WELCOME

TODAY'S DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH _____
Last First Middle

ADDRESS: _____ SEX: M F

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

EMAIL ADDRESS: _____
May we leave messages on your answering machine? YES NO

MOTHER/LEGAL GUARDIAN: _____ DATE OF BIRTH: _____
SSN: _____
EMPLOYER: _____ OCCUPATION: _____ WORK#: _____
FATHER/LEGAL GUARDIAN: _____ DATE OF BIRTH: _____
SSN: _____
EMPLOYER: _____ OCCUPATION: _____ WORK#: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____
INSURANCE ID#: _____
INSURANCE GROUP#: _____
PERSON CARRYING THIS INSURANCE: _____
DATE OF BIRTH _____
RELATIONSHIP TO PATIENT: _____

_____**SELF-PAY-PLEASE INTIAL AND DATE**

EMERGENCY CONTACT OTHER THAN PARENTS

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
HOME PHONE: _____ WORK PHONE: _____

ASSIGNMENT OF BENEFITS

IN THE EVENT THAT SERVICES RENDERED ARE NOT PAID FOR BY THE RESPONSIBLE PARTY, I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO Hill Country Pediatrics, P.A. AND ANY ASSISTING PROVIDERS FOR THE SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFIT. I FURTHER AGREE A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE: _____ DATE: _____

THANK YOU FOR YOUR TIME!!!

FINANCIAL POLICY

Thank you for choosing us as your health care providers. The following is a statement of our Financial Policy. Your agreement with this policy is required prior to any treatment.

All patients must complete our Patient Information and Medical History forms before seeing the doctor.

Regarding Insurance

- **All co-pays, co-insurance amounts and deductibles are due at the time of service. These amounts are based on our agreement with your insurance company. If you have a Health Savings Account, please make sure that you notify the front office staff.**
- In the event the patient's insurance coverage is not a plan in which we are participating providers, it is the obligation of the patient's responsible party to file the claim with the insurance company. Payment is expected at the time of service for patients filing their own claims.
- We accept assignment of insurance benefits for which we are participating providers. We cannot file the insurance company without complete and accurate insurance information. The insurance policy is a contract between the patient's responsible party and the insurance company. Any balances not paid within 60 days will be billed to the responsible party. Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is your responsibility to determine this with your insurance company.
- As of September 1, 2000 my office, as well as the offices of my call partners, will charge for any medical advice given after hours.

Minor Patients

The parent or legal guardian accompanying a minor is responsible for payment at the time of the visit. For patients not accompanied by a parent or legal guardian, written permission to treat the child is required before any treatment will be given.

Missed Appointments

All cancellations of appointments require 24-hour prior notice. Missed appointments will be assessed a $25.00 fee. Please help us serve you better by keeping scheduled appointments.

I have read the above Financial Policy, and I understand and agree to its terms and conditions.

Parent/Guard. Signature: _____ Date: _____

Patient Name: _____ Date: _____

Hill Country Pediatrics, P.A.
6618 Sitio Del Rio # A 101
Austin, TX 78730

Notice of Privacy Policy

Our privacy policy describes how your child's personal and health related information may be used and disclosed by our office. We are required by applicable federal and state law to maintain your child's privacy as well as provide you this Notice about our practices, our legal duties, and your rights concerning your child's health information. This notice takes effect April 1, 2003 and will remain in effect until that time at which a new policy is established.

We reserve the right to change our privacy practices at any time (within the scope of applicable laws). We reserve the right to make the changes in our policy effective for all health information that we maintain, including health information we created or received prior to said change. Prior to any change taking effect, we will amend this policy and make the new policy available to you. You may request additional copies of the privacy policy at any time.

Uses and Disclosures of Health Information

1. **Treatment**: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to you.

2. **Payment:** We may use and disclose your child's health information to Hill Country Practice Management to bill your insurance company for services provided to your child. We maintain a business agreement with them such that they are bound by our privacy policy as well. Their phone number and address available upon request.

3. **Healthcare Operations**: We may use and disclose your child's health information in connection with routine operation of our clinic. This include quality assessment and improvement activities, reviewing the competence or qualifications of our office staff and physicians, conducting training programs, accreditation, licensing and certification, or credentialing activities.

4. **Your Authority:** In addition to the above listed activities, you may give written authorization to use and/or disclose your child's health information to anyone you designate. You may revoke, in writing, such authorization at any time. Your revocation will not affect any disclosures permitted by your authorization at the time your original authorization was in effect. Both the original authorization and the revocation must be in writing, with any limitations on health information to be disclosed or time frame clearly delineated.

5. **To Your Family:** We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member or friend to the extent necessary to help with his/her health care or for payment, but only with your written permission. This includes occasions when a non-parent brings a child in for an examination.

6. **Special Situations:** As required by law, such as when your child is reasonably suspected of being the victim of abuse or neglect, we will disclose medical information to the appropriate authorities to the extent necessary to ensure the safety of your child. Likewise, if there is a protective order from a court on file in the chart or a legal custody arrangement on file that restricts release of information to one parent, we will follow the guidelines of such document. Otherwise, both parents have access to their child's health information.

7. **Public Interests:** If your child has developed one of several reportable diseases, that information as required, will be released to the public health authority in order to help track infection as well as provide contact information in times of epidemic or national security interests.

8. **Voice Mail/Cell Phone:** We may disclose your health information to provide you with appointment reminders via voice mail, and, if you provide permission to do so, test results. Please understand there will be occasions when a physician may return your call, especially after hours, via cell phone and there may be a chance some of your health information may be inadvertently overheard by others.

