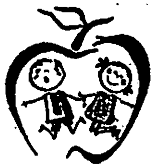


LAKE VISTA PEDIATRICS
An Integrative Approach

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: (   ) ____________________

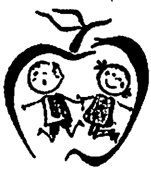
Release of Information

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

Signature: ____________________

Printed Name: ____________________

Date: ____________________



LAKE VISTA PEDIATRICS

An Integrative Approach

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 of policy 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 service are contracted between the physician and your insurance company. Payment is required on the day of service for all office visits, except when other arrangements that are agreed to by Lake Vista Pediatrics are made in writing. This payment includes co-payments, deductibles, and non-covered services. ***Please note there will be an additional $20 fee if appropriate payment is not made on the date of service.*** 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 and contracted 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.

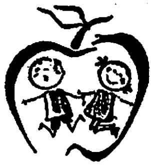
Our staff members are available to discuss and explain situations that may compromise the compliance of our policies.

I have read and understand the above terms and conditions set forth and agree to comply accordingly.

Patient Name ________________________

Parent/Guardian Signature ________________________

Date ________________________



LAKE VISTA PEDIATRICS
An Integrative Approach

Appointment Policy

In an effort to keep appointments running smoothly and in a timely manner, the following policies have been implemented. Please read completely before signing. If you have any questions, they can be directed to our business office staff.

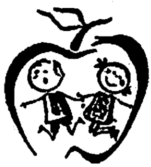
- For a first time office visit, please arrive 15-20 minutes early. Screening and administrative forms must be completed prior to your appointment with the physician. For your convenience and review, these forms are also available on our website at *www.lakevistapeds.com*.
- If you are unable to make a previously scheduled appointment, please call **24 hours** in advance to cancel or reschedule. Failure to do so will result in a $50.00 "NO SHOW" fee.
- In the event your child already has a scheduled appointment and you wish for the sibling to be seen on the same day, please call the office staff prior to the visit to ensure both children have dedicated appointments. If you request an additional sibling visit in the office, there may be a sibling add-on fee of $25.00, along with the appropriate copay/deductible.
- Forms (such as school sport physical forms, camp clearance forms, etc.) are generally completed at the time of the visit. If forms are requested to be completed more than 2 weeks after a visit, there will be a $15.00 fee. Please allow 3-5 business days for these forms to be completed.
- To ensure all concerns are addressed, all attempts are made to ensure appointment length reflects the present health concerns. When making an appointment, please note the exact reason for your visit (i.e., an acute illness visit, a wellness checkup, or a consultation regarding specific behavioral problems). Often, lengthy delays result from parents asking for additional time to address issues other than what was scheduled. Please be considerate of others waiting.

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

Patient Name ______________________________

Parent/Guardian Signature ______________________________

Date ______________________________



LAKE VISTA PEDIATRICS

An Integrative Approach

Statement of Office Policies

Our goal is to provide the highest quality care as well as maintain a good physician–patient relationship. The following office policies allow for a good flow of communication and enables us to achieve our goal. Please read this document carefully. If you have any questions, do not hesitate to ask a staff member.

1. Insurance cards: Upon arrival, please sign in at the front desk and present your insurance card. This is your verification of correct insurance and consent to file on your child's behalf. At this time, you will be asked to pay any required co-pay.
   If the insurance company you designate is incorrect, you will be responsible to provide updated insurance information and/or submit payment for any outstanding balances.
2. Primary Care Physician: If you are required to list a primary care physician, be sure that the physician you have selected is appropriately designated by your insurance company.
3. Payment responsibility: According to your insurance plan, you are responsible for any and all co-payments, co-insurance, deductibles and non–covered services, including annual physical charges, hearing and vision screening, and some immunizations which your insurance company does not cover. Please review and know your benefits. ***Please note there will be an additional $20 fee if appropriate payment is not made on the date of service.***
4. Referrals: We ask that you are familiar regarding your benefit plan. It is important that you inform the office staff of any necessary referrals or authorizations required to see specialists and pre-authorizations for testing procedures.
5. Physician participation: If our physicians do not participate in your insurance plan, your account will be considered a private account, and payment in full is expected from you at the time of your child's visit.
6. Billing Statements: Patient balances are billed immediately upon receipt of your insurance explanation of benefits. Your remittance is due within 30 days upon receipt of your bill.
7. Duplication of Medical Records: Copies of medical records are obtained through a written request either by parents, the insurance company or any other authorized designated parties requesting records. Duplication fees are established by the Louisiana State Statute and are in accordance with their guidelines. See policies of Medical Record Duplication (can be found on our website *www.lakevistapeds.com*).
8. NSF (Not Sufficient Funds) Check: A $35.00 fee will be charged for any checks returned for insufficient funds. We will no longer accept checks on an account once the NSF fee has been applied. Other Methods of payments, such as credit card or cash will be offered thereafter.
9. Forms: All forms required for your child that are not associated with an office visit will be completed with a $15.00 charge per form. Please allow 3-5 business days for these forms to be completed.

