2913 Corporate Circle, Suite 300, Flower Mound, TX 75028
Phone 817-997-4084
Fax 817-333-1190
www.flowermoundfamilyhearing.com

PEDIATRIC PATIENT INFORMATION

Patient Information

Last Name: ______________________ First Name: ____________________ MI: ______

Address: ____

City, State and Zip: ____

Patient's Date of Birth: ________________ Mother's Name: ____________________

Home Phone: ______________________ Mother's Date of Birth: ____________________

Parent/Guarantor Information (Guarantor is the person responsible for payment for service rendered by Family Hearing Practice)

Last Name: ______________________ First Name: ____________________ MI: ______

Address: (If different than Patient)________________________________

City, State and Zip: ____

Date of Birth: ______________________ Cell Phone: ____________________

SSN: ______________________ Work Phone: ____________________

Email Address: ____

Insurance Information

Primary Insurance:

Plan Name: ______________________ Policy/ID#: ______________ Group #:__________

Subscriber's Name: ________________ Patient Relationship to Subscriber: ______________

Subscriber's DOB: ________________ Subscriber's Employer: ____________________

Secondary Insurance

Plan Name: ______________________ Policy/ID#: ______________ Group #:__________

Subscriber's Name: ________________ Patient Relationship to Subscriber: ______________

Subscriber's DOB: ________________ Subscriber's Employer: ____________________

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical and surgical benefits to Family Hearing Practice, PLLC. **I also agree to abide by Family Hearing Practice 24 hour cancellation policy and understand that I may be charged between $35 and $100 if proper notification is not given.**

____ ______________________

Signature of Patient or Guardian Date

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PEDIATRIC MEDICAL HISTORY

Patient's Name: ________________________ Today's Date: ________________________

Pediatrician: ________________________ Referring Doctor: ________________________

Pediatrician Address: ________________________ Referring Doctor Address: ________________________

____

Phone Number: ________________________ Phone Number: ________________________

Birth Hospital: ________________________

BIRTH HISTORY

1. What is the reason for today's visit? ________________________
2. Did the child's mother experience any complications/illnesses during pregnancy? ❑Yes ❑No
   a. If yes, please describe: ________________________

   ____
3. Length of Pregnancy__________Length of Labor__________Childs Birth Weight__________
4. Was the child in the NICU (Neonatal Intensive Care Unit)? ❑Yes ❑No
   a. If yes, how long was the child in the NICU? ________________________
5. Did your child receive oxygen? ❑Yes ❑No
   a. If yes, for how long? ________________________
6. Did your child receive any known medications/treatments while in the NICU? ❑Yes ❑No
   a. If yes, please list: ________________________
7. Please check an y conditions that were present at the time of your child's birth:

   ❑Jaundice ❑Toxoplasmosis ❑Seizures ❑Cytomegalovirus (CMV)
   ❑Breathing Problems ❑Herpes Simplex❑Rubella
   ❑Blood Exchange ❑Hyperbilirubinemia ❑Syphilis
   ❑Other: ________________________

8. Please check if your child has experienced any of the following illnesses or conditions:

   ❑Allergies ❑Asthma ❑Colds ❑Tonsillitis
   ❑Headaches ❑Dizziness ❑Tinnitus ❑Sinusitis
   ❑Pneumonia ❑Convulsions ❑Croup ❑Chicken Pox
   ❑Encephalitis ❑Measles ❑Mumps ❑German Measles
   ❑High Fevers ❑Ear Infections ❑Draining Ears ❑Mastoiditis
   ❑Influenza ❑Meningitis ❑Head Injury
   ❑Other: ________________________

