PATIENT INFORMATION

Last Name_____First Name_____MI_____

Birthdate_____/_____/_____ Age_____ Male_____Female _____

Address _____, Apt #_____, City _____, State _____ Zip_____

If student, School Attending:_____

Referring Physician _____***Phone*** (____) _____

Pediatrician/PCP_____

First Parent Last Name _____ First Name _____MI ____

Birthdate_____/_____/_____ Texas Driver's Lic. #_____ Occupation _____

Phone (H) (_____) _____ Phone (W) (_____) _____ Cell Phone (____) _____

Employer_____ Email Address:_____

Second Parent Last Name _____ First Name _____MI ____

Birthdate_____/_____/_____ Texas Driver's Lic. #_____ Occupation _____

Phone (H) (_____) _____ Phone (W) (_____) _____ Cell Phone (____) _____

Employer_____ Email Address:_____

Alternate Contact (when we cannot reach you) Name_____

Phone_____ Relationship to the patient_____

INSURANCE INFORMATION

(Please submit insurance card and driver's license for copying)

Primary Insurance_____Verification Phone(_____)_____
ID#_____**Group Plan #**_____Employer_____
Claims Address _____City_____State_____Zip_____
Insured's Last Name_____***First Name***_____***MI***_____
Birthdate_____/_____/_____ Texas Driver's Lic. #_____ Relationship to Patient_____
Phone (H) (_____) _____ Phone (W) (_____) _____ Cell Phone (____) _____

*Secondary Insurance*_____Verification Phone(_____)_____
ID#_____Group Plan #_____Employer_____
Claims Address _____City_____State_____Zip_____
*Insured's Last Name*_____*First Name*_____*MI*_____
Birthdate_____/_____/_____ Texas Driver's Lic. #_____ Relationship to Patient_____
Phone (H) (_____) _____ Phone (W) (_____) _____ Cell Phone (____) _____

"I hereby authorize Children's ENT of Houston / Pediatrix to provide any information associated with my care to my referring physician, other allied health professionals, or my insurance carrier."

Patient/Guarantor signature _____ Date _____

Children's ENT of Houston

Smith Tower
6550 Fannin Street, Suite 2001
Houston, Texas 77030-2717

Methodist Sugar Land Hospital
16651 Southwest Freeway, Suite 520
Sugar Land, Texas 77479-2362

Memorial City
920 Frostwood, Suite 630
Houston, Texas 77024

713-[illegible] Appointments
713-796-8472 Facsimile
888-733-[illegible] Toll Free
www.ChildrensENTHouston.com

James T. Albright, MD, [illegible]
Newton O. Duncan, III, MD, [illegible]
Joseph L. Edmonds, MD, [illegible]
[illegible], MD, [illegible]
Meredith M. [illegible], MD, [illegible]

[illegible] Griffin, [illegible]
Anila [illegible]
[illegible]

Minor Child Policy

Dear Parents or Guardians:

We are prohibited by law from seeing minor children without a parent, legal guardian or designated representative present. Proof of your identity, in the form of a valid photo ID or passport, must be presented at the time of your child's visit. Please bring the appropriate identification with you when you come for your child's appointment.

If you will be sending your child to our office with a family member, friend, or care-giver, it will be necessary for you to complete the lower authorization portion of this notification, sign it and have it brought to your child's appointment by your designated representative. Your designated representative must also sign this form and, at the time of the visit, present their valid photo ID or passport.

I, ____, parent or legal guardian of ______________________________________, a minor child, grant permission to ______________________________ ____________, my designated representative, to bring my child to Children's ENT of Houston / Pediatrix for care; to sign necessary paperwork to facilitate care; to provide consent; and to sign the financial responsibility documents assuring payment of any fees for which I am responsible. I warrant that any balance due will be paid by my representative at the time of service.

This authorization will remain in force until such time as I revoke it in writing.

____

Signature of Parent/Guardian Date

____

Signature of Designated Representative Date

CONSENT FOR TREATMENT

Patient Name:_____**Date of Birth:** _____

All procedures will be explained to you.
Specialized procedures may require an additional consent form.

I hereby consent to a general and specialized examination of my head, neck and organ systems relating to my condition. I understand that the examination and treatment *may* include any of the following:

- General medical history
- Inspection of my head, ears, eyes, nose, mouth, throat and neck
- Examination with mirrors or lighted scopes (endoscopy)
- Examination of the chest, abdomen and nervous system, when appropriate
- Examination and cleaning of my ears under a microscope
- The use of topical or local anesthesia
- The use of ear impression materials for ear related products, equipment or services
- The application or injection of antibiotics or other therapeutic drugs
- The collection of secretions, sputum or drainage
- Venipuncture for blood collection
- X-rays, hearing and balance studies, or audiologic testing when indicated
- Photographic or video documentation of my findings

I have the right to ask questions regarding the purposes and risks of the examination, diagnostic studies and treatments.

