SportsSafe

New Patient Information/Acknowledgement of Privacy Practices

Today's Date: _____ MEDICAL CHART #: _____

Child's Name: (L) _____ (F) _____(MI)_____

Date of Birth: _____Place of Birth: _____ Sex: ☐ Female ☐ Male

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Preferred E-mail Address: _____

Parent 1 Name: _____ DOB: _____ SSN#: _____

Occupation: _____ Mobile Phone: _____Work Phone: _____

Parent 2 Name: _____ DOB: _____ SSN#: _____

Occupation: _____ Mobile Phone: _____Work Phone: _____

Preferred Pharmacy: _____ Location _____

I give consent for PAA to obtain Medication History and ERX benefit information from insurance carrier. ☐ Yes ☐ No

Preferred Form of Communication:(Must complete Consent for Electronic Communication, Voicemail of Medical Info & ERX)

☐ Email Address ☐ Text Message (Parent 1 or 2) ☐ Voicemail to Home Phone ☐ Voicemail to Mobile Phone

How did you hear about Pediatric Associates: ☐ Friend/Relative ☐ Web-site ☐ Insurance Plan

☐ Doctor _____ ☐ Other _____

Siblings: Child's Name (Last, First, Middle)	Date of Birth	Sex	Chart #
_____	_____	☐ Female ☐ Male	_____
_____	_____	☐ Female ☐ Male	_____
_____	_____	☐ Female ☐ Male	_____
_____	_____	☐ Female ☐ Male	_____

Primary Ins. Co. Name: _____ ID#: _____ Group #: _____

Ins. Co. Address: _____ City: _____ State: ____ Zip: _____

Policyholder Name: _____ DOB: _____ SSN#: _____

Home Address: _____ Phone #: _____

Employer: _____Work #: _____

Employers Address_____

_____

Secondary Insurance: If you have a secondary insurance, please notify the front desk.

I UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS:

1. This office expects payment at the time of service, unless specific arrangements are made in advance with the financial counselor.
2. Insurance claims will be filed only for those insurance plans we have contracted with as a participating provider.
3. Copay's, deductibles and Non-covered services are to be paid at the time of service.
4. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to PEDIATRIC ASSOCIATES OF AUSTIN, P.A.

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH 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.

_____ DATE: _____

Parent/Insured's Signature

Pediatric Associates of Austin

Notice of 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.

Purpose of this Notice

Pediatric Associates of Austin, P.A. (PAA) is required by law to maintain the privacy of your protected health information (PHI). This notice applies to all records of the health care and services you received at PAA. This notice will tell you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI. **A more detailed version of this notice may be found on PAA's website and a paper copy will be provided upon request.**

Pediatric Associates Commitment

We are required by law to: (i) make sure that your PHI is kept private; (ii) give you this notice of our legal duties and privacy practices with respect to your PHI; (iii) follow the terms of this notice as long as it is currently in effect (if we revise this notice, we will follow the terms of the revised notice as long as it is currently in effect); (iv) train our personnel concerning privacy and confidentiality; and (v) mitigate (lessen the harm of) any branch of privacy/confidentiality.

How We May Use and Disclose Information about You

The following categories (listed in bold-face print, below) describe different ways that we use and disclose your **protected health information (PHI)**. For each category of uses or disclosures we will explain what we mean and give you some examples, but not every use or disclosure in a category will be listed.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you or providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose your PHI to health care providers that are not affiliated with Pediatric Associates who may be involved in your medical care, such as physicians, who will provide follow-up care, physical therapy organizations, medical equipment suppliers, and skilled nursing facilities.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at/by PAA may be billed to (and payment may be collected from) your insurance company or a third party. For example, we may need to give your health plan information about the procedure you received at PAA so your health plan will pay us or reimburse you for the procedure.

For Health Care Operations. We are permitted to use and disclose your PHI for our business operations. These uses and disclosures are necessary to run PAA and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.

To Business Associates for Treatment, Payment, and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment of health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for health care services we provide.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative, or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person's involvement in your care. WE also may release information to someone who helps pay for your care. We may tell your family or friends that you are at PAA and what your general condition is.

Other Uses/Disclosures. We may use and disclose medical information: (i) to tell you about health-related benefits or services that may be of interest to you; (ii) to give you information about treatment options or alternatives that may be of interest to you; or (iii) to contact you as a reminder that you have an appointment for treatment or medical care at PAA.

Special Situations: We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities: We may disclose your PHI for certain public health activities (e.g., controlling disease, injury, or disability; reporting abuse or neglect; reporting drug reactions), but only if you agree or when required or authorized by law.

