Please Complete this Page and Bring it to your Appointment.

# PATIENT INFORMATION

LAST NAME: FIRST NAME: INITIAL: NICKNAME:

SEX: BIRTH DATE: SS# HOME PHONE (area code)

ADDRESS: CITY: STATE: ZIP: COUNTRY:

FATHER'S NAME: DOB: HOME#: CELL#:

ADDRESS:(if different from above) CITY: STATE: ZIP: SS# :

FATHER'S EMPLOYER: WORK PHONE:

MOTHER'S NAME: DOB: CELL PHONE:

ADDRESS:(if different from above: CITY: STATE: ZIP: SS#

MOTHER'S EMPLOYER: WORK PHONE:

LEGAL GUARDIAN: (if different from above) PHONE (area code):

ADDRESS: CITY: STATE: ZIP: COUNTRY:

EMERGENCY CONTACT (OTHER THAN PARENT): PHONE:

REFERRING PHYSICIAN: PHONE:

ADDRESS: CITY: STATE: ZIP:

PRIMARY CARE PHYSICIAN: PHONE:

ADDRESS: CITY: STATE: ZIP:

INSURANCE CO: INSURED:

DOB:( if different from above) ID#: GROUP#:

**PHARMACY:** **ADDRESS:**

I UNDERSTAND DPNA DOES NOT ACCEPT MEDICAID.

I AUTHORIZE DPNA TO DISCLOSE/PROVIDE INFORMATION AT ANY OF THE PHONE NUMBERS LISTED BELOW. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY DPNA OF ANY CHANGE IN THESE NUMBERS. BY SIGNING BELOW, I UNDERSTAND DPNA IS AUTHORIZED TO LEAVE A MESSAGE IF I CANNOT BE REACHED DIRECTLY.

I AUTHORIZE DPNA TO DISCLOSE THE FOLLOWING PROTECTED INFORMATION TO THE NUMBERS INDICATED BELOW: LAB RESULTS, TEST RESULTS, APPOINMENT REMIDERS, PROCEDURES AND OTHER HEALTHCARE SERVICES.

LIST IN ORDER OF PRIORITY, WHICH NUMBER WE CAN CONTACT YOU AND/OR LEAVE A MESSAGE

PREFERRED CONTACT: ( ) MOM HOME WORK CELL (CIRCLE WHICH IS APPROPRIATE)

( ) DAD HOME WORK CELL (CIRCLE WHICH IS APPROPRIATE)

SIGNATURE: _____ DATE: _____

**BRING YOUR REFERRAL AND INSURANCE CARD OR A COPY OF INSURANCE INFORMATION TO EACH APPOINTMENT**

## Credit Policy

All services rendered by this association are charged directly to the patient. As a courtesy we will file your insurance claims at no charge and credit their payment to your account. Unless we are contracted with your insurance carrier as a participating provider to accept what they approve, your deductible or the percentage not covered by the carrier is due at the time of service.
Managed care co-pays are due at the time of service.
If you do not have insurance payment is due in full at time of service.
Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.

## Fee Disclosure Acknowledgement

We will make available our fee schedule for medical procedures upon request. Most fees are for office and/or hospital procedures. However, fees will also be incurred when you request special services in addition to your regular services. **Fees are not covered by your insurance plan.** The following is a brief, non-comprehensive listing of such services:

| | | |
|---|---|---|
| 1) | Telephone conferences | 25.00 first 15minutes,<br>1.00 Each add'l minute |
| 2) | Records processed for transfer | 35.00 and up |
| 3) | Returned checks (NSF) | 25.00 |
| 4) | Form completion or Written Correspondence for employer or school | 10.00-30.00 |
| 5) | Replacement of lost or expired prescriptions | 10.00 |
| 6) | Processing triplicate prescriptions | 15.00, 25.00 same day |
| 7) | Time expended for unusually complicated collections | (Pro-Rated for time spent) |
| 8) | Insurance Override on Prescription | 25.00 |
| 9) | Cancel less than 24 hour notice | 150.00+ |

Signature_____ Date_____

# DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY MEMBERS/FRIENDS

**Patient Name:** _____ **DOB:** _____

In our effort to adhere to HIPAA guidelines, Dallas Pediatric Neurology Associates (DPNA) needs your authorization to release medical/financial information connected to your child's/your care. **Please complete the information below so that we may release any necessary information to your *family member(s) or friends*.**
**If you are over the age of 18 you must give authorization for our physicians/staff to speak to your parents!**
Please check the appropriate box if you do NOT wish this information to be released.