I understand that this consent is effective starting today and remains in effect for all subsequent clinic visits to Children's ENT of Houston / Pediatrix and applies to all physicians in the group as well as medical staff assisting the physicians.

If patient is a Minor (not on active military duty; not 16 years of age or older and residing outside of parents' home; not managing own financial affairs; not unmarried parent (with custody) of child; and not confined to a Texas Criminal Justice facility) parent or legal guardian MUST SIGN BEFORE patient is examined.

Name of Consenting Adult:_____

Relationship to Patient:_____ Date_____

Signature of Consenting Adult _____ Date _____

When parent is a minor and is 16 years of age or older, is unmarried (with custody) of child, resides outside of parents' home, and manages his/her own financial affairs; or is on active military duty, confined to a Texas Criminal Justice facility or otherwise legally emancipated, minor parent MUST SIGN BEFORE patient is examined.

Name of Consenting Parent:_____

Signature of Consenting Parent _____ Date _____

FINANCIAL POLICY

Thank you for selecting Children's ENT of Houston / Pediatrix (CENT) for your medical care. In order to prevent any misunderstanding over the responsibility of payment for medical and surgical services provided to our patients, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of any balance due following the office visit, test or procedure. We accept cash, personal checks (NSF charges), and credit cards (American Express, Discover, VISA, MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment of any balance due at the time of service. Should you need documentation to secure reimbursement, a copy of the bill is furnished at each visit.

If a referral from your primary care physician is required by your insurance plan, it must be received in our office by your appointment time. If we have not received the referral by the time of your arrival, your appointment will be rescheduled. You will be asked for your insurance card and driver's license at the registration desk for identification purposes.

CENT Contracted Insurance Coverage

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we require a copy of your insurance card and payment of your deductible and/or co-insurance at the time of service.

Non-CENT Contracted Insurance Coverage

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we require a copy of your insurance card, and payment of your deductible and/or co-insurance at the time of service. We will file the claim as a service to you.

Medicaid (applicable plans)

If you have Medicaid coverage, we must be able to verify that you have coverage on the date of the visit. If coverage cannot be verified, you must either pay for the visit or reschedule the appointment. If, within three months after the visit, you receive a retroactive card that covers the date of the visit, payment will be refunded after Medicaid has paid for the visit. You must pay for non-covered services, such as swim molds, at the time of service.

Medicare

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the $147 annual deductible for the calendar year, and you are responsible for any non-covered services. If you have supplemental insurance, we will be glad to file it for you.

I have read all the information above and agree that, regardless of my insurance status, I am responsible for my account balance for any professional services rendered. Disclosed, non-covered medical services are my responsibility.

In the event my insurance company is billed, I irrevocably assign and transfer benefits to Children's ENT of Houston / Pediatrix. A photocopy of this agreement shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my claim to any insurance company, adjuster, or attorney involved in this claim.

I authorize CENT to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of responsible party _____ Date _____

I authorize the release of any medical information necessary to process my claims.

Signature of patient (or guardian)_____ Date _____

RELEASE OF MEDICAL RECORDS

Date: _____

Re: Patient Name: _____ Birthdate: _____
Gender: _____

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information:

_____ Complete record
_____ Record of care from _____ to _____, only
_____ Record of care concerning the following condition(s) _____
_____
_____ Other. Specify: _____
_____ Confer with another person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.
Initial: _____ Date: _____

to the following person(s): _____
Name
_____
Street
_____
City State ZIP

The reason or purpose for this release of information is as follows: _____
_____

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. (The fee will be waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement that confirms that such an application or appeal has been filed or is pending).

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

PEDIATRIX MEDICAL GROUP

PEDIATRIX CARDIOLOGY

OBSTETRIX MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name of Patient/Authorized Representative

IMPORTANT INFORMATION FOR HMO REFERRAL-REQUIRED AND MEDICAID PATIENTS:

HMO Referral-required plans:

If your insurance plan requires a referral, your contract makes it your responsibility to have a current/valid referral in our office before your appointment time. Anyone arriving without a referral will be allowed 15 minutes to obtain a valid referral. If the referral cannot be received in our office within 15-minutes of your appointment time, we regret that your appointment will have to be rescheduled or you can elect to pay for the entire visit as a self-pay patient.

