

# KID CARE PEDIATRICS

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Haslet, Texas 76052  
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Fax: 817-847-1353

PLEASE PRINT

## PATIENT REGISTRATION

Patient's Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Preferred Email for appointment reminders: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_ Work # \_\_\_\_\_  
\_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Mobile Phone # \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_ Work # \_\_\_\_\_  
\_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Mobile Phone # \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_ ID # or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_ ID # or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Kid Care 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# KID CARE PEDIATRICS

Child's Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Surgical History:  None (type of surgery and when)

Hospitalizations:  None (for what illness and when)

Allergic Reactions:  None (to what and when)

Allergy to: \_\_\_\_\_ Date of reaction: \_\_\_\_\_

Allergy to: \_\_\_\_\_ Date of reaction: \_\_\_\_\_

What happened:  Rash  Difficulty Breathing

Vomiting  Facial Swelling

Other: \_\_\_\_\_

Medication History:  None (list on back if needed)

Daily Medications:

What: \_\_\_\_\_ Dose: \_\_\_\_\_

What: \_\_\_\_\_ Dose: \_\_\_\_\_

As Needed Medications:

What: \_\_\_\_\_ Dose: \_\_\_\_\_

What: \_\_\_\_\_ Dose: \_\_\_\_\_

Are Immunizations up to date?  Yes  No

(Please provide our office with a copy)

Developmental Milestones:

Rolling Over Age: \_\_\_\_\_ Walking Age: \_\_\_\_\_

Sitting Up Age: \_\_\_\_\_ Talking Age: \_\_\_\_\_

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

Family 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 -before 55  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: \_\_\_\_\_ Who \_\_\_\_\_

Birth History:

Birth weight lb \_\_\_\_\_ oz \_\_\_\_\_

Was the baby circumcised?  Yes  No

Was the baby born at term?  Yes  No \_\_\_\_\_ weeks

Was the delivery  Vaginal  Cesarean? If cesarean, why?

Were there any complications before birth 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

During pregnancy, did mother:

Use tobacco?  Yes  No Drink alcohol?  Yes  No

Use drugs or medications?  Yes  No

What \_\_\_\_\_ When \_\_\_\_\_

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?  No  Yes

If so, what kind and how many? \_\_\_\_\_

Pool at home?  No  Yes

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

Smoke exposure?  No  Yes

Daycare?  No  Yes How many days \_\_\_\_\_

Who lives in the home?  Mom  Dad  Stepmother

Stepfather  Grandmother  Grandfather

\_\_\_\_\_

How many siblings? \_\_\_\_\_ Siblings ages \_\_\_\_\_

Are there any custody concerns?  No  Yes (explain)

Let us get to know you:

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

How long has your family lived in this area? \_\_\_\_\_

Where did you live before coming to this area?

Who was your last doctor?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**KID CARE PEDIATRICS  
AUTHORIZATION FOR THE RELEASE OF INFORMATION  
AND/OR MEDICAL RECORDS**

I consent and authorize Kid Care 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.

Kid Care 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.

**The undersigned certifies that he or she has read, understands, and accepts this authorization form, and is the legal parent, guardian, or representative of the patient(s).**

\_\_\_\_\_  
Signature of Parent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Legal Representative

\_\_\_\_\_  
Relationship

# **KID CARE PEDIATRICS CONSENT TO TREAT AND FINANCIAL AUTHORIZATION**

**CONSENT TO TREAT:**

The undersigned consents to any examination or medical treatment, and or services rendered to the patient by the providers of Kid Care Pediatrics in their best judgment during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

**FINANCIAL RESPONSIBILITY:**

It is agreed that regardless of any and all assigned benefits and or monies the undersigned agree to be responsible for the total charges for services rendered. I agree that any amount that may be my responsibility are due upon request, payable to Kid Care Pediatrics. Should this account become delinquent, I agree to pay all expenses including attorney fees. If this account has a credit balance at any time, I agree that it will be applied to any previous outstanding balance prior to any monies being refunded.

**ASSIGNMENT OF BENEFITS AND INSURANCE REQUIREMENTS:**

In consideration of goods and services rendered or to be rendered, I irrevocably assign and transfer to Kid Care Pediatrics all right, title and interest in benefits or monies payable for goods or services. I understand that in the event that Kid Care Pediatrics files a claim on my behalf that the same does not impose any contractual obligation upon Kid Care Pediatrics, and that I remain responsible for instituting suit within the applicable statute of limitations. I authorize pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of the patient (and or parent or guardian), or legal agent. I authorize payors listed herein and any other payors to release any and all information requested and or related to my claims to Kid Care Pediatrics.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND ACCEPTS THE CONSENT TO TREAT AND AUTHORIZATION, AND IS THE LEGAL PARENT OR GUARDIAN OF THE PATIENTS, OR THE LEGAL REPRESENTATIVE OF THE PATIENTS.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**KID CARE PEDIATRICS  
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 49<sup>th</sup> Street  
Austin, TX 78756