Health Oversight Activities. WE may disclose PHI to a government health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court of administrative order or in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. In certain designated situations, we may release PHI if asked to do so by a law enforcement official.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI: (i) to a coroner or medical examiner to identify a deceased person or to determine the cause of death; or (ii) to a funeral director as necessary to help them carry out their duties.

Other Special Situations. We may use and/or disclose PHI: (i) to organizations that handle or facilitate organ procurement or transplantation; (ii) to law enforcement when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person; (iii) as required by applicable military command authorities (if you are a member of the armed forces); (iv) to authorize federal officials for certain national security purposes; or (v) for workers compensation purposes.

When Your Authorization is Required
Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with you written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

Your Rights: You have the following rights regarding the PHI we maintain about you:

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for you care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. We will accommodate all reasonable requests.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Psychotherapy notes may not be inspected or copied. We may deny your request to inspect or receive a copy in certain very limited circumstances.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for PAA. You must include a reason that supports your request. We may deny your request for an amendment in certain limited circumstances.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" that has been made by PAA in the past six (6) years.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice (even if you have agreed to receive this notice electronically). You may ask us to give you a copy of this notice at any time.

Changes to this Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on PAA premises and on PAA's website. The notice will contain, in the lower left-hand corner, the effective date. In addition, each time you register at, or are admitted to, PAA for treatment purposes, you may request a copy of the current notice in effect.

Requests, Questions, and Complaints
If you have any questions or would like additional information on these rights, you may contact the PAA Privacy Officer at 512-458-5323. Additionally, if you believe your privacy rights have been violated, you may file a complaint with either PAA's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. You will not be penalized in any way for filing a complaint.

Please acknowledge the receipt of this Notice of Privacy Practices by completing and signing the Pediatric Associates of Austin New Patient Information Form. This form is for your records.

Pediatric Associates of Austin, After Hours Kids & SportsSafe

Consent for Electronic Communication and Voicemail Delivery of Medical Information

Pediatric Associates of Austin (PAA), After Hours Kids (AHK) and SportsSafe (SS) offer Electronic Communication and Voicemail Delivery of Medical Information, in an effort to provide efficient, quality, patient-friendly medical care. In order to be HIPAA compliant, we ask that you authorize these forms of communication. **(HIPAA (Health Insurance Portability & Accountability Act of 1996) provides specific guidelines to protect patient's privacy specifically restricting Protected Health Information (PHI). Detailed information regarding HIPAA, PHI and patient privacy can be found in the Notice of Privacy Practices, which you received on your first visit to our office, following the enactment of HIPAA. Additional copies of the Notice of Privacy Practices are available at our front desk.)**

- Electronic communication means talking through texts and emails.
- Voicemail Delivery of Medical Information is available in an effort to avoid "phone tag" issues often associated with informing patients of their test results.

Electronic Communication is a great way for us to communicate with each other.

We use texts and emails:
To remind you of appointments;
To notify you of health services that may need to be scheduled, such as well checks, labs and/ or immunizations;
To notify you of new services available at PAA;
To notify you of Holiday Closures and/or Bad Weather Delays.

You can use email to:
Send in school and camp forms to be completed;
(Please allow 72 hours to complete.)
Send non-urgent messages to our nurses/doctor;
Request a refill for your child(ren)'s prescriptions;
Request a Specialists name and contact information.

There are risks of using electronic communication, including:

- Someone who does not have permission to see your email may see it. Protect your cell phone, computer, user name, and password. Even if you protect your user name and password, someone might be able to guess it.
- Someone who does not have permission to see your email may break the law and hack into your account.

There may be other risks of using electronic communication not listed here. PAA, AHK and SS are NOT responsible for messages sent by mistake.

We DO NOT give emergency care by electronic communication. If you have an emergency, call 911. Additionally, we DO NOT use electronic communication to give you advice about your health, prescribe you a new medicine, or sell any information.

Patient Acknowledgement and Agreement to Electronic Communication and Voicemail Delivery of Medical Information

Please indicate which consents you wish to accept or decline, by check marking the appropriate boxes below:

☐ I have read this form. I fully understand the consent to communicate electronically. I understand the risks and agree to the terms. I agree to follow the rules of the electronic communication services, and understand that PAA, AHK and/or SS may stop communicating with me electronically if I do not follow these rules. I understand that PAA, AHK and/or SS may stop this service at any time and for any reason. Further, I understand that it is my choice to use these services. I can opt-out of, or stop using these services at any time by e-mailing PAA at patientcare@pediatricassociates.net.