O Please DO NOT release this information.

I, the undersigned, hereby authorize DPNA to disclose information from my child/my medical or financial record to the following family member(s) or friends:

Name: _____ Relationship: _____

Contact information: _____

Type of information that DPNA can provide to them: O Medical O Financial O Both

Name: _____ Relationship: _____

Contact information: _____

Type of information that DPNA can provide to them: O Medical O Financial O Both

_____ _____
**Signature of Parent/Patient** **Date**

# DALLAS PEDIATRIC NEUROLOGY ASSOCIATES

## Disclosure Agreement

Patient's Name: _____

Reason For Office Visit:

[] New Patient Neurological Exam
[] Follow-up Neurological Exam

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FOR NON-INSURED PATIENTS:

I/my child does not have any form of medical/healthcare insurance including Medicare or any form of Medicaid. _____(initials)

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IF WE ARE CONTRACTED WITH YOUR INSURANCE AND WE ARE FILING WITH YOUR INSURANCE FOR YOUR OFFICE VISITS:

*Check appropriate box(es).*

[] My insurance plan covers New Patient Neurological exams.
[] My insurance does not cover New Patient Neurological exams.
[] I do not know if my insurance plan covers New Patient Neurological exams.
[] My insurance plan covers Follow-up Neurological exams.
[] My insurance does not cover Follow-up Neurological exams.
[] I do not know if my insurance plan covers Follow-up Neurological exams.

I recognize that I am responsible for providing my insurance information to Dallas Pediatric Neurology Associates at the time of service. If I do not have this information, I must pay for my visit and will be provided a statement to file with my insurance carrier myself. _____(initials)

I agree to pay for any and all medical services I receive from the physicians of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason (i.e. non-covered services, terminated coverage, my failure to secure a referral from my primary care physician), I will pay for service upon written/verbal notice of their refusal. Failure by your insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. _____(initials)

_____ _____

Signature of Patient or Responsible Party Date

# DALLAS PEDIATRIC NEUROLOGY ASSOCIATES

## Acknowledgement of Receipt for Notice of Privacy Practices and General Consent for Medical Treatment

I hereby give my consent to the physicians of Dallas Pediatric Neurology Associates to use the medical information of my child for the purposes of treatment, payment, or health care operations. I understand that should my child's physician be absent, this consent is transferable to the physician covering the practice. Assignment of Benefits: I request that payments of medical benefits be made to Dallas Pediatric Neurology Associates. I authorize release of medical information necessary to provide treatment, payment of claim, or health care operations: A photo static copy is as valid as the original.

My signature below verifies I have received a copy of the "Notice of Privacy Practices" for Dallas Pediatric Neurology Associates (7777 Forest Lane B248 Dallas, Texas 75230) and that I have been provided with a copy of the office policy. I understand fees are payable at the time services are rendered and I understand the physicians of Dallas Pediatric Neurology Associates do not accept Medicaid or Medicare.

| | |
|---|---|
| Parent Name (please print) | Patient Name (please print) |
| Parent Signature | Date |

*For Office Use Only*

We attempted to obtain written acknowledge and receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining acknowledgement

___ Emergency situation prevented us from obtaining acknowledgement

___ Other – Please specify: _____

Initial and Date: _____

**DALLAS PEDIATRIC NEUROLOGY ASSOCIATES**

Kazi Imran Majeed, M.D.
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
WITH QUALIFICATION IN CHILD NEUROLOGY
8390 LBJ Freeway 10th Floor
Dallas, Texas 75243

469-902-0020 FAX 469-902-0021

Your physician may order tests, which are essential in assisting him/her in determining a prognosis and treatment plan for you/your child. Your physician may repeat this test at up-coming follow up visits, this will aid in determining the progress of you/your child. This will be filed with your insurance carrier. We make every effort to confirm benefits for these test to determine your out of pocket, however you should be aware the information given by your carrier is not a guarantee of coverage it is only a quote of the benefits. Claims are reviewed once received and a final determination is done by your carrier at that time.

These tests may or may not be covered by your insurance.

By signing below, you state that you understand should your insurance deny payment for this/these test you are responsible for the allowable amount.

If you have any questions please feel free to ask.

Dallas Pediatric Neurology Associates collects co-pays/deductible/co-insurance payments upon arrival, before seeing the physician and/or testing being done.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Parent/Guardian Date

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Dear Parent:

Enclosed please find a copy of all forms that are relative to our office. Please read the office policy, HIPAA procedures as well as complete the general consent and disclosure forms and bring them with you to your appointment. You must arrive 15 minutes prior to your scheduled appointment time to check in. All children under the age of 18 must be accompanied to their appointments by a parent or legal guardian. The initial consultation will take approximately one hour. If your insurance requires you to have a referral, it is your responsibility to bring it with you to your appointment. If you do not have your referral when arriving for your appointment, it will be necessary for your appointment to be rescheduled. Please bring your insurance card to each visit as we verify eligibility at every office visit.

You will receive a reminder call from our office to confirm your appointment 2-3 business days in advance. If we must leave a message, please call back to confirm your appointment. If you need further clarification on directions to the office please call. If you need to cancel your appointment we must have at least 24 hours advanced notice. If you do not cancel your new patient appointment at least 24 hours in advance, we may not allow you to reschedule. If you cancel a follow up appointment with less than 24 hour notice or do not show we charge a fee of $150.00 that is not billable to your insurance carrier. If you have other children we ask that you not bring them with you to the appointment.

Thank you.

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Dallas, Texas 75243

# *OFFICE POLICY*

In an effort to answer your questions and improve our efficiency, we have compiled the following office policy.

**OFFICE HOURS: 8:30-4:30pm (Monday-Friday) APPOINTMENTS: 8:45-3:30pm** When you call for an appointment, please tell the appointment secretary the nature of the problem. More acute cases are given priority. We make every effort to keep on schedule however, delays can occur. Please help us keep on schedule by arriving for your appointment 30 minutes (for a new patient) and 15 minutes (for an established patient) prior to your appointment time.

**THE ROLE OF THE REFERRING PHYSICIAN**: Since this is a practice in consultative Pediatric Neurology, it is mandatory that each child have a primary care physician, be it a general pediatrician or family doctor. Your child's primary care physician will be kept informed of your child's progress and current neurological status. Your primary care physician is the doctor you should contact for your child's routine care.

**AFTER OFFICE HOURS:** The phone is answered 24 hours a day, 7 days a week via a voice mail system. Instructions are given as to how the physician on call may be contacted if you have an emergency after hours. **Please do not have the physician paged for non-emergent calls.** After hours emergencies are handled by the physician who is on call at the time of the emergency. If you subscribe to "Caller ID" and "Anonymous Call rejection", please be advised that most phones utilized by our doctors and staff have caller ID blocking and will reflect "anonymous" or "private" when your phone calls are returned. Be aware that this could cause a problem if the doctor or staff needs to reach you with information regarding your child. There may be a charge for after hour phone calls. These charges are billed directly to you; we will not file this with your insurance. **Prescription refills are not handled after hours.**

**MEDICATION:** Request for medication refills should be called in during regular office hours to our prescription refill line. Please do not request refills for medication after hours. Keep track of your supply of medication and request refills before running out. Forty-eight hours (two working days) notice is required to refill regulated prescriptions. There is a $15.00 charge to process each regulated prescription and must be paid when picked up or mailed, this is not covered by your insurance company and will not be filed. There is a $25.00 charge for requests for same day. Note the date of the prescription; you have 21 days to have it filled. There is a $20.00 fee for replacing duplicate or lost prescriptions. Expired prescriptions not filed by the pharmacy must be returned to our office. Follow up appointments are very important. Refills will not be authorized if follow up appointments are not kept. If you do not keep your appointment with our doctor, you will need to follow up with your PCP to get your refill. If your insurance company requires an override on the medication your doctor has chosen, you will be charged $25.00 for this process. If an authorization is required there is a fee of $10.00. This is not filed with your insurance carrier and you are responsible for the fee.

**MEDICAL RECORDS:** Letters and narrative reports are routinely sent to the primary care physician. We require written consent from a parent or guardian prior to sending medical records to anyone other than your primary care physician. **NO INFORMATION REGARDING PATIENTS WILL BE RELEASED TO ANYONE WITHOUT WRITTEN AUTHORIZATION FROM THE PARENT OR GUARDIAN.** If you want

a copy of your child's records to be sent to another physician for any other reason, you must provide us with written authorization including the name and address where you wish records to be sent. We request ten working days to process medical records requests. In addition, there may be a fee charged for copying the records of $35.00 and up.

There is also a charge for form completion. Phone call charges and form completion are not covered by insurance carriers and we will not file for those charges. Physicians will complete school related forms for a fee of $25.00 and up, however please allow 6-8 weeks for such forms to be completed.

**POLICY REGARDING PAYEMNT:** Payment is due when services are rendered. To keep our office overhead down, we do not file insurance for companies we are not contracted with. If you have any questions regarding payment, you may discuss them with the finance manager. We are affiliated with some HMO/PPO insurance companies. If you are enrolled in a plan we have a contract with, you are only required to pay the co-payment or deductible/co-insurance (contracted amount) at the time of your visit provided you bring your referral with you on the day of your visit. We do not collect from HRA/HSA accounts unless we can confirm the balance on your account.

For insurance plans we are not contracted with, payment is due at the time of service. We provide a receipt that has been specifically designed to enable you to file your insurance. This receipt is simply attached to your insurance form and submitted. You will be reimbursed directly according to your plan benefits.

**YOUR INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO OBTAIN A CURRENT INSURANCE REFERRAL FOR YOUR APPOINTMENT PRIOR TO THE DAY OF THE APPOINTMENT. IF YOU DO NOT HAVE YOUR INSURANCE REFERRAL UPON ARRIVAL, WE MAY NEED TO RESCHEDULE YOUR APPOINMENT. PAYMENT OF YOUR ACCOUNT IS YOUR RESPONSBILITY.** Billing is automated and accounts over 90 days past due are automatically turned over to an agency for collection. There is a $25.00 fee if we have to turn your account over to an agency for collection.

**PLEASE BE ADVISED OUR OFFICE DOES NOT TAKE CHECKS, OUR FORMS OF PAYMENT ARE CASH, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS FOR YOUR CONVENIENCE.**

**IF YOU WOULD LIKE TO MAKE YOUR PAYMENT ONLINE WE ARE ABLE TO ACCEPT ELECTRONIC CHECK AND THE CREDIT CARD TYPES THAT ARE REFERENCED ABOVE. PLEASE VISIT OUR WEBIST AT WWW.DALLASPEDIATRICNEUROLOGY.COM AND CLIKC ON LOGIN OR REGISTER UNDER MAKE PAYMENTS ONLINE.**

Patients with Medicaid are seen at the Continuity Clinic which is held each Thursday morning at Children's Medical Center. Medicaid assignment is not accepted at this office.

**AS FOR THE MATTER OF DIVORCED PARENTS:** Payment is the responsibility of the parent who brings the child to the appointment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts and we cannot be placed in the middle. If the divorced parents cannot agree on treatment for their child we may not be able to continue to treat them.

**HOSPITALIZATIONS:** The doctors are affiliated with Medical City Dallas Hospital.

Thank you for your cooperation. We are looking forward to working with you and your child.

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**This Notice Describes How Medical Information About Your Family May Be Used and Disclosed As Well As How You Can Get Access To This Information. PLEASE REVIEW CAREFULLY.**

As required by the Privacy regulations created as a result of the Health Insurance Profitability and Accountability Act of 1996, also known as HIPAA, we are required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with the Notice of your privacy practices, our legal duties, and your rights concerning your health information.

Our office is required to abide by the terms of this Notice of Privacy Practices. As time passes our privacy practices and the law related to them may change which may require a change to this notice. The revised notice will be posted in our office. For more information about our privacy practices, or additional copies of the notice, please contact us using the information listed at the end of the notice.

Protected Health Information (PHI) includes, but is not limited to, medical records, lab reports, referrals, radiology/imaging specialist consultations, immunization records, current demographics, insurance information, telephone conversations and/or messages.

Permissible Uses and Disclosures without Your Written Authorization
We will use and disclose health information about your family for treatment, payment and healthcare operations. For example:

**Treatment**: To maintain high quality healthcare, it will be necessary to share projected health information with all members of your treatment team. This can include employees in this office as well as other health care providers; we may also use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.

**Payment:** Necessary information will be shared with appropriate payor sources and their representatives for payment purposes including, but not limited to, eligibility, benefit determination, claim processing and utilization review. It will also be necessary for our billing personnel to have access to PHI information to carry out their billing and collection efforts.

**Healthcare Operations**: Necessary information will be shared for the continuing operations for this office. Some examples include, but are not limited to, peer review, accreditation, and compliance with all federal and state laws.

We may also disclose PHI to our business associates for the treatment, payment of healthcare operations, or to other healthcare providers when such PHI is required for them to treat you, receive payment for service they render to you, or conduct certain health care operations, such as quality assessment and improved activities.

**Specific Authorization required for other uses and disclosures**

Other uses and disclosures of your projected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form you provide. Any specific authorizations you request will remain in effect till you revoke the authorization in writing. Some examples include, but are not limited to; marketing activities, the use or disclosure of psychotherapy records in our possession, transferring of your child's medical records in our possession to other doctors and in some instances for research purposes.

**Other uses and disclosures may be made without your authorization**

The following are situations where this office may use or disclose your PHI without your consent or authorization

- As required by law, court orders, a legal process, or government agencies
- For matters of public health for the purpose of controlling disease as dictated by law
- Disclosures may be made to public health authorities in situations of suspected abuse or neglect
- Disclosures to Institutional Review Boards of your de-identified information for the purpose of medical research

Patient Rights effective April 14, 2003

- In general you will have the right to look at or receive a copy of your protected health information. Request for this information must be in writing and detail the information you are requesting. Some exceptions include but are not limited to: psychotherapy notes, information compiled for use in civil, criminal, or administrative proceedings. There will be an administrated charge for expenses such as copies and staff time. Please allow 5 business days for copies to be make available.

- You have the right to request a restriction of the disclosure of your protected health information for treatment, payment or operations. This office is not required to agree to the request, but will do so at our discretion based on medical and business needs. This request may not apply in some emergency situations.

- You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests. These requests must be submitted in writing.

- You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment, and healthcare operations. Only one request a year will be allowed. There will be a charge for the preparation of this information.

- You have the right to request we amend your protected health information in your medical records. If you desire to amend your records, please submit a written request with changes outlined to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete and or other special circumstances apply.
- You may submit a written complaint to the Director, Office of Civil Rights of the US Department of Health and Human Services if you (1) are concerned that we may have violated your privacy rights, (2) disagree with a decision we made about access to your health information, (3) disagree with a response we made to a request to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. We would ask that you first contact us regarding your problem and allow us the opportunity to resolve your issue. At no time will there be any retaliation against a family for filing a complaint.

**Questions and Concerns**

If you need additional information regarding our privacy practices, or have questions or concerns please contact our Privacy Officer

DALLAS PEDIATRIC NEUROLOGY,