TMHP ☐ Managed Care Plan

Telephone # ( ) -

Subscriber ID	Group#	Group Name
PCP Copay $	Well Visit Copay$	Deductible Amount $

Registrar:________________________________ Date:_________________

ID#: ______________

Patient Previous Medical History

Please check all that apply & provide dates, location, medical details when needed or any comments

Information about the patient	YES	NO	Details
Serious Injury or Accident			
Surgeries			
Hospitalizations			
Chickenpox			
Frequent Ear Infections			
Problems w/ Ears or Hearing			
Asthma			
Bronchitis or Bronchiolitis			
Pneumonia			
Allergy to Animals			
Outdoor Allergens			
Indoor Allergens			
Heart Problems / Murmur			
Anemia or Bleeding problems			
Blood Transfusion			
Frequent Abdominal Pain			
Constipation requiring Dr. visits			
Bladder or Kidney Infections			
Bed-Wetting (after age 5)			
Acne, Eczema (Chronic)			
Convulsions or Neurological problems			
Diabetes			
Thyroid or other Endocrine problem			
Use of Alcohol or Drugs			
Other Significant problem			
Serious Illness or Medical problem			
Serious Behavioral Mental Health Problems			
Receiving care from a Specialist			
Taking daily medications, vitamins or supplements			
Delayed or missing immunizations			

Family History

Condition	Mom	Dad	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings
Deafness							
Nasal Allergies							
Asthma							
Tuberculosis							
Heart Disease (Prior to age 50)							
High Blood Pressure (Prior to age 50)							
High Cholesterol							
Anemia							
Bleeding Disorder							
Liver Disease							
Kidney Disease							
Diabetes (Prior to age 50)							
Bed-Wetting (After age 10)							
Epilepsy or Convulsions							
Alcohol Abuse							
Drug Abuse							
Mental Illness							
Mental Retardation							
Immune Problems (HIV/AIDS)							

Social History

Who lives at home?	
What is the visitation status of a non-custodial parent (if applies)	
Age & Sex of Siblings	
Please list any Pets	
Does anyone smoke in the home?	
Are there guns in the home?	
Are any guns locked & kept separate from ammunition?	

Registrar:____ Date:____________________________

 ID#:____________

I hereby authorize Champions Pediatric Associates, to furnish information to insurance carriers concerning _________________________________ illness and /or treatment and hereby assign to the physician all payment for medical services rendered to myself and/or dependents. I understand that I am responsible for any amount not covered by insurance.

____ ________________________
Parent/ Guardian Printed Name Relationship to the patient

____ ________________________
Parent/Guardian Signature Date

Notice of Privacy Practices & Financial Policy Acknowledgement

I acknowledge that Champions Pediatric Associates provided me with a written copy of their Notice of Privacy Practices and Financial Policy.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and Financial Policy and ask questions.

____ ____________________
Parent/Guardian Printed Name Relationship to Patient

____ ____________________
Signature of Parent/Guardian Date

NO SHOW / LATE CANCELATION POLICY ACKNOWLEDGEMENT

To minimize delays in accommodating appointment requests our office will be enforcing a **$25.00** No-Show / Late Cancellation fee. **(This fee is NOT covered by any insurance carrier)**

In order to avoid this fee, please call our office at least 24 hours in advance to cancel or reschedule your appointment. We will be happy to assist you with an appointment to better accommodate your scheduling needs. If the appointment is cancelled less than 24 hours prior to the appointment, then a **$25.00** fee will be charged to each patient's account.

If you are late for a Well Child / Routine Physical Exam, the appointment may have to be rescheduled.

____ ____________________
Parent/Guardian Printed Name Relationship to Patient

____ ____________________
Parent/Guardian Signature Date

Registrar:_________________________________ Date:_________________

 ID#:_______________

Consent to Treat

General Consent to Treat:
I am the parent/guardian of ____(name of child). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize the consent to such medical care, treatment, and diagnostic tests that Champions Pediatric Associates deem are necessary for my child. I understand that by signing this form, I am giving permission to the physicians, practitioners, physician assistants, nurses and other health care professionals to provide treatment to my child as long as this child is a patient in this office, or until I withdraw my consent. I understand that an official withdrawal should be in writing and should include the name and address where to release my child's medical records. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Delegation of Consent:
I hereby authorize (when I am unavailable to give consent) the following individual(s): ____

____

Whose relationship to this child is ____ to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes, but is not limited to, medical & surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

I understand that my child will NOT be seen at Champions Pediatric Associates if accompanied by someone that is not listed on this delegation of consent.

____ ___________________________
Parent/Guardian Printed Name — Relationship to patient

____ ___________________________
Parent/Guardian Signature — Date

____ ___________________________
Witness — Translator/Reader (if applicable)

Deductible Collection Policy Acknowledgment

As of January 1, 2016 Champions Pediatric Associates is introducing a new Deductible Collection Policy that we need to make each and every parent aware of. Champions Pediatric Associates providers work very hard caring for the children we see each and every day and feel we need to receive compensation for that hard work, therefore our management staff has decided that upon a patient making an appointment and the verification process shows there is a Deductible that applies towards that exam we will begin collecting a portion of the Deductible upfront.