☐ **I AGREE** ☐ **I DO NOT AGREE** to use these electronic services.

I prefer the following forms of communication: ☐ Email -- Preferred Email Address: _____

☐ Text messages – Preferred Cell Phone: _____

☐ **I DO** ☐ **I DO NOT** authorize PAA, AHK and/or SS, its physicians and employees to leave detailed messages specific to my child(ren)'s medical care, including test results on my voicemail. I understand that once a voicemail message exists, it is no longer covered under HIPAA, and therefore is not protected from unauthorized access. I understand that this authorization can be revoked at any time, by submitting a written request to the practice.

Name of Each Child in Practice: _____ _____ _____ _____

Signature: _____ Printed Name: _____

Relationship to Children: _____ Date: _____

Revised June 2017

PEDIATRIC ASSOCIATES OF AUSTIN

PERMISSION TO TREAT MINOR WITHOUT PARENT/GUARDIAN PRESENT

By law, if your child(ren) need(s) medical care, a parent must give permission, except in true emergency situations. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, trying to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

When you cannot be reached for permission, we will look to this document to determine who can consent to your child's general pediatric health care. Additionally, if your child is 16 years of age or older, and you wish for him/her to see the physician without your presence, we will also need your permission.

By providing the information below and signing, you are giving permission to the physicians and nursing staff of Pediatric Associates of Austin, P.A., to diagnose and treat your children, under the care of those appointed below, in the event you cannot be present. **Please remember that those appointed below will need to provide a photo I.D. at the time of the visit. This authorization is valid until rescinded by the parent or guardian.**

Name of Minor(s)	**Date of Birth**	**Children 16 and older can be seen without an appointed adult listed below:**	**Children 16 and older can receive vaccines without an appointed adult listed below:**
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

I/ We, being the parent(s) or legal guardian(s) of the above-named minors(s), do hereby allow the following person (s) to act on my/our behalf in authorizing medical treatment for the above-named minors(s) during the period of my/our absence. I authorize any treatment necessary as deemed by the physicians at Pediatric Associate of Austin. Please also authorize approval or denial of vaccine administration in the area below.

Name (Relative, Friend, Babysitter, etc.)	**Relationship to Child**	**Phone #**	**I authorize vaccines to be administered while under the supervision of the following person (s):**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Parent/Legal Guardian (Print Name) _____ **Relationship to Child** _____

Signature of Parent / Guardian _____ **Date** _____

Signature of Witness _____ **Date** _____

SPORTSSAFE
Concussion. Brain. Body.

Financial Responsibility and Communication Authorization Form

Patient Name: _____ Patient DOB: _____

Office Visit and Testing Charges:

Office Visit: We charge insurance for a comprehensive history assessment and neurologic examination as well as a balance assessment and cognitive test interpretation. A first visit is typically a 99205/99215 E&M code, and a follow/up visit is typically a 99214 E&M code. It may be helpful to contact your insurance company before the appointment to determine insurance coverage and possible out of pocket costs. **If your insurance policy does not cover all charges, you will be personally responsible.**

Post-injury Cognitive Testing: **The charges for cognitive testing are for test interpretation**, rather than administration. Therefore, when a cognitive test is administered **in our office *or at your child's school by his/her athletic trainer*, both will be associated with charges filed to your insurance company for test interpretation**. Cognitive testing types include ImPACT, SWAY, and Cogstate/Axon

While we will file the charges for cognitive testing interpretation to your insurance company, not all insurance companies pay for this service. Each insurance policy has its own particular stipulations regarding covered services or amount of coverage. **If your insurance policy does not cover or allow coverage for cognitive testing interpretation, you will be personally responsible for the charges.** We do our best to keep the cognitive testing services to a minimum, however, if multiple interpretations are requested by the school athletic trainer, we must bill the charges according to the interpretation services rendered. If you'd like to verify that your insurance covers cognitive testing interpretation, we recommend you call them to discuss our billed codes, which include CPT code: 96132 and diagnosis code S06.0X0D.

Post-injury cognitive test interpretation (ImPACT, SWAY, Axon): $165 per test

Parent Signature: _____

Post-injury BioSway Balance Testing: We charge at time of testing for BioSway balance tests but also file charges to your insurance company. Each insurance policy has its own particular stipulations regarding covered services or coverage amount. If your insurance policy covers Biosway balance testing and therapy, we will reimburse your payment. The insurance companies that do not typically cover the cost of BioSway testing are Aetna and Humana; due to this, we do our best to only administer this test once, thus only requiring one out-of-pocket payment.

