

AUSTIN CHILDREN'S CHEST ASSOCIATES
Pediatric Patient Information Record

PLEASE PRINT

Patient Name: _____ **SSN:** _____ **Date of Birth:** ____ / ____ / ____
(Last, First, Middle)
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home phone: _____ **Email address:** _____
Referring Physician: _____ **City:** _____ **Phone:** _____
Primary Care Physician: _____ **City:** _____ **Phone:** _____

Responsible Party: _____ **SSN:** _____ **Date of Birth:** ____ / ____ / ____
(Last, First, MI)
Relationship to Patient: _____ Check box if same address as patient
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Work phone: _____ **Home phone:** _____ **Cell phone:** _____
Employer: _____ **Occupation:** _____

Other Parent's Name: _____ **SSN:** _____ **Date of Birth:** ____ / ____ / ____
(Last, First, MI)
 Check box if same address as patient
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Work phone: _____ **Home phone:** _____ **Cell phone:** _____
Employer: _____ **Occupation:** _____

If parents are divorced/separated, who has custody? MOTHER ___ FATHER ___ OTHER _____
Person(s) who have access to patient's medical information: _____
Person(s) who have legal rights in deciding patient's medical care: _____

Primary Insurance and Policy Holder Information

Policy/Member ID# _____ **Group/Account #** _____
Insurance Company Name: _____ **PPO** ___ **HMO** ___ **OTHER** _____
Insurance Policy Holder: _____ **SSN:** _____ **Date of Birth:** ____ / ____ / ____
(Last, First, MI)
 Check box if patient is policy holder **Relationship to Patient:** _____ Check box if same address as patient
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Work phone: _____ **Home phone:** _____ **Cell phone:** _____
Employer: _____ **Occupation:** _____
 CHECK BOX IF THERE IS A SECONDARY INSURANCE

EMERGENCY CONTACT (other than parents)

Name: _____ **Relationship to Patient:** _____
Work or Cell Phone: _____ **Home phone:** _____

Please note: Unless prior arrangements are made, payment is required at the time services are rendered. **Medical care:** I authorize my physician to provide myself or child with reasonable and proper medical care according to today's standards. **Medical Information:** I authorize the physicians and staff of this office to release any information they have acquired in the course of myself or child's treatment to my insurance company, my employer or any third party payor so that they may obtain payment for medical services rendered. **Insurance Authorization:** I authorize the physicians of this office to furnish information to my insurance carriers concerning myself or child's illness and treatment. **Assignment of Benefits:** I authorize my insurance company or any third party payor to pay any benefits due directly to this office should they accept assignment on my claim. **I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** ____ / ____ / ____

AUSTIN CHILDREN'S CHEST ASSOCIATES

CO-PAY, NO SHOW AND LATE CANCELLATION POLICY

It is the policy of Austin Children's Chest Associates to optimize the use of physician clinic time by working to ensure that scheduled time block are filled by scheduled patients. Courtesy "reminder calls" are attempted for all scheduled patients 48 – 72 hours prior to the scheduled appointment. The calls are given to you as **a courtesy** reminder.

If you need to cancel or reschedule an appointment we ask you to provide us with 24 hours (one business day) notice. Messages left on our voicemail for cancellation or reschedules are acceptable but still require a 24 hour notice. If you do not provide the clinic 24 hours(one business day) notice for appointment cancellations or reschedules it will be considered a "no show or late cancellation" and you will be charged a fee of \$50 for missing the appointment. ACCA physicians reserve the right to discontinue patient care when a patient misses three (3) appointments.

New patients will not be rescheduled after two confirmed appointments are missed. Patient guarantors of established patients will be notified in writing that a third missed appointment will result in termination of physician-patient relationship.

"Co-pay and /or Co-insurance deductibles" will be collected at the time of service. Common examples are \$40 co-pay for a specialist office visit and 10% co-insurance of total charges for the office visit. Please have your method of payment ready or your appointment will be rescheduled. We accept Visa, MasterCard, cash and checks.

No Show or Late Cancellation charges will be collected at the next scheduled appointment for established and new patients.

Thank you for your cooperation.

BY SIGNING I AGREE TO ALL TERMS STATED ABOVE:

Parent/Guardian Signature

Month/Date/Year

Child or Children's Name(s)

Month/Date/Year



AUSTIN CHILDREN'S CHEST ASSOCIATES

TELEPHONE CALLS, QUESTIONS and REFILLS

The physicians of the ACCA medical group offer you the gratuitous service of telephone advice, consultation and refilling of medications. To provide a more efficient service to our patients please be aware of the following:

1. **If your child is experiencing a true medical emergency please take them to the nearest emergency facility or call "911".** We will be ready to speak with the emergency care physician or other personnel from the emergency room *after you have arrived there.*
2. Phone calls are generally answered by the late afternoon hours. Should you feel that it is important to relay your questions or concerns directly to the pulmonologist, it may be necessary to schedule an appointment to do so.
3. When you call in during regular office hours, generally you will need to leave a message for the pulmonary physicians or medical staff. **Non-urgent messages will be returned within 24 hours, if you are available.**
4. During the regular office hours our medical staff will return sick calls (non-urgent medical calls) for us, get more information and offer advice. They will relay appropriate information and discuss all calls with the pulmonologists after they have been triaged. The medical staff will decide, based on the current pending phone messages, in what order calls will be returned.
5. **After-hours or on weekends, non-emergency calls** about sick children will be returned to you as quickly as possible, but depending on how busy the on-call pulmonologist is a *return call may take some time.*
6. The pulmonologists do not return phone calls to beeper numbers, message services or to neighbors.
7. As a rule, telephone calls regarding non-pulmonary or non-respiratory medical problems, or regarding medications that the pulmonologists do not prescribe, should be referred directly to your child's pediatrician, family physician or appropriate specialty physician.
8. **Refills of medications** will be handled **during the work week from 8:00 AM to 4:30 PM.** Note that on **Thursdays our office closes at 1:00 PM.** Please take weekends and any holidays into consideration. We ask you have your pharmacy fax us your request(s) for refill(s) and *allow 24 hours for refills to be filled.* If you need to leave us a message leave the full medication name(s), dosage, frequency, prescription number and pharmacy telephone number.

Parent/Guardian Signature

Month/Date/Year

Child or Children's Name(s)

AUSTIN CHILDREN'S CHEST ASSOCIATES
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law or we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical

examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Ginger Douglas
3305 Northland Dr, Ste 512
Austin, TX 78731
(512)380-9200

This notice is effective 5/1/07.

AUSTIN CHILDREN'S CHEST ASSOCIATES

**ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date

Name of Patient (if different from above)