Helotes pediatrics

PATIENT INFORMATION

Child's Name (Last, First Middle)				Today's Date	
Date of Birth	Age	Gender Male / Female	Patient's SSN		
Home Address (Street/Apt)		City		State	Zip

PARENT / GUARDIAN INFORMATION

Mother or Guardian/Responsible Party			Relationship to Patient		
Home Address (Street/Apt)		City		State	Zip
Home Phone	Cell Phone	E-Mail		Preferred Phone No	
Employer		Work Phone			
Employer Address		City		State	Zip
Father or Guardian /Responsible Party			Relationship to Patient		
Home Address (if different from above) (Street/Apt)		City		State	Zip
Home Phone	Cell Phone	E-Mail		Preferred Phone No	
Employer		Work Phone			
Employer Address		City		State	Zip

PRIMARY INSURANCE

Name of Insurance Company		Phone			
Address		City		State	Zip
Name of Policy Holder			Relationship to Patient		
DOB of Policy Holder	SSN of Policy Holder	Group Number		Policy ID Number	

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Phone			
Address		City		State	Zip
Name of Policy Holder			Relationship to Patient		
DOB of Policy Holder	SSN of Policy Holder	Group Number		Policy ID Number	

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Authorization Form

PATIENT INFORMATION	
Child's Name (last, first, middle)	Today's Date

PLEASE INITIAL THE FOLLOWING STATEMENTS	
	I authorize the release of any medical information necessary to process the applicable claim.
	I authorize payment of medical and surgical benefits to Helotes Pediatrics, PA

Signature of Responsible Party	Date
Relationship to Patient	

Please let us know if you would ike medical records transferred to our office. We will be happy to help you.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Parent/Guardian	Date
Relationship to Patient	

IS ANY OTHER PERSON ALLOWED TO BRING THE ABOVE PATIENT IN FOR A MEDICAL VISIT?		
Name	Relationship to Patient	Cell Phone
Name	Relationship to Patient	Cell Phone

IN CASE OF EMERGENCY, CONTACT:		
Name		Relationship to Patient
Home Phone	Cell Phone	Work Phone
Name		Relationship to Patient
Home Phone	Cell Phone	Work Phone

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Confidential Health History

Patient's Name:	Patient's Date of Birth:	Today's Date:

PAST MEDICAL HISTORY: Please check any current or past medical conditions (for patient) listed below

☐ ADD	☐ Autism	☐ Eczema	Please list any others:
☐ ADHD	☐ Celiac Disease	☐ Immune Deficiency	_____
☐ Anaphylaxis	☐ Congenital Heart Defect	☐ Migraine Headaches	_____
☐ Anxiety	☐ Depression	☐ Scoliosis	_____
☐ Asthma	☐ Diabetes Mellitus, Type I (Juvenile)	☐ Seizure	

SURGICAL HISTORY: Please check any past surgeries (for patient) listed below

☐ Adenoidectomy Date/Age:	☐ Heart Surgery Date/Age:	☐ Pyloric Stenosis Date/Age:
☐ Appendectomy Date/Age:	☐ Hernia Repair Date/Age:	☐ T&A Date/Age:
☐ Eye Surgery Date/Age:	☐ PET (ear tubes) Date/Age:	☐ Tonsillectomy Date/Age:
Other:	Other:	Other:

HOSPITALIZATIONS: Please list any inpatient hospitalizations (do not include simple ER visits)

Date	Hospital	Reason for hospitalization

MEDICATIONS: Please list all medications and dosages

MEDICATION	Dose and frequency	MEDICATION	Dose and frequency

LATEX ALLERGY: Is the patient allergic to Latex?	If yes, what type of reaction does the patient experience?
☐ Yes ☐ No	

MEDICATION ALLERGY: Please list any drug/medication allergies below

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

11085 Bandera Rd Ste. 102 San Antonio, TX 78250
(210) 372-0505

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FOOD ALLERGIES: Please list any severe food allergies			
Name of Food	Type of Reaction	Name of Food	Type of Reaction

FAMILY HISTORY: Please check any illnesses in close family members and indicate relationship to patient

- ☐ ADD
- ☐ ADHD
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Diabetes Mellitus, Type I (Juvenile)
- ☐ Diabetes Mellitus, Type II (Adult onset)
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Scoliosis
- ☐ Seizure (Febrile or Non-Febrile)

OTHER:

SOCIAL HISTORY:

Who does the patient live with?
(Please check below)

- ☐ Both Parents
- ☐ Mother
- ☐ Father
- ☐ Grandparents
- ☐ Foster Parents
- ☐ Siblings

Education:

- ☐ Public School
- ☐ Private School
- ☐ Home School
- ☐ Special Education
- ☐ Day Care

Type of Pets at Home

_____
_____
_____
_____

Preferred Pharmacy (ex. Walgreens on Braun/1604) : _____

Parent signature: _____

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(210) 372-0505

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Patient Name: _____ DOB: ___/_____/_____

New Patient Information & Financial Policy

Welcome to Helotes Pediatrics! We appreciate the opportunity to work with you and your child. The following information is provided so that we may serve you better:

