Kid Approved Pediatrics, PLLC
11875 Coit Rd, Ste 100
Frisco, TX 75035

Authorization to Release Confidential Medical Information

I hereby request that my medical records be released to:

Facility: Kid Approved Pediatrics, PLLC

Address: 11875 Coit Rd. Suite 100
Frisco, TX 75035

Phone: 972-787-0044 Fax: 214-382-0065

My records are being transferred from:

Facility:_____
Address:_____
City:_____ State: _____
Phone:_____ Fax:_____

Reason for request of records: _____

___Entire Health History __Test Results ___Growth Chart & Immunization Records

___Other:_____

As the guardian of the patient named below, I give permission to release all medical, mental, and social information to the facility listed. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Parent Signature:_____ Date:_____

Parent Printed Name:_____

PLEASE RETURN FORM TO KAP BY EMAIL: staff@kidapprovedpediatrics.net

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Kid Approved Pediatrics, PLLC

Patient Registration

(PLEASE PRINT CLEARLY)

Patient's Legal Name: Last _____ First_____
** Preferred Name**

_____

Address:_____ Street_____ Apt#_____

City_____ State_____ Zip_____

Date of Birth:_____

Sex: Male Female

Required by Government Mandate but you may refuse:

Language:_____ Race:_____ Ethnicity:_____

MOM- Parent/Legal Guardian: _____

Birthdate:_____ SS#:_____

Address (if different): _____

Home#:_____Cell #:_____

Email:_____

DAD- Parent/Legal Guardian: _____

Birthdate: SS#:

Address (if different): _____

Home#:_ _____Cell #:_____

Email:_____

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Send Statements too: MOM DAD

Contact Preference: Home Mom Cell Dad Cell

Parent's Marital Status: Married Widowed Divorced Legally Separated Other

Other Siblings & Birthdates: _____

PRIMARY INSURANCE:

Policy Holder: _____

Sex: M F Date of Birth:_____

Id#_____ Grp#_____

SECONDARY INSURANCE:

Policy Holder: _____

Sex: M F Date of Birth:_____

Id#_____ Grp#_____

How were you referred to our office:

Internet Facebook Magazine Drive By Insurance Friend Hospital
Daycare Specific Other:_____

I agree that the above information is true and correct to the best of my knowledge.

_____ _____

Parent Signature/ Printed name Date

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this Information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

* Obtain payment from third party payors.

* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

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_____

Patient Name Date of Birth

_____

Signature of Patient or Parent/Guardian Date

Phone: 972-787-0044 www.kidapprovedpeds.com Fax: 214-382-0065

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Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE:

* Payment is due regardless of who brings the child in for the service, Grandparents, caregivers, aunts, etc., payment is expected.

* For separated or divorced parents, payment is still expected at the time of service, we will not bill the other parent. You are welcome to call the other parent at the time of check out.

* Insurance must be provided and active in order to utilize your benefits. If insurance cannot be determined as active, patient will be considered Private Pay for that visit.

* Financial responsibility is determined from the benefits we receive from your insurance company. Your insurance determines if you have a copay, deductible and/or co-insurance

* Verification of insurance is not a guarantee of payment; you are still responsible for all services provided to your child, until your insurance processes and pays KAP for our services.

* Acceptable forms of payment include cash, check, Visa, MasterCard and Discover. KAP is willing to offer payment holds or payment plans on large balances.

NO SHOW or CANCELLATION FEES: $50.00 fee applies to all Well Child Visits and ADD/ADHD visits, cancelled less than 24 hrs prior to appointment or No Show to appointments. $25.00 fee applies to all other No Show appointments.

By signing this form, I am agreeing to the above financial policies. I understand that this agreement will be in effect until I revoke it in writing.

Patient Name	Date of Birth	Parent/Guardian	Date

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Consent & Authorizations for Services

AUTHORIZATION FOR TREATMENT: I authorize Kid Approved Pediatrics, PLLC to provide treatment to the below named patient.