Patient Rights

1. **Access:** You have the right to review or obtain copies of your health information, with limited exceptions. You must request in writing to obtain access to your medical record in advance of when they are needed. If you are requesting copies of your records, we will charge $0.50 per page with a minimum charge of $20 to cover staff time to locate and copy records for you. If you prefer, we will provide a summary of your child's visits, to include vaccine records and growth charts free of charge.

1. **Marketing Health Services**: We will NOT use your health information for marketing, neither will we provide your personal information to pharmaceutical companies for direct marketing.

3. **Restriction:** You have the right to request in writing that we place additional restrictions on our use and disclosure of your health information. We are not required by law to agree to these restrictions, but if an agreement is reached in writing, we will abide by it.

4. **Amendments:** You have the right to request in writing that we amend your health information. Such requests must explain why your information should be amended. We may deny your request under certain circumstances, and such communication to you will also be in writing.

Questions and Complaints

The privacy of your health information is important to Hill Country Pediatrics, P.A.
If you feel we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend, or restrict the use or disclosure of your health information, you may complain to us in writing. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with this address upon request.
Contact: Stella Mathey
Address: Hill Country Pediatrics, P.A.
6618 Sitio Del Rio #A101
Austin, TX 78730
Fax: (512) 241-1374
Phone : (512) 241-1370

By signing this form I acknowledge that Hill Country Pediatrics, P.A. has provided me with a copy of their privacy policy.

Name/Date/Relationship to Patient _____ Witness _____

Patient Name /DOB _____ Date _____

NEW PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____ Sex: _____
Your Name: _____ Relationship to Child: _____
Address: _____
How long has the child been in your care?: _____ Phone: _____
Mother's Name: _____ Age: _____ Occupation: _____
Years of Schooling Completed: _____
Father's Name: _____ Age: _____ Occupation: _____
Years of Schooling Completed: _____
Who lives in the home with the child? # of Adults: _____ # of Children: _____
Please list names and ages of brothers and sisters:
Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Pets: _____ Type: _____ Type of Home: __Apartment __Trailer __House

Smokers in Household (inside or outside): Y N Who:
Water Source: ___City ___Well ___Bottled ___County

MEDICAL HISTORY

Pregnancy History:
Did patient's mother use any of the following substances or have any of the following symptoms during pregnancy?

	Y	N	Don't Know	DOCTOR'S NOTES
Medication Please Name:				
Street Drugs Please Name:				
Alcohol:				
Smoking:				
Vaginal Infections				
Urine Infections				
Other Problems:				

BIRTH HISTORY:

	DOCTOR'S NOTES
How long was the Pregnancy?	
In which hospital was the baby born?	
What was the baby's birth weight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal?	
Did the baby have any problems?	

MEDICAL HISTORY (cont'd)

NOTES

Has your child ever been hospitalized overnight?	Y	N	Don't Know
Has your child ever had surgery?	Y	N	Don't Know
Does your child have any allergies?	Y	N	Don't Know
To what? _____			
Does your child get regular dental care?	Y	N	Don't Know
Is your child on any medications?	Y	N	Don't Know
Please list _____			
Has your child gone to an ER this past year?	Y	N	Don't Know
Has your child ever had:			
Ear infections	Y	N	Don't Know
More than 2 strep throats	Y	N	Don't Know
Pneumonia	Y	N	Don't Know
Heart Problems	Y	N	Don't Know
Chickenpox	Y	N	Don't Know
Any major illnesses	Y	N	Don't Know
Reaction to any immunization or medications	Y	N	Don't Know
Urinary tract infection	Y	N	Don't Know
Wheezing	Y	N	Don't Know

FAMILY HISTORY

Check if close blood relatives have the following:

DISEASE							
Asthma	Y N	Who _____	Heart Attack <50 yrs	Y N	Who _____		
Sickle cell disease	Y N	Who _____	Urine Infections	Y N	Who _____		
Cystic Fibrosis	Y N	Who _____	Hay fever	Y N	Who _____		
Tuberculosis	Y N	Who _____	High blood pressure	Y N	Who _____		
Kidney Infections	Y N	Who _____	Anemia/Blood probs	Y N	Who _____		
Diabetes	Y N	Who _____	Learning Problems	Y N	Who _____		
Hyperactivity	Y N	Who _____	Seizures	Y N	Who _____		
Mental Retardation	Y N	Who _____	Emotional Problems	Y N	Who _____		
Sudden Death	Y N	Who _____	Born w/heart probs	Y N	Who _____		
Birth Defects	Y N	Who _____	Death shortly after Birth	Y N	Who _____		

SCHOOL/DAYCARE BEHAVIOR HISTORY

Child's School _____ Grade: _____

Does child attend special classes or receive special help?	Y	N	Don't know
Are you concerned about school behavior problems?	Y	N	Don't know

Does your child have problems with:

Frequent nightmares	Y	N	Doesn't apply
Difficult to control	Y	N	Doesn't apply
Fighting a lot	Y	N	Doesn't apply
Trouble making friends	Y	N	Doesn't apply
Bedwetting or stooling probs	Y	N	Doesn't apply
Vision/Hearing	Y	N	Doesn't apply
Appetite	Y	N	Doesn't apply

Name of child's previous doctor: _____ Address: _____

How did you hear about our office? _____

Are there any specific issues you would like to discuss with your doctor?: _____

Signature of person completing form _____ Date: _____

Reviewed by Dr. _____

THANK YOU VERY MUCH!!!

Hill Country Pediatrics' Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illnesses and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some versions of the flu vaccine, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedules are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of underimmunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years, and due to airline travel we have already imported some measles which has caused a small outbreak in unvaccinated children and adults in the U.S. in 2008.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as physicians.** Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,

Elizabeth Bartlett, M.D., F.A.A.P.

Leslie Wells, M.D., F.A.A.P.

Natalie Tarrant, M.D., F.A.A.P.