Appointments:

- **Appointments** can be scheduled through our office at 210-372-0505 Monday through Friday. ONLY parents or legal guardians may schedule appointments. ONLY parents or legal guardians MUST accompany patients at first initial visit. Picture ID will be required for EVERY visit along with proof of insurance.
- **Cancellations / No shows:** If you need to reschedule your appointment, please call us at least 24 hours in advance of the scheduled time. If you must cancel an appointment our office requests a minimum 2-hour notice so that we may care for another child in need. Missed appointments without proper notice will incur a fee. Effective 06/01/2023, there will be a flat fee of $50 for all NO SHOWS.
- **Late Arrivals:** Clients arriving more than TEN minutes late will be worked in only if another patient seeing the same physician can be moved up. Otherwise, rescheduling may be necessary.
- **Walk-ins:** We are currently not taking walk-ins however we do maintain a waiting list for same-day appointments, which are often available due to a prior cancellation. Please call our office about availability.
- **Minor Patients:** We cannot see a minor patient without a parent or other responsible adult. Please do not send your minors in for a visit alone. Minor patients who arrive alone will not be seen until a parent arrives, within the 10 min window. When your child turns 18, they are considered legal adults and as such we cannot release any information without their written consent.

Initials _____

Insurance & Billing/Collections:

- **Insurance:** Helotes Pediatrics, PA participates with many insurance plans. Inclusion in the insurance plan does not indicate that we participate in ALL groups provided by these insurers. Please verify with your insurance plan or employer / agent that we participate with your specific group plan. Please remember that your insurance is a contract between you and your insurance company. You are personally responsible for any bill, or portion thereof, not paid by your insurance company. Payment is due at the time services are rendered, including co-pays. If your health plan determines any service to be "not covered," you will be responsible for the complete charge. Prior to your child's first visit, we verify eligibility and benefits with your insurance carrier. Prior to succeeding visits, please notify us of any changes in your insurance.
  Parents are responsible for non-covered services.
- **Payments:** All applicable fees, deductibles, coinsurance, or copays must be paid at the time of your appointment. We accept cash, checks, VISA, MASTERCARD, AMEX, and DISCOVER. There is a $25 charge for returned checks. Parents who present checks that are dishonored are required to pay future amounts due with cash, money orders or credit cards.
- During your wellness visit if another problem or diagnosis is discovered, discussed, and treated there may be an additional charge.
- As an advocate for our young patients, Helotes Pediatrics, PA will not intervene in any custody dispute or financial responsibility dispute between parents or other responsible parties. Helotes Pediatrics PA will send a statement to the address provided and cannot look to more than one party for financial responsibility.

Initials _____

HMO Referrals:

- If your HMO insurer requires written authorization (referrals or pre-certifications) from your Primary Care Physician or Insurance, a copy of the authorization must be on file in our office before we schedule your appointment. It is ultimately your responsibility to ensure that your visit is pre-approved and that your insurance company will pay; otherwise, you are responsible for payment in full.

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Newborns:

- Most insurances no longer provide auto coverage for newborns on policies and will not pay for visits during the first 30 days UNLESS the child has been added to the policy by the parent during that time. For newborn visits during the first 45 days, full payment will be due at the time of the visit. We will promptly refund and credit balances after insurance has confirmed active coverage and payment has been received.

Medication Refill Request:

- All refill requests are processed through our parent portal unless your physician prescribes them at the time of your visit. You may also request refills through your pharmacy. After business hours, we will only approve medication refill requests on an emergency basis. NOTE: ADHD medication refills should be initiated 2-3 days in advance.

Telephone Consultations:

- Our physicians do not conduct telephone consultations. Please utilize the Patient Portal for inquiries. We will do our absolute best to respond on the same day, however scheduling may dictate that messages are returned the following day.

Lab Test Results:

- Lab results will be provided through the Patient Portal. Please make sure your account is active and monitored.

Emergency Service:

- If your child has a life-threatening emergency, call 911 or proceed to the nearest emergency facility. For minor emergencies and acute illness (i.e., fever, vomiting) after hours, Call-A-Nurse is available at 210-226-8773.

Answering Service:

- We operate a 24-hour answering service for emergencies. Call our main number at 210-372-0505.

"I, the parent or legal guardian, agree to the above policies and agree to the terms regarding payment and payment responsibilities." I also agree to give my consent for Helotes Pediatrics P.A. and their staff to leave voicemail messages at the primary number listed on file.

Signature _____ Print _____ Today's Date____/_____/____

Patient Name _____Witness Signature_____

How did you hear about us? Please circle one.

Social Media **Friend/Family**

Newspaper **Insurance** **Drove by** **Mailer _____**

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Patient Financial Responsibility Statement

The patient, parent or guardian accompanying the patient is responsible for providing our office with a valid and current insurance card. We must be notified of any changes prior to rendering services. Patients unable to provide valid insurance information may be required to pay in full at time of service or reschedule their appointment.

The patient, parent or guardian accompanying the patient must pay any co-payment and applicable deductible amounts, as directed by insurance, at the time of service unless prior arrangements have been made with our office.