YES

NO

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Signature of Parent or Legal Representative of the Patient

---

Relationship

---

Date

*Records with "No" consent will not be forwarded to the State-wide Immunization Registry (ImmTrac).*



## CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Legal Guardian's Printed Name: \_\_\_\_\_

Parent or Legal Guardian's Printed Name: \_\_\_\_\_

I hereby authorize the following person(s) to seek medical care and make decisions in relation to advice rendered from Kid Care Pediatrics and/or its employees for my child in my absence:

\_\_\_\_\_  
Printed Name Relationship

\_\_\_\_\_  
Printed Name Relationship

\_\_\_\_\_  
Printed Name Relationship

\_\_\_\_\_  
Printed Name Relationship

For the following period:

\_\_\_\_\_ through \_\_\_\_\_

Until such time as this authorization is revoked in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date



230 N. Rufe Snow Drive  
Keller, Texas 76248  
817-337-5503

6618 Fossil Bluff Dr #116  
Fort Worth, Texas 76137  
817-847-6420

590 FM 156 South #100  
Haslet, Texas 76052  
817-439-0303

### Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- a) **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan;
- b) **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies).
- c) **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible.

\_\_\_\_\_  
Patient's Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (or guardian, if a minor)

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

**HOW DID YOU FIND OUT ABOUT US AND/OR WHO MAY WE THANK  
FOR REFERRING YOU TO KID CARE PEDIATRICS?**

CHECK ALL THAT APPLY

Do you have other children that are patients of Kid Care Pediatrics?  Yes  No

- Friend(s) or Relative(s): \_\_\_\_\_ (Name of Relative/Friend)
- Previous patient
- Sibling is a patient
- Physician Referral: \_\_\_\_\_ (Name of Physician)
- Discovered while driving by
- Online yellow pages
- Tarrant County Medical Society Referral Line
- Baylor Grapevine Physician and Services Directory
- St. Elizabeth Ann Seton Church Bulletin
- Insurance Company Website
- Internet: \_\_\_\_\_ (which site)
- Other: (Business Cards, Flyer, Daycare, Pharmacy, etc.) \_\_\_\_\_

☺ ☺ ☺ **COME GROW WITH US!** ☺ ☺ ☺

Thank you for the opportunity to provide medical care to your child(ren)!

**Please consider telling others about your pleasurable experience here at KID CARE PEDIATRICS.**





## **KID CARE PEDIATRICS POLICY PAGE**

**We want to welcome you to Kid Care Pediatrics. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about your child's healthcare.**

### **Appointments:**

-Call the office at (817) 337-5503, (817) 847-6420 or (817) 439-0303 twenty-four hours prior to an appointment if the appointment is not going to be utilized/if the visit is being cancelled or postponed.

We reserve the right to charge \$25 for no show appointments without 24-hour cancellation notice.

Please be aware patients that arrive more than 5 minutes late for their appointments may be asked to reschedule.

### **Payments:**

We collect all co-pays, deductibles and co-insurance at the time of service according to the benefit quote that our office obtains from your insurance company.

We have a \$30.00 fee for all returned checks.

### **After Hour Calls:**

There is a \$15.00 processing charge for all after hours urgent nurse triage calls.

For prescription refills, ask the pharmacy to forward a medication refill request to our office. For patients that are seen at the Keller office use (FAX # 817 337-0110) and for patients that are seen at our Fort Worth office use (FAX # 817-847-6412) and for patients seen at our Haslet office use (FAX # 817-847-1353) or call the office for a refill request with 24-48 hours prior notice if possible in order to ensure a timely response. (Keller Phone # 817-337-5503) (Fort Worth Phone # 817-847-6420) (Haslet Phone# 817-439-0303)

### **Holidays:**

The office is closed for all major holidays. For urgent and emergency care, parents are to use the Cook Children's URGENT CARE and EMERGENCY CARE GUIDELINES.

### **Inclement weather:**

For inclement weather office hours, please check our website at [www.kidcarepediatrics.com](http://www.kidcarepediatrics.com). For urgent and emergency care when the office is closed due to inclement weather, please use the URGENT CARE and EMERGENCY CARE guidelines previously listed.

Kid Care Pediatrics physicians see patients from 0 – 18 years of age. Once 18 years of age, patients are referred to physicians that care for adults.

### **Vaccines:**

Kid Care Pediatrics providers believe in the efficacy of vaccines and strongly recommends patients receive state and school mandated immunizations. Elective vaccines are also offered. For families who will be refusing/declining vaccines for their children, Kid Care Pediatrics will kindly refer families to the Tarrant County Medical Society (PH# 817 732-2825) to search for other medical practices in agreement with an anti-vaccine medical philosophy.