MORE ON BACK

MEDICAL HISTORY

1. Has your child been diagnosed with a syndrome? qYes qNo
   a. If so, please describe: ______________________________
2. Has your child been hospitalized? qYes qNo
   a. If so, please describe: ______________________________
3. Is your child currently on medication? qYes qNo
   a. If so, please describe: ______________________________
4. Is there a family history of hearing loss? qYes qNo
   a. If so, please describe: ______________________________
5. Does your child have a vision impairment? qYes qNo
   a. If so, please describe: ______________________________
6. Did your child pass their newborn hearing screening at birth? qYes qNo
   a. If no, was follow-up testing pursued? qYes qNo
7. Has your child ever received a hearing test? qYes qNo
   a. If yes, where and what results were obtained? ______________________________
8. Has your child ever had ear surgery? qYes qNo
   a. If yes, where and what results were obtained? ______________________________
9. H as your child ever received a speech/language evaluation? qYes qNo
   a. If yes, where and what results were obtained? ______________________________
10. Do you suspect that your child has a hearing loss? qYes qNo
11. Are you concerned regarding your child's speech production abilities? qYes qNo

SCHOOL INFORMATION

School Name: ______________________________ Grade: ______________

Does your child receive any special services? ______________________________

Does your child currently have an IEP (Individualized Education Plan)? qYes qNo

If yes, please describe: ______________________________

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PATIENT PAYMENT POLICY

Thank you for choosing Family Hearing Practice for your treatment and care. We understand that medical bills can be costly and unexpected; therefore, we try to make the payment process as easy on you as possible.

Do you file to my insurance?
We file to your insurance company as a courtesy to you. We will attempt to verify your insurance benefits before each visit so that you are aware on any charges you may incur beforehand. It is important to understand that some co –insurance amounts are not able to be determined until insurance pays on a claim. Any statement you receive from our office is sent to you as a request for payment, not as a notification of insurance payment. If you are receiving a statement from our office, it is because your insurance has said that the amount owed is your responsibility. If you are questioning the bill, you may contact your insurance company directly to find out why they have applied the amount to your out of pocket expenses. You may also contact our office.

Do I need a referral?
If you have an HMO plan with which we are contracted, you may need a referral authorization from your primary care physician. Our office will attempt to obtain a referral prior to your visit, but if we have not received one at the time of your visit, you will be charged for the visit.

How may I pay?
Our office accepts payment by cash, Visa, MasterCard, American Express, and Discover. We also accept checks, but there will be a $30 charge on any returned checks for insufficient funds, and our office may seek legal action. If an account is not paid within 90 days from the date of service, a $20 service fee will be added to the total amount owed.

Do you take Care Credit?
Our office does accept Care Credit as a form of payment. Care Credit is a medical credit card that enables you to pay your bills at 0% interest, and you are able to apply in the comfort of your own ho me at CareCredit.com. If you have any questions about Care Credit or wish to sign up, please ask to speak to speak to one of our office staff.

Do you charge for Medical Records?
Our office may charge for certain medical records that are sent. Some records sent for continuing treatment are complimentary. Federal disability forms are charged $18. Complete medical records are $25, and any records being requested by law firms where we may be a witness for you in a law suit are $50.

I acknowledge that I have read, understand, and will comply with these payment policies.

Signature: ____ Date: ____

Patient, Guarantor, or Legal Guardian

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Family Hearing Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with our healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Family Hearing Practice *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Family Hearing Practice has the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices,* the revised *Notice* will be mailed to me if information for treatment, payment, or healthcare operations and that Family Hearing Practice is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Family Hearing Practice has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my protected health information:

____

____

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I give permission for my protected health information to be disclosed for purposes of communicating results, finding, and care decisions to:

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

(Please make sure if the patient is a minor that you have included any family members you would like for us to share information with.)

I have been provided and reviewed the Family Hearing Practice *Notice of Privacy Practices.* I understand that if I have any questions or complaints, I may contact the practice's HIPAA Compliance Officer at 817-997-4084.

Printed Name: ______________________________

Signature: ______________________________ **Date:** ______________________________

If not patient, relationship to patient: ______________________________

If you are the patient's Power of Attorney, please provide us with documentation for our records.