LAKE VISTA PEDIATRICS
An Integrative Approach

Patient Information

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth (MM/DD/YY): _____

Gender (circle): MALE FEMALE

Address: _____

City: _____ State: ____ Zip: _____

Cell Phone: (___) _____

Home Phone: (___) _____

Work Phone: (___) _____

Parent/Guardian Information

_____ MOTHER _____ FATHER _____ OTHER

If Other, please specify: _____

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YY): _____

___ Check if address is same as patient information

Address: _____

City: _____ State: ____ Zip: _____

Cell Phone: (___) _____

Home Phone: (___) _____

Work Phone: (___) _____

E-mail Address: _____

_____ MOTHER _____ FATHER _____ OTHER

If Other, please specify: _____

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YY): _____

___ Check if address is same as patient information

Address: _____

City: _____ State: ____ Zip: _____

Cell Phone: (___) _____

Home Phone: (___) _____

Work Phone: (___) _____

E-mail Address: _____

Insurance Information

Insurance Carrier: _____

Policy Holder: _____

Policy Holder SSN#: _____

ID/Policy/Member #: _____

Group #: _____

Relationship to Patient: _____

Insurance Information #2 - *If applicable*

Insurance Carrier: _____

Policy Holder: _____

Policy Holder SSN#: _____

ID/Policy/Member #: _____

Group #: _____

Relationship to Patient: _____

Emergency Contact (other than Parents)

Contact Name: _____

Relationship to Patient: _____

Cell Phone: (___) _____

Home Phone: (___) _____

Close Relative (not at your address)

Contact Name: _____

Relationship to Patient: _____

Cell Phone: (___) _____

Home Phone: (___) _____

Release of Information

By signing below, I authorize Lake Vista Pediatrics furnish all necessary medical information to my insurance company.

Signature: _____

Printed Name: _____

Date: _____

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STATEMENT OF OFFICE POLICIES

The following office policies are implemented to assure a pleasant office visit.

Insurance Cards: Upon arrival, please sign in at the front desk and present your insurance card. If a new policy is in effect, be prepared to have the new card copied/scanned. It is your responsibility to have the PCP (Primary Care Physician) listed as Lake Vista Pediatrics or the doctor's name. Out of network insurance policies will reflect higher charges. All policies differ in co-payments and subject-to deductibles. Please review your policy and know your benefits. Insurance companies do not guarantee coverage of service until the claim is processed.

Demographics: Upon arrival of appointment, you will be asked to fill out a form to update any demographics (address, phone, email) that may have changed, if applicable.

Payments: Copays are collected at the front desk before your visit with the doctor, and if you are subject to deductible, your payment will be collected after your visit. We accept CASH, CHECK, AMEX, DC, MC and VISA. NSF (Non-Sufficient Funds) checks will be charged a fee of $50.00.

Billing Statements: Patient balances are billed immediately upon receipt of your insurance EOB (explanation of benefits). Remittance is due within 30 days of receipt of your billing statement.

Medical Records: A signed HIPAA regulation form is required before records are released. There is a $15.00 charge for records (per patient), when requested by parent/guardian/doctor's office. Records are copied to CD or printed if not more than 25 pages. Please allow one week for completion.

Referrals: It is important that you inform the medical assistants of any referrals or authorizations required to see specialists and pre-authorized test procedures. You must fully understand your insurance policy requirements.

Patient Name _____ **Parent/Guardian Signature** _____ **Date:** _____

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IMMUNIZATION POLICY

Lake Vista Pediatrics maintains a pro-immunization stance, as the overall benefits of immunizations are evidence based, and the adverse reactions to date have been studied extensively and found to be a rare occurrence. It is our mission to assist parents in keeping your children free of contagious harmful diseases. We offer all individual vaccine formulations, except when unavailable, such as is the case with MMR and DTAP, and follow a conservative schedule of administration without compromising your child's healthcare needs.

Lake Vista Pediatrics feels strongly that every child deserves quality healthcare, and is committed to serving children in the community who are under-immunized. However, it is paramount that parents of these children recognize our goal, and understand that we cannot be held accountable for the untoward consequences of vaccine preventable diseases in children whose parents choose not to immunize or under immunized.

Patient Name	Parent/Guardian Signature	Date:
_____	_____	_____

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Financial Policy

We recognize the need for clear understanding between the patient/parent/guardian and the physician regarding the financial arrangements for medical care. This statement represents the policies of the physicians at Lake Vista Pediatrics covering treatment and diagnostics studies in the office as well as in the hospital.