The bill will be sent to the health plan on record for direct payment to our office.

If insurance has not paid our claim within 60 days, we may expect payment from the patient.

If by mistake, the health plan remits payment to the patient, payment should be forwarded to our office along with all the paperwork sent to you at the time.

The patient, parent or guardian will remain responsible for any services that are not covered or noted as patient responsibility by the health plan.

Some of the reasons health plans may refuse or deny payment of a claim are:

- The provider of service is not listed as the primary care physician “PCP” for the patient, and/or no referral was obtained, or the provider is out of network.
- Services provided were for a pre-existing illness that is not covered by the patient’s health plan.
- The patient’s deductible or co-insurance amount has not been met.
- The type of medical services received is not covered by your plan or subject to a maximum benefit allowance (generally per calendar year).
- The health plan was not in effect at the time the service was rendered.
- Failure to provide required documentation requested by insurance company.
- The patient has other insurance noted as the primary carrier which must be filed first.
- The insurance company requires the patient to contact them regarding whether or not the patient is covered by another health plan (generally required to update at least annually).
- Services indicate the patient was seen for an injury or accident. The patient must provide information regarding the accident or injury to the health plan as requested before the claim is paid.
- The patient or dependent receiving the services is not shown as a covered dependent under the health plan.

Please note that payment collected at the time of service may not reflect the full patient responsibility after insurance. Our office is not responsible for any limitations in coverage that may be included in your plan. Should your health plan deny claims for any of the above reasons, you will then become responsible for the bill. It is the responsibility of the patient to pay the denied amounts in full. We advise our families to understand their insurance benefits and review explanation of benefits and patient billing statements carefully. If you feel there has been an error, always contact the appropriate party with questions within a timely manner. Patient amounts owed are considered past due 30 days after the date of the initial billing statement. Anytime the patient is aware there will be a delay in payment, whether by the patient or insurance, it is important to notify our billing office of the situation. Helotes Pediatrics P.A. understands that circumstances can sometimes arise. However, to allow additional time to pay, work through insurance problems or to establish other payment arrangements, we must be informed.

Failure to Pay

Continued failure to respond to billing statements or make payments may result in the suspension of certain non-urgent services and ultimately in dismissal from our practice. Please be advised outstanding debts will be forwarded to a collection service where unpaid balances will be reported to the appropriate credit agencies. Should you feel you have made an overpayment to our office or are awaiting a refund based on insurance reimbursement, please contact the appropriate account representative in our Billing Office with questions. If you are entitled to a refund, our office will issue a refund check to the responsible party listed on the account, upon request. Due to the frequency of visits in pediatrics, if we do not receive a specific request for a refund, overpayments are applied as a credit to the patient's account and applied towards future visits in our office. Should you have any questions about this summary or any billing issues, we encourage you to discuss it with our Billing Office. We appreciate your dedication to our physicians and are happy to have your family as part of our practice. We look forward to providing many years of service to your family.

Newborn or Dependent Changes and Insurance

We understand when a change in dependent status occurs it is likely to be a very busy time in our families' lives. However, it can be very costly to overlook the requirements of your health plan with relation to dependent changes. It is extremely important to understand this process and the time restrictions involved.

Upon the birth of a newborn dependent, adoption, or other change to a dependent status, you must contact the employer and/or health plan to add new dependents within the time limits defined by the health plan. Most insurances companies require notification of the change within 30 days from the date of birth, adoption, or event date. If you already had dependent coverage prior to the birth of a newborn, adoption, etc., please be advised the insurance company will not automatically add the new dependent to the health plan. Failure to add the new dependent may result in a lapse of insurance coverage for the new dependent, meaning all services provided during the lapse time are the responsibility of the patient. Contact the employer or health plan with further questions regarding this process.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature _____ Print _____ Today's Date____/_____/____

Patient Name _____Witness Signature_____

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Medical Records Release Authorization

Patient Name:_____ Date of Birth:_____ Date of Request: _____

Address:_____City:_____ State:_____ Zip: _____

1) I authorize the release of my confidential health information, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.
2) The following individual or organization is authorized to make the disclosure

Doctor or Office:_____

Address:_____City:_____ State:_____ Zip: _____

Phone Number: _____ Fax Number: _____ Dates to be released:_____

3) The type of Information to be disclose:

__Complete Health Record	__Lab results	__Progress Notes
__History and Physical Report	__Old Records	__Immunization Record
__Consultation Report	__Physical/Wellness Exams	__Hospital Records

Reason for Request:_____

4) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5) This information may be disclosed to and used by the following individual or organization for the purpose of Continuity of Care:

☐ Please mail to: **Helotes Pediatrics, PA**
11085 Bandera Rd. Ste. 102
San Antonio, TX 78250
Phone: (210) 372-0505

☐ Please fax to: Fax: **(210) 372-0404**

6) I understand that I have a right to revoke this authorization at any time; I understand that if I revoke this authorization I must do so in writing and present my revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire after **180 days.**
7) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information I can contact the office manager.
8) A copy of this authorization is as valid as the original. Member/Patient has a right to a copy of this authorization.

Signature:_____ Date:_____ Phone Number:_____