Alamo Heights Pediatrics - Patient Demographic Info.

PATIENT LEGAL Name :_____ **Male/Female** **Date of birth:**_____

SSN:_____ **Name Child Would Like to Be Called (if different from above):**_____

***Address:**_____ **City/State/Zip:** _____

In compliance with Federal HIPPA Privacy Regulations, will you authorize Alamo Heights Pediatrics to leave a detailed message on your answering machine/voicemail that may include appointment reminders, lab and x-ray results, referral information, and other private information protected by privacy rules?

Telephone Consent Authorization **YES or NO** ***← CIRCLE ONE***

Main contact phone #: _____ **Secondary phone #:** _____

Email: _____

Parent 1 Name:_____ **Parent 2 Name:**_____

Address:_____ **Address:**_____

City/State/Zip:_____ **City/State/Zip:**_____

SSN:_____ **DOB:**_____ **SSN:**_____ **DOB:**_____

Primary Phone:_____ **Primary Phone:**_____

Employer:_____ **Employer:**_____

Siblings:

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

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

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

****Authorized Family Members/Adults****

It is the policy of Alamo Heights Pediatrics that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals, other than parents, are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

Name:_____ **Phone:**_____ **Relationship:**_____

Name:_____ **Phone:**_____ **Relationship:**_____

Responsible Party is the individual who agrees to accept financial responsibility for the payment of all services performed at Alamo Heights Pediatrics.

The individual may not necessarily be the insurance card holder. The responsible party must read and sign below.

Name:_____ Relationship to Patient:_____

Address (if different from above)_____ Social Security Number:_____

Phone # :_____ Email: _____

Parent/Guardian/Self:_____ **Date:**_____

(Please complete BACK SIDE of form) →

Physical Consent Policy - Notice to all patients receiving Physical.

Please be aware of your benefits from YOUR insurance carrier prior to your visit to ensure benefits and coverage for a Routine Physical **(depending on insurance, sometimes hearing and vision are not covered).** Any symptoms you might have outside the Preventative Routine Physical will be coded as an Office Visit and your insurance may require your co-pay and/or additional fees.

A normal physical will *only* include preventative care.

For further explanation please contact your insurance carrier. If there are any abnormal symptoms, diagnosis, medication refills or other examination due to acute illness, or acute behavioral concerns, your health care provider is required to document the chart with additional codes that may result in an Office Visit charge in addition to your Physical. In these cases, the insurance will require you to pay the contracted co-pay at the time of service or it may be billed once insurance has processed the EOB (explanation of benefits)

By signing below, I acknowledge that I have read, understand, and agree to abide by the terms stipulated above.

Payment for professional services is the responsibility of the accompanying parent/guardian at the time services are rendered. Co-pays and/or any deductible as well as all outstanding balances on the account are due upon check-in. As a courtesy, the office will file an insurance claim for reimbursement. It is the policy holder's responsibility to verify coverage under his or her policy, including co-pays and deductible provisions prior to any appointment. If for any reason the insurance plan declines to cover a service, it becomes the obligation of the parent/guardian to pay in full for such services. **There is a $20.00 fee charged for any appointment that is cancelled the same day it's scheduled for, or a no show will incur a $25.00 fee. Each consecutive No-Show after will increase by $5.00. After 3 consecutive on-time visits, we will reduce the no-show fee back to $25.00, this fee is not covered by insurance**.

I hereby authorize this office to release my medical records to my insurance company for the purpose of filing claims. We reserve the right to sever doctor/patient relationships if these terms are not met. I have read and agree to abide by this payment for services policy. I understand that my information may be used to send e-scripts to my pharmacy. This authorization will remain in effect until changed or terminated by you or another individual/legal entity authorized to do so by court order or law submitting a written request to the Alamo Heights Pediatrics Privacy Manager in person or by mail to: Alamo Heights Pediatrics, 1919 Oakwell Farms Parkway, Suite 257, San Antonio, Tx 78218.

By signing below, I hereby acknowledge that I have read and agree to all terms and conditions of the office policies, demographic information and Notice of Privacy Practices provided by Alamo Heights Pediatrics.

Parent/Guardian/Self:_____ **Date:**_____

(revised 10/2024)