Fees for professional services are contracted between the physician and your insurance company. Payment is required on the day of service for all office visits. This payment includes co-payments, deductibles, and non-covered services. Our insurance department will file with your insurance company, but if payment is not rendered by your insurance company within 30 days of the date of filing, you may be asked to contact your insurer to inquire about the nature of the delay. You may be requested to make payments on the account, pending resolution. Any overpayment will be credited to you in a timely manner. Please understand that we are obligated by contract to submit your claim as soon as possible after services are rendered, and that your insurance is obligated by law to submit payment within 30 days subsequent to filing. Any deviation from this declaration from either party renders this contract null and void.

Our office has the option to assign delinquent accounts past 60 days to our collection agency, Southern Credit Recovery, once an account is transferred, healthcare will be terminated by all physicians at Lake Vista Pediatrics. You will be responsible for the charges incurred as a result of the account transfer, which will include your unpaid delinquent balance and any collection fees associated with the account transfer.

Our staff members are available to discuss and explain situations that may compromise the compliance of our policies.

***** I have read and understood the above the terms and conditions set forth and agree to comply accordingly*****

Patient Name **Parent/Guardian Signature** **Date:**

_____ _____ _____

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APPOINTMENT POLICY/SPECIAL REQUEST

In an effort to keep appointments running smoothly and in a timely manner, the following policies have been implemented. Please read completely before signing.

- When making an appointment, please note the exact reason for your visit (i.e., an acute illness visit, wellness checkup, consultation regarding specific behavioral problems). All attempts are made to ensure appointment length reflects the concerns.

- If you are unable to make a previously scheduled appointment, please call 12 or more hours in advance to cancel or reschedule, otherwise, A NO SHOW FEE OF $50.00 will be assessed. If necessary, call the morning of your appointment to cancel or reschedule.

- In the event your child already has a scheduled appointment and you wish to add a sibling(s), please call the office prior to the visit to ensure the patients have dedicated appointment times. If you request an additional sibling while in the office, there will be an add-on-fee of $25.00, along with the appropriate copay/deductible.

- Walk-in-patients are discouraged because it disrupts the scheduled appointments, which will be assisted first. It is best to call during office hours and be placed on the schedule. A $25.00 charge will be added for walk-in appointments.

- Special forms are generally completed at the yearly well visit. This includes school forms, sports physical forms, or day/overnight camp forms. If forms require only a doctor's signature, a $15.00 fee is assessed if the request is two weeks past the well visit. Please allow one week for completion of the form. Immunization records through LINKS are free of charge, but allow up to one week for completion. Forms that are more comprehensive and require a thorough review of medical records will be assessed a fee of $20.00.

- Letters written for special concerns and requiring a doctor's signature are assessed a $25.00 fee. Please allow up to one week for completion.

Lake Vista Pediatrics is committed to timely appointments,
We thank you for your cooperation and understanding.

Patient Name	**Parent/Guardian Signature**	**Date:**
_____	_____	_____

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PATIENT PORTAL POLICIES

In an effort to better serve you, Lake Vista Pediatrics requires every patient to be registered for Sevocity, our (electronic health record vendor) secure patient portal. We hope this will be an effective tool to improve communication as well as enhance your overall patient care experience.

The patient portal is not designed to replace face-to-face encounters. It is designed to supplement it.

General guidelines for communication:

- Please do not use the portal it there is an urgent need for communication. In case of emergency, please dial 911.
- Please be concise as possible. Although most questions/concerns can be addressed quickly using the portal, if you have a complex inquiry, do not hesitate to call the office.
- Be sure to include an appropriate subject line such as "Appointment", "Refill", etc.
- Our goal is to respond to all inquiries within 1 to 2 business days.

The patient portal can be used for:

- Non-urgent health care questions.
- Any follow up questions from a recent visit.
- Requesting prescription refills—please make sure to include your preferred pharmacy. All requests may not be automatically approved, and follow up appointment may be necessary.
- Viewing your demographic information such as address, and insurance information.
- Sending lab results

Privacy and security:

- All communication will be retained as part of the medical record of the patient.
- All messages sent will be encrypted.
- Your e-mail address is confidential and protected information, as well as your medical and other personal information.
- Messages may be read and addressed by staff other than physicians.
- All access to the internal network and electronic health records is password protected.
- For further information, please refer to the Lake Vista Pediatrics HIPAA handout on privacy practices.

*****PLEASE NOTE***** Patient communications are no longer accepted through out traditional email, lakevistapeds@bellsouth.net, we have developed the EMR portal method of messaging to ensure your privacy in compliance with Federal and State regulations.

Thanks you in advance for your cooperation. Please call the office if you do not wish to receive e-mail verification of portal registration to ensure the correct information was added.

Patient Name: _____ **Parent/Guardian Signature:** _____ **Date:** _____

E-mail: _____