Medicaid Plans:

Children's ENT of Houston physicians accepts several Medicaid plans including Medicaid Traditional, TCH Star Medicaid, Molina, Amerigroup and others. Please be sure to check with your plan to confirm our participation. Medicaid patients who have not selected one of our contracted plans are considered "out-of-network." All out-of-network Medicaid patients MUST provide a referral to be seen by a Children's ENT of Houston practitioner. Patients appearing without a referral will be allowed 15 minutes to obtain a valid referral. If the referral cannot be received in our office within 15-minutes of your appointment time, we regret that your appointment will have to be rescheduled or you can elect to pay for the entire visit as a self-pay patient.

Welcome to Children's Ear, Nose Throat of Houston!
In order to provide you with the best possible care please fill out both pages of this medical history form. All information is completely confidential.

Patient Medical History Form: Child

Drug/Latex Allergies:_____
_____
(if none, please write "none")
If yes, type of reaction:_____
_____

Today's date:_____

Patient Name:_____
Date of Birth:_____Age_____
Weight:_____ Male_____ Female_____
Pediatrician or Family Doctor:_____
Physician who referred you today?_____

History of Present Illness
What is the reason for your child's visit today? _____
_____
How long has your child had this problem? _____
What other physician has treated your child for this problem?_____
Has your child been evaluated by any of the following:
☐ Allergist ☐ Pulmonologist ☐ Speech Pathologist ☐ Orthodontist/Dentist ☐ Gastroenterologist

Past Medical History
Birth history: ☐ Full-term ☐ Pre-term _____# weeks
☐ Single ☐ Twins *(Fraternal___ or Identical____)* ☐ Multiple #_____

Does your child now have or has he/she ever had any of the following?

☐ ADHD
☐ AIDS/HIV positive
☐ Allergies
☐ Anemia
☐ Asthma
☐ Blood disease
☐ Blood transfusion
☐ Cancer
☐ Congenital heart disease
☐ Cystic Fibrosis
☐ Diabetes
☐ Down Syndrome
☐ Ear infections
☐ Epilepsy / seizures
☐ Hearing Problems
☐ Heart Failure
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Hospitalized at birth
☐ Irregular heartbeat
☐ Kidney problems
☐ Lung disease
☐ Psychiatric disease
☐ Reflux disease
☐ Sickle cell disease
☐ Sinus infections
☐ Strep throat
☐ Tuberculosis

Please list any other serious illness not listed above:_____

Past Hospitalization or Emergency Room Visits
Please list the date/s and reason for any hospitalizations or emergency room visits:_____
_____

Past Surgical History
Please list the type/s and date/s of all surgical procedures your child has had:_____
_____
_____

Medications

Please list all medications your child takes regularly, including over the counter and herbal medicines:_____

_____

_____

Any aspirin or ibuprofen use? ☐ YES ☐ NO How often?_____

Review of Systems

Does your child now have or has he/she ever had any of the following?

☐ Abdominal pain
☐ Abnormal bleeding
☐ Anesthesia difficulties
☐ Blood in stool
☐ Breathing problems during sleep
☐ Bruise easily
☐ Chest pain
☐ Convulsions / seizures
☐ Cough
☐ Dizziness
☐ Ear fluid or infections
☐ Frequent headache
☐ Frequent spitting up
☐ Hay fever
☐ Headaches
☐ Hearing loss
☐ Hoarseness
☐ Joint swelling
☐ Limb swelling
☐ Malignant hyperthermia
☐ Mouth breathing
☐ Noisy breathing
☐ Sinus disease
☐ Skin lesions / swellings
☐ Snoring
☐ Sore throat / strep throat
☐ Speech / Language difficulties
☐ Tonsil problems

Family Medical History

Do any of your family members (living or dead) have any history of the following:

☐ AIDS
☐ Allergies
☐ Anesthesia problems
☐ Asthma
☐ Blood disease
☐ Cancer
☐ Cystic Fibrosis
☐ Diabetes
☐ Dizziness
☐ Ear fluid or infections
☐ Excessive bleeding
☐ Epilepsy / seizures
☐ Headaches
☐ Hearing loss
☐ Hemophilia
☐ High blood pressure
☐ Kidney problems
☐ Sickle cell disease
☐ Sinus disease
☐ Sleep apnea
☐ Stroke
☐ Thyroid disease
☐ Tonsil problems
☐ Tuberculosis

Please list any other serious illness not listed above:_____

Social History

Is your child in daycare? ☐ YES ☐ NO

Is your child in school? ☐ YES ☐ NO If in school, what grade?_____

Does your child use a pacifier? ☐ YES ☐ NO

Does anyone in your household smoke? ☐ YES ☐ NO

Please list siblings and ages: _____

Please list siblings previously seen by physicians at our practice and the reason/s for visit or treatment:_____

The information provided is a complete and accurate reporting of my child's medical history and health status.

Parent/Guardian Signature:_____Date:_____

_____

Reviewed by Physician:_____MD Date:_____