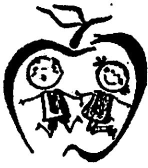
Our office staff works diligently to verify your benefits, however it is important to note that insurance companies do not guarantee coverage of services until the claim is processed. In such an event, you may receive a statement from our office declaring a balance due.

I have read and understand the above terms and conditions set forth and agree to comply accordingly.

Patient Name ______________________________

Parent/Guardian Signature ______________________________

Date ______________________________



LAKE VISTA PEDIATRICS

An Integrative Approach

Patient Name: ____ DOB: ______________

In an effort to better serve you, Lake Vista Pediatrics requires every patient to be registered for the 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 designated to replace face-to-face encounter - it is designated to supplement it.

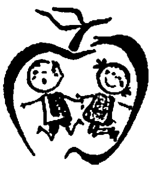
- General Guidelines for Communication
  - **Please do not use the portal if there is an urgent need for communication or emergency. *In case of emergency, please dial 911.***
  - Please be as concise as possible. Although most questions/concerns can be addressed quickly using the portal, if you have a complex inquiry, do not hesitate to call the office
  - Be sure to include appropriate subject line such as "Appointment", "Refill", etc.
  - ***Our goal is to respond to all inquiries within 1-2 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 a follow up appointment may be necessary*
  - Viewing and updating your demographic information such as addresses, phone numbers, and insurance information
- 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. We will protect this information as well as your medical and other personal information.
  - Similar to phone communications, messages may be read and addressed by staff other than physicians
  - All access to the internal network and electronic health records (EHR) is password protected.
  - For further information, please refer to the Lake Vista Pediatrics HIPAA handout on privacy practices
  - **Please note: Electronic patient communications are no longer accepted through traditional email. We have developed this secure method of messaging to further ensure your privacy in compliance with Federal and State regulations.**

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

Parent's Signature: ________________________________ Date: ____________________________

Email Address: ____

Username: Patient's first name followed by day that they were born (Example: Jane01)
Password: LVP123 **for security purposes, please change after first login**



LAKE VISTA PEDIATRICS
An Integrative Approach

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB
ADDRESS		SSN
CITY	STATE	ZIP

OFFICE RECEIVING MEDICAL RECORDS	PROVIDER AUTHORIZED TO RELEASE MEDICAL RECORDS		
Lake Vista Pediatrics 6517 Spanish Fort Blvd New Orleans, LA 70124 Office Phone: 504.283.7306 Office Fax: 504.283.7308	DR./PRACTICE NAME		
	ADDRESS		
	CITY	STATE	ZIP
DATE	EVENT		

Purpose of this Disclosure:

PHI AND DATE OF PHI AUTHORIZED FOR USE OF DISCLOSURE

Description	Start Date	End Date
All PHI in the record		
Progress Notes		
Laboratory Tests		
X-Ray Tests/Reports		
History and Physical Examination		
Discharge Summary		
Consultation Reports		
Itemized Billing Statement		
Other:		

The following information will be released when included in the above information, unless you indicate otherwise:

- AIDS or HIV test results
- Alcohol, drug or substance abuse treatment
- Psychiatric or mental care/treatment
- Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PATIENT'S REPRESENTATIVE (if necessary)	DATE
PERSONAL REPRESENTATIVE'S RELATIONSHIP OF PATIENT	