REFERENCE LABORATORY SERVICES: I understand that Kid Approved Pediatrics, PLLC utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Kid Approved Pediatric, PLLC and providing demographic information as necessary for billing purposes.

ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay and hereby assign directly to Kid Approved Pediatrics, PLLC all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize release of copies of pertinent medical records to providers outside of Kid Approved Pediatrics, PLLC who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

AUTHORIZATION FOR RELEASE FOR QUALITY IMPROVEMENT: Texas Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose.

AUTHORIZATION FOR REVIEW OF PRESCRIPTION HISTORY: I authorize Kid Approved Pediatrics, PLLC to access my electronic records of previously prescribed medications through the external electronic prescribing network, sure scripts.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION: My insurer may share my past, current and future health and account records with Kid Approved Pediatrics, PLLC about services I've received from Kid Approved Pediatrics, PLLC and other care providers unrelated to Kid Approved Pediatrics, PLLC. These records may be used by Kid Approved Pediatrics, PLLC as needed to manage or coordinate my care and to improve the quality of that care. By signing this form, I am consenting to treatment, and agreeing to all above policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____

Patient Name Date of Birth Parent/Guardian Date

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Vaccination Policy

Kid Approved Pediatrics, PLLC supports vaccination according to the CDC and AAP standard immunization schedule. Vaccines are safe and effective in preventing diseases and health complications in children and young adults.

CDC and AAP recommended Immunization Schedule example:

Patient Age	Immunizations
* Birth	Hep B
* 1 month	Hep B
*2 months	Rotavirus, DTaP, Hib, PCV13, IPV
* 4 months	Rotavirus, DTaP, Hib, PCV13, IPV
* 6 months	Rotavirus, DTaP, Hib, PCV13, IPV
*9 months	Hep B
*12 months	PCV13, MMR, Varicella, Hep A
* 15 months	DTaP, Hib
*18 month	Hep A
* 4-6 years	DTap, IPV, MMR, Varicella
* 11-12 years	TdaP, Menigococal
* 11-12 years	HPV#1,2,3 (or later)
* 16 years	Meningococal

I understand and have been notified of the recommended CDC and AAP standard immunization schedule by Kid Approved Pediatrics, PLLC.

_____ _____

Patient Name Date of Birth Parent/Guardian Date

_____ _____

Patient Name Date of Birth Parent/Guardian Date

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Patient Portal and Use of Electronic Communications

To better serve our patients, our office has established a Patient Portal, for some forms of communication. The Patient Portal is a simple way to access your child's health information online. In addition, the Patient Portal allows you to:

- View and request appointments
- View and print immunization records for school and day care
- Request prescription refills
- Retrieve test/lab results
- View billing statements and balance
- Make secure credit card payments for balances
- Communicate with our office by sending and receiving secure messages regarding lab results, medical questions, medication refill request, referral requests.

For routine matters that do not require immediate response, we ask that you contact our office through the Patient Portal . Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is approximately one business day. Should you require urgent or immediate attention, please contact our office directly.

Communications relating to diagnosis and treatment will be filed in your medical record.

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Patient Consent for Use of Electronic Communications

I understand that this office will not be responsible for information loss, delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above electronic communications policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____

Parent/Guardian signature Relationship to Patient

Date

Patient Portal Access should be available for:

Name: _____ Relationship: _____

Email address: _____

Full Access _____ or Billing Only Access _____

Name: _____ Relationship: _____

Email address: _____

Full Access _____ or Billing Only Access _____

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INITIAL HEALTH QUESTIONNAIRE

Patient Name:_____ Date Completed:_____

Form Completed by: _____ Patient Birth Date: _____

MALE **FEMALE** Age: _____

HOUSEHOLD

	NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Are there siblings not listed? If so, please list their names and ages and where they live.

_____

If mother and father are not living together or if child does not live with parents, what is the child's current custody status?

_____

If one or both parents are not living in the home, how often does he or she see the parent/parents not in the home?