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Initials

## BILLING POLICIES

### Newborns

- Please be aware that not all plans cover newborns with automatic coverage and patients may be asked to pay for the visit in full if our office staff is not able to verify coverage for the date of service.
- Newborn charges are often put to patient responsibility because the baby has not been added to the health plan. It is the parent's responsibility to contact our office once the baby is added to the policy so that we may submit the charges to the correct insurance, and they are processed correctly. If the parent fails to contact the office within filing time limits, the charges will remain patient responsibility. **Please call your insurance to add newborn within 30 days. Failure to add newborn child within 30 days may result in the child being denied coverage until the next enrollment period for the plan.**

### Well Child Exams

- Please be aware that a physician may bill a sick office visit (99202-99205, 99212-99215) in addition to a previously scheduled preventative visit. Per CPT coding rules the well child visit code applies only to preventative medical care but does not include any issues related to chronic diseases or acute illness. Insurance companies process these claims according to their policy guidelines and the patient may have a balance due for the unrelated sick office visit.
- All labs, hearing screen and vision screen are billed separate from the preventative office visit. Please be aware that each policy processes these charges according to your benefit guidelines and the patient may receive a bill for these services.
- We recommend that you bring with you any school forms, physical forms and medication forms to the well child visit to avoid any processing fees if the forms are not provided at the time of the appointment.
- We charge a nominal processing fee to complete School Physical forms, Medication Forms, Day Care forms if the form is not given to the Provider at the time of the appointment. You may request a copy of fee schedule from the staff.

### Current Insurance

- We verify insurance benefits prior to your child being seen by our providers. We ask that you present your current insurance card at every visit so that the office staff may copy it. Failure to update our office with correct insurance information on the date of service will result in the charges being billed to the patient. We are not able to bill new insurance if it is not provided to us in a timely manner.
- Our office staff is only given a quote of benefits by your insurance company. It is never a guarantee of payment. We do our best to verify all vaccines and office visit co-pays and deductibles; however, ANY portion that is applied to patient responsibility by the insurance company is due in full at the time of service. If you have any questions about your benefits, we recommend you contact your insurance company so that they can explain your benefit package to you. Similarly, you can ask our staff about the benefits that were quoted.

### Vaccines

- If your health plan provides no vaccine coverage or you do not have health insurance, please let the staff know. We may be able to refer your child to the county health department for vaccines.

### Payment

- We collect payment (fees, co-pays and deductibles) at the time of service. Statements will be mailed out monthly for any portion due that insurance may apply and payment in full is expected on receipt. Please review statements to ensure accuracy from all parties. **We accept cash, personal check and all major credit cards (Amex, Visa, MC and Discover) for your convenience.** Credit card payments can be paid online at [www.kidcarepediatrics.com/payments](http://www.kidcarepediatrics.com/payments).
- We charge a processing fee for FMLA letters and Letters of Medical Necessity.

### Current Information

- The parents must update new address and phone information with the front office staff. Failure to do so will result in statements being undeliverable and accounts possibly being sent to collections.

### Refunds

- Refunds must be requested from the office for any credit balance you may have on your account. They will not be automatically issued. Please allow ten business days to process. Refund will not be processed by credit card transactions. All refunds will be issued by paper check.

### Collections

- Accounts that remain unpaid will be sent to a collection agency for further collection proceedings and will result in patients being dismissed from the practice. The account will be assessed a \$25.00 collection fee.
- If you have a question about your account, please call our office at 817.337.5503 and speak to someone in the billing department. We are happy to assist you in any way that we can.

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Patient Name    DOB

Parent Signature

Date

**KID CARE 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.**

\_\_\_\_\_ **BILLING FEE:** All insurance co-pay and deductible amounts are due in full at the time of service. Your account will be charged a \$10.00 billing fee if you do not pay your co-pay or deductible on the day of your visit.

\_\_\_\_\_ **NO SHOW FEE:** Kid Care Pediatrics will charge a \$25.00 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. Please be aware that your insurance will not cover any no-show fees.

\_\_\_\_\_ **PATIENT RESPONSIBILITY:** We will submit to primary and secondary plans 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 patient responsibility. Please call your insurance if you have any questions.

\_\_\_\_\_ **WELL CHILD VISITS:** Many insurance carriers will now cover well child exams at 100% with 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 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.

\_\_\_\_\_ **COLLECTIONS FEE:** 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 \$25.00 collection fee.

\_\_\_\_\_ **NSF CHECKS:** There will be a \$30.00 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.

\_\_\_\_\_ **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 30 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.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of the healthcare service you receive from Kid Care Pediatrics, health records are generated and maintained describing your care including but not limited to your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatment, and plans for future care or treatment. This information is called "Protected Health Information".

This Notice of Privacy Practices describes how Kid Care Pediatrics may use and disclose your information and the rights that you have regarding your health information.