BioSway Cost for post-injury assessment: $50 per test

Baseline ImPACT cognitive testing: Baseline tests are not filed with insurance, and you are responsible for these charges. SportsSafe offers baseline ImPACT cognitive testing. Schools may offer ImPACT, SWAY, or Cogstate/Axon.

ImPACT baseline administration in office (12 and up): $45
ImPACT baseline administration in office (4-11): $50
BioSway baseline assessment: $25 per test

Contact Sports Physicals

Many insurance providers do not cover a Sports Physical and Well-Check Up within one calendar year. For this reason, we do not bill insurance for this service but charge a flat fee of $45. We promote annual well-checks with your PCP.

Phone consultations

Phone consultations to discuss concussion symptoms, academic concerns, ImPACT testing results, etc., are $20. Insurance does not cover this cost; therefore, you are personally responsible for the charges. We do not charge this fee for routine appointment scheduling calls or consult calls lasting less than 5 minutes.

Authorization for communication with school and primary care provider

I give permission to SportsSafe Concussion Testing to share information pertinent to my child's concussion with his/her school through the athletic trainer or school nurse and with his/her primary care provider. Information may be shared via phone call, email correspondence-*which may not be secure*, or facsimile. SportsSafe shall not be held liable if you agree to these forms of communication. Parent Signature: _____

I have read the above and understand my possible financial responsibility of services rendered and hereby affix my signature as an acknowledgement of this understanding.

Completed by (signed): _____ Date: _____

Relationship to patient: _____

SportsSafe Financial Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed-care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual benefits of the plans. Each one has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated or which policy you have chosen to enroll in. Please keep in mind, while we do have contracts with most of the major carriers; we are NOT providers for many of the Affordable HealthCare Act Policies they offer.

Please read the following information carefully. If you have any questions regarding our Financial policy, you may contact our billing department.

- Before enrolling or purchasing new healthcare coverage we strongly advise that you verify, with your **INSURANCE COMPANY,** that your healthcare providers are "in- network". We only file claims for insurance policies we have contracts with. If we are "out-of-network", we still welcome you as a patient; however you will be responsible for all charges incurred.

- We verify eligibility at every appointment; however the information we receive is very basic. For detailed information regarding your insurance benefits, please contact your insurance company directly. **ANY SERVICE RENDERED WILL BE THE RESPONSIBILITY OF THE PATIENT IF THE INSURANCE DOES NOT COVER THE SERVICE.**

- All payments are due at the time of service; this includes any co-pay, co-ins, deductibles or private pay charges incurred. We do understand that there may be a time when paying for these services is not possible. In order to set up a payment arrangement, you will need to speak with our billing department BEFORE your appointment.

- **Account Guarantor:** In divorce situations, the parent who brings the child in for the visit is responsible for payment of copays and deductibles collected at the time of service. The parent who signs the financial agreement is the parent responsible for balances remaining on the account after insurance has paid. **WE ARE UNABLE TO NEGOTIATE SETTLEMENT OF YOUR MEDICAL BILLS BETWEEN YOU AND YOUR EX-SPOUSE. IF PARENTS ARE UNABLE TO RESOLVE THESE ISSUES IN ORDER TO KEEP THEIR ACCOUNT CURRENT, YOU MAY BE DISMISSED FROM THE PRACTICE for non-payment**. If you have any questions, you may contact our billing department.

- **Patient Billing/Collections:** We appreciate prompt payment of your account. If your account is past due and if a valid payment arrangement is not made or kept, your account will be sent to an OUTSIDE COLLECTION AGENCY and a 30% fee will be added to the account. In most cases, once sent to collections, the family is dismissed from the practice. To keep this from happening, please pay your bills upon receipt, or call to set up payment arrangements. We understand financial hardships may prevent you from paying your bill from time to time, but we cannot work with you if we don't hear from you. It is your responsibility to contact us about balances on your account.

I understand the Financial Policy of this office. Please <u>initial</u> each line below:

1. The office expects payment at the time of service unless specific arrangements are made in advance with the billing department. _____
2. Copay, deductibles and non-covered services are to be paid at the time of service. _____
3. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to Pediatric Associates of Austin, P.A. _____
4. By signing below, I agree that I am responsible for balances remaining on the account. _____
5. I understand that it is my responsibility to contact my insurance company prior to my child's appointment to verify a prior authorization is not required and we are an in network provider. _____

*****Fees are subject to change without notice***

_____ _____ _____

Signature Relationship to Child(ren) Date

_____

Printed Name