This will actually help in two ways.

#1. It will reduce the amount of your responsibility upon processing of the claim by your insurance.
#2. We should see an increase in our patient collections.

Upon Insurance Verification and it is discovered that the Deductible has not been satisfied we will collect Deductibles as follows:

- Deductible amounts that have not been satisfied that are **over** $50 we will collect $50.00 at the visit
- Deductible amounts that have not been satisfied that are **under** $50 we will collect the balance that is left.
  For example: if the amount remaining towards your deductible is $27.50 we will collect $27.50, if its $.49 we will collect $.49.

We appreciate your understanding and as always Thank You for allowing Champions Pediatric Associates to care for your child (ren).

____ ___________________________
Parent/Guardian Printed Name — Relationship to patient

____ ___________________________
Parent/Guardian Signature — Date

Registrar:_____________________________________ Date:______________________

Addressing your Vaccine Concerns

A generation ago, America faced one of the most contagious diseases in the world – so contagious that just one infected person could spread it to nearly all their close contacts. Each summer for decades, we also faced a dreaded childhood illness that could cause paralysis and respiratory failure. Thanks to immunizations, these illnesses: measles and polio and many others have been largely eliminated in the U.S.

Although we do not often see these diseases in our communities anymore, they are only a plane ride away. The germs that cause them still exist around the world. Just one case of polio would reintroduce it into our country, if people are not immunized, according to the American Academy of Pediatrics (AAP). Hence, the threat of disease is still out there for anyone who is not immunized, including infants too young for vaccinations and children with medical conditions whose vaccinations must be delayed.

Vaccines are tested and studied for as long as 10 years before they are made available to the general public, and most side effects are mild. Some parents oppose immunizations out of concern for their children's safety. Although this is understandable, medical evidence has proven that the risk of contracting disease is much higher than the risk of adverse effects from immunizations.

Unfortunately, people tend to take vaccinating and its importance for granted because they do not see diseases like polio, whooping cough, meningitis, chicken pox or tetanus. This is only because the vaccinations are doing exactly what they are meant to do and that is to help protect our communities.

Any doubts or concerns regarding vaccinating your child should be brought to your medical provider's attention at your first visit.

Our Office Policy

As pediatric medical providers, our entire group recognizes your concern for your child's welfare and we do respect your right to decide what is best. We hope that you will appreciate our education, training and sincere desire to help keep your child healthy and strong.

It is with this genuine care and concern for your child that we implement and enforce all guidelines and vaccination schedules provided by both the American Academy of Pediatrics and the Centers for Disease Control.

If you absolutely refuse to vaccinate your child despite our efforts, we would ask that you would find another provider who shares your philosophy.

I understand that by refusing vaccines I am acting against the recommendations of my child's medical provider and am placing my child at risk. I understand that Champions Pediatric Associates or any of its physicians or employees are not legally liable for any claims or expense that may arise should my child contract a related illness due to my decision not to vaccinate. Furthermore, I acknowledge that these illnesses can be safely prevented by commonly administered immunizations.

______________________________ ____ _______________
Printed Name (Mother) Signature Date

______________________________ ____ _______________
Printed Name (Father) Signature Date

______________________________ ____ _______________
Printed Name (Guardian) Signature Date

Registrar:____ Date:________________

 ID#________________

New Born Dependent Policy / PCP Selection

○ Please note that newborns **MAY** have coverage under the mother's insurance for up to 30 days. Please verify length of coverage for your specific insurance, as this information may differ. Newborn dependents **MUST** be added to the insurance (by the policyholder) before the end of the termination date. The process of adding the dependent can take up to 10 days to work through the system. If not added, parents will be responsible for all charges. This includes examinations, vaccinations, newborn screenings, ect.

○ Please select Dr. Shams S. Nandwani as your child's Primary Care Physician. This PCP must be selected prior to the next visit. Contact your insurance company for further information. Please speak with our scheduling staff regarding any questions or concerns.

Patient Name ____________________ Date of Birth ____________________

Parent/Guardian Printed Name ____________________ Relationship to patient ____________________

Parent/Guardian Signature ____________________ Date ____________________

Assignment and Release

Your signature acknowledges your understanding of the Patient Consent section on this form. Your signature indicates your choices regarding the following acknowledgements, consents, authorizations, releases and assignments:

- Receipt of Notice of Privacy Practices
- Release of Photos/ Radiographs/ Videos
- Release of Medical Information
- Disclosure to Patients

Your signature below also authorizes Champions Pediatric Associates to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed. "I authorize that any benefits due be paid directly to my physician. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given)."

Patient Name ____________________ Date of Birth ____________________

Parent/Guardian Printed Name ____________________ Relationship to patient ____________________

Parent/Guardian Signature ____________________ Date ____________________

Registrar:____ Date:________________