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**PATIENT REGISTRATION**

## Parent/Legal Guardian

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

## Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: Occupation: \_\_\_\_\_\_\_\_

Preferred Contact Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to leave messages or lab results on voicemail: \_\_\_\_\_yes \_\_\_\_\_\_\_\_ no

## Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child 1:** Last Name: First Name: MI:

DOB: / / Sex: M / F

**Child 2:** Last Name: First Name: MI:

DOB: / / Sex: M / F

**Child 3:** Last Name: First Name: MI:

DOB: / / Sex: M / F

**Pharmacy Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Pharmacy Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (City/State/Zip)*

## Guarantor (if different than legal guardian)

Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

## Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: Occupation: \_\_\_\_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kids’ World Pediatrics may leave messages or lab results via: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Non-Parental Consent** (Others Authorized to bring in child)

Name: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Access to the patient’s records? Yes / No

Name: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Access to the patient’s records? Yes / No

## Additional Contact Questions

If parents are divorced or separated please fill out this section:

Who has custody? \_\_\_\_\_\_\_

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child’s medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF BENEFITS FORM**

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Kids’ World Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

**Assignment of Benefits**

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Kids’ World Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Authorization to Release Information**

I hereby authorize Kids’ World Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Kids’ World Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child/Children(s) Name(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

Kids’ World Pediatrics participates with many insurance plans. Each insurance policy is different and may have different coverage terms. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

**Copayments and Deductibles**

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, debit, or credit card. We also accept Health Savings Account (HSA) cards for payment. Checks are not accepted.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the office. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if needed.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

**Patients Without Insurance Coverage**

KWP is happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if paid in full on the day of service. This discount does not apply after the day of the visit.

**Administrative Fee for Loss of Forms**

If your child needs forms filled out, Kids’ World Pediatrics is happy to assist. If you lose a copy of your signed form, there is a $10 fee for it to be completed and signed again.

**Request of Medical Records**

Immunizations are available on the patient portal. If you are needing a complete medical record for yourself, there is a $25 fee. There is no fee if records need to be transferred to another medical provider.

**No-Show Fee**

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no-show fee of $25. Repeated no-shows will result in the family being advised to transfer care out of the practice.

I have read, understood, and agree to the above policy.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA and Confidentiality**

It is the policy of Kids’ World Pediatrics to respect and protect the privacy of our patients, families, and employees. To that end, all patient related information is treated as confidential.

HIPAA - HIPAA refers to the “Health Insurance Portability and Availability Act of 1996.” This act led to the HIPAA Privacy Rule which went into effect in 2003. This privacy rule protects the unauthorized disclosure of any personally-identifiable health information (also known as protected health information or PHI).

As a health care provider, we may share information for the purposes of:

Payment – example sending claims to an insurance company

Operations – example hiring a chart auditor to review our coding and billing practices

Treatment – example referring a child to a subspecialist requires sharing of information

If PHI is to be disclosed for any other PURPOSE, the patient’s parents’ or legal guardians’ written authorization is mandatory. Additionally, when PHI is released, we will release only as much information is necessary and no more.

If PHI is to be released over the telephone, Kids’ World Pediatrics will verify the identity of the individual receiving the information. Kids’ World Pediatrics employees will, prior to disclosing PHI, ask specific questions that could only be answered by the patient’s family and/or legal guardian such as patient’s DOB or home address.

Signature of this document acknowledges that I have been offered and provided with a copy of KWP’s HIPAA policy which describes how medical information may be used and/or disclosed. I also understand that I am entitled to be notified if there is a breech in this policy as it pertains to my child’s medical record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship to Patient

FOR OFFICE USE ONLY:

I made a good faith effort to obtain a written acknowledgement of receipt of HIPAA policy from the above-named patient, but was unable to because:

 \_\_\_\_ patient declined to sign this written acknowledgment

 \_\_\_\_ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treat Minor**

I hereby give consent to Kids’ World Pediatrics and its designated staff to provide services as indicated by license and/or title including physical and/or mental health assessments or examinations, lab testing, immunizations, medical diagnosis or treatment as appropriate. I understand that this authorization is given in advance of any specific diagnosis or treatment.

If anyone other than a parent/legal guardian on file accompanies the child for a visit, a signed authorization is required and the accompanying adult must have their valid photo identification.

Texas law enables minors to consent to treatment without parental consent for various things including but not limited to pregnancy testing as well as diagnosis and treatment for certain sexually transmitted diseases. Kids’ World Pediatric will enforce this Texas law.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that a preventative exam (well child check or routine physical) is designed to review my child’s general health status, immunizations, nutrition, growth and screening tests.

I understand that if specific or new concerns are addressed, prescriptions given, or other situations which may have warranted a separate visit, this may incur an additional charge.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_