### **Uses and Disclosures of Health Information without Authorization**

When you obtain services from Kid Care Pediatrics, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

**Your health information will be used for treatment.** For example: Disclosure of medical information about you may be made available to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

**Your health information will be used for health care operations.** For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf if the information is necessary. Examples include external laboratories, billing agencies, and copying services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified on our contract.

### **Disclosures Required by Law or otherwise allowed without Authorization or Notification**

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;
- From public health purposes, such as reporting information about births, deaths, report child abuse or neglect and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices. Generally to prevent or control disease, injury or disability.
- For health oversight activities, such as audits, inspections, or licensure investigations;
- If you are an organ donor, organ procurement organizations for the purpose of tissue donation and transplant;
- For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information.
- To coroners and funeral directors for the purpose of identification, determination of the cause of death, or to perform their duties as authorized by law;
- To avoid a serious threat to your health or safety and the health and safety of the public or another person. Disclosures will be made only to someone who may be able to help prevent threat.
- For specific government functions, such as protection of the President of the United States;
- For Worker's Compensation purposes;
- To military command authorities as required for members of the armed forces;
- To authorized federal officials for national security and intelligence activities as authorized by law;
- We may release Health Information if asked to by law enforcement officials.

**Other Allowable Uses and Disclosures without Authorization:** Other uses or disclosure of your health information that may be made include:

- Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives;
- Notifying you of health-related benefits and services that may be of interest to you.
- When appropriate, we may share Health Information with a person involved in your medical care or payment for care (family or friend).
- We will also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- Protected Health Information may be disclosed to provide legally required notices of unauthorized access to or disclosure of your health information
- Health Information may be disclosed in response to a court or administrative order. It may also be disclosed in response to subpoena, discover request or other lawful process.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

**Uses and Disclosures Requiring Us to Give You an Opportunity to Object and Opt**

- Unless you object we may disclose your Protected Health Information to a member of your family, relative, friend or any other person you identify information that directly relates to that person’s involvement in your health care. If you object to such disclosure, we may disclose such information if necessary if we determine that it is in your best interest based on our professional judgment.
- We may disclose Protected Health Information to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition during a disaster.

**Your Written Authorization is required for Other Uses and Disclosures**

The following uses and disclosures require your written authorization:

- Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information
- Under certain circumstances we may disclose Health Information for research if approval is obtained.

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

**YOUR INDIVIDUAL RIGHTS UNDER HIPAA**

1. You have the right to request restrictions or limits on certain uses and disclosures of your protected health information. By example, you may wish to restrict your employer from knowing about medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share Protected Health Information with the Covered Entities.
2. You have the right to receive your Protected Health Information in a confidential communication from our office, such as the U.S Mail.
3. You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses of producing them. If your Protected Health Information is maintained in an electronic format, you have the right to request an electronic copy or have your information transmitted to another individual or entity. We may charge a reasonable, cost-based fee for this.
4. You have the right to request that we amend your Protected Health Information. In some cases, we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number listings.
5. You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered entities.
6. If you have read and responded to this notice through electronic media such as our practice website (if any) or e-mail, you have the right to receive a paper copy of this notice upon request.
7. You have the right to be notified upon any breach of any of your unsecured Protected Health Information.

If you would like to exercise any of these rights, please contact Bertha Gomez at (817) 337-5503, to request that necessary arrangements be made for you.

Kid Care Pediatrics is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which is currently in effect.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office and on our practice website (if any). In addition, you may receive notification by direct mail, e-mail, or other such communication as our practice may implement from time to time.

Should you ever believe your privacy rights have been violated, we request you to file a complaint with our office by contacting Bertha Gomez at (817) 337-5503. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy.

Any complaints you file will be used strictly to improve our operating procedures and in no way will you be retaliated against for filing a complaint. Should you have any questions or concerns, please contact Kid Care Pediatrics at (817) 337-5503 to obtain further information.

*I understand that I have the right to privacy of my Protected Health Information as maintained by Kid Care Pediatrics. By my signature below, I certify that I have read and understand my rights to the privacy of my Protected Health Information as well as the terms and conditions of this notice.*

Patient/Legal Representative Signature: \_\_\_\_\_

Name of Legal Representative: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

*Effective Date of Notice: Sept 25, 2024*

**Kid Care Pediatrics**  
**NOTICE TO PATIENT REGARDING USE OF A PROVIDER NOT IN NETWORK**  
**(please initial by each section below)**

\_\_\_\_\_ 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.

\_\_\_\_\_ You acknowledge that you have the right to a copy of this form.

\_\_\_\_\_  
**Signature of parent of legal guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Date of Birth**



## Advanced Practice Nurse Consent for Treatment

Patient's name \_\_\_\_\_ Patient's DOB \_\_\_\_\_

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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_