_____

BIRTH HISTORY

Birth Weight: _____ Birth Length: _____ If early, how many weeks: ____

Did your baby have any problems right after birth? If so, please explain:

_____

Did your baby go home with mom from the hospital? If not, please explain:

_____

Please circle one:

Was the baby born: TERM EARLY LATE
Was the delivery: VAGINAL CESAREAN

If cesarean, why? _____
Did mother have any illness or problems with her pregnancy? YES NO

If so please explain: _____

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During pregnancy did mother do any of the following?	SMOKE	DRINK ALCOHOL	USE DRUGS

GENERAL

Do you consider your child to be in good health?	YES	NO	DETAILS:
Does your child have any serious illness or medical condition?	YES	NO	DETAILS:
Has your child had serious injuries:	YES	NO	DETAILS:
Has your child had any surgery?	YES	NO	DETAILS:
Has your child ever been hospitalized?	YES	NO	DETAILS:
Are you concerned about your child's development?	YES	NO	DETAILS:
Any concerns with your child's mental development?	YES	NO	DETAILS:
Any concerns with your child's attention span?	YES	NO	DETAILS:

FAMILY HISTORY

Have any family members had any of the following:

DEAFNESS:	YES	NO	WHO:
NASAL ALLERGIES:	YES	NO	WHO:
ASTHMA:	YES	NO	WHO:
TUBERCULOSIS:	YES	NO	WHO:
HEART DISEASE:	YES	NO	WHO:
HIGH BLOOD PRESSURE <50:	YES	NO	WHO:
HIGH CHOLESTEROL:	YES	NO	WHO:
ANEMIA:	YES	NO	WHO:
BLEEDING DISORDER:	YES	NO	WHO:
LIVER DISEASE:	YES	NO	WHO:
KIDNEY DISEASE:	YES	NO	WHO:
DIABETES <50:	YES	NO	WHO:
BED WETTING >10:	YES	NO	WHO:
EPILEPSY OR CONVULSIONS:	YES	NO	WHO:
ALCOHOL ABUSE:	YES	NO	WHO:
DRUG ABUSE:	YES	NO	WHO:
MENTAL ILLNESS:	YES	NO	WHO:
IMMUNE PROBLEMS:	YES	NO	WHO:

ANY ADDITIONAL FAMILY HISTORY: _____

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PAST HISTORY

Does your child have, or has he/she ever had:

CHICKENPOX	YES	NO	DETAILS:
FREQUENT EAR INFECTIONS	YES	NO	DETAILS:
PROBLEMS WITH HEARING	YES	NO	DETAILS:
NASAL ALLERGIES	YES	NO	DETAILS:
PROBLEMS WITH EYES OR VISION	YES	NO	DETAILS:
ASTHMA, BRONCHITIS, OR PNEUMONIA	YES	NO	DETAILS:
ANY HEART PROBLEM OR MURMUR	YES	NO	DETAILS:
ANEMIA OR BLEEDING PROBLEM	YES	NO	DETAILS:
BLOOD TRANSFUSION	YES	NO	DETAILS:
FREQUENT ABDOMINAL PAIN	YES	NO	DETAILS:
CONSTIPATION REQUIRING DOCTOR VISIT	YES	NO	DETAILS:
BLADDER OR KIDNEY INFECTION	YES	NO	DETAILS:
BED WETTING > 5 YEARS OLD	YES	NO	DETAILS:
ANY CHRONIC SKIN PROBLEMS	YES	NO	DETAILS:
FREQUENT HEADACHES	YES	NO	DETAILS:
CONVULSION OR NEUROLOGICAL PROBLEM	YES	NO	DETAILS:
DIABETES	YES	NO	DETAILS:
THYROID OR ENDOCRINE PROBLEM	YES	NO	DETAILS:
ANY OTHER SIGNIFICANT PROBLEM	YES	NO	DETAILS:
USE OF ALCOHOLD OR DRUGS	YES	NO	DETAILS:

Parent Signature:_____ Relationship to patient:_____ Date:_____