BrightBeginnings PEDIATRICS

Demographic Form

Patient Information:

Name: _____
Date of Birth: _____
Sex: ☐ Female ☐ Male
First Visit at Office: ☐ Yes ☐ No

Sibling Information:
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Parent Information:

Guardian 1:
Name: _____
Date of Birth: _____
Address: _____
City: _____ Zip: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Relationship to Patient: _____
Sex: ☐ Female ☐ Male

Guardian 2:
Name: _____
Date of Birth: _____
Address: _____
City: _____ Zip: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Relationship to Patient: _____
Sex: ☐ Female ☐ Male

Insurance Information:

Policyholder Name: _____
Date of Birth: _____
Relationship to Patient: _____
Employer: _____

Insurance Name: _____
ID #: _____
Group #: _____

Emergency Contact/Consent for another caregiver:

I give the following person(s) permission to obtain care for my child at Bright Beginnings Pediatrics in my absence. I also give this person(s) permission to contact Bright Beginnings Pediatrics to obtain any medical advice, medical information/records, and/or insurance/billing information necessary for said child.

Name:	Phone Number:	Relationship to Patient:

I attest that the above information is correct and acknowledge that it is my responsibility to let Bright Beginnings Pediatrics know if any of my information changes.

Signature: _____ Date: _____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction; a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient; a state agency having legal custody of the child; a Texas school or child-care facility in which the child is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations

Stock No. C-7
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HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at **brightbeginningspediatrics.com** or calling the Privacy Officer at **936-404-4602**.

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at **936-404-4602**, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your healthcare provider.

Bright Beginnings Pediatrics

2001 Tulane Drive
Lufkin, TX 75901

Phone: 936-404-4602
Fax: 936-262-6504

BrightBeginnings
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Financial Policy

Bright Beginnings Pediatrics participates with most insurance plans. Each insurance policy is different, and therefore, it is impossible for us to know what your potential benefits may be. It's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations might be at the time of service.

Insurance Information

Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. For services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service. When insurance information is received *after* the timely filling requirements of your insurance company, the charges for those services are your responsibility. You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits. Bright Beginnings Pediatrics reserves the right to reschedule or deny future appointments for delinquent accounts.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. Payment may be made in cash, by check, or by card. We also accept Health Savings Account (HAS) cards for payment. All returned checks will be subject to a service charge of $30.

Please note that the copayment is a contractual requirement for the insurance company and cannot be written off by the clinic. 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-preventative services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

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

Credit Card on File[1]

To make sure that we can collect your portion of the bill once your insurance company processes the claim, we encourage you to consider leaving a valid credit card on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation of Benefits (EOB). This autopay is for amounts owed which are equal to or less than $75. If the amount owed is greater than $75, we will contact you prior to making any charges to make sure you want to pay the amount with your credit card.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are 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 settled in full on the day of service. This discount does not apply after the day of the visit.

Administrative Fee[1]

At Bright Beginnings Pediatrics, coordination of care is central to making sure that children get good quality healthcare. This means several hours are spent providing services that insurance does not pay for. Some of these services include processing various administrative requests, such as lengthy FMLA paperwork. A $25 fee may be charged for such items.

No-Shows

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens. We request notice of at least 1 business day for all cancellations. A $40 no show fee may be assessed for all well and specialty consult visits not previously cancelled.

Divorced/Separated Parents and Custodial Arrangements

Bright Beginnings Pediatrics does not get involved in disputes between divorced, separated, or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial, or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

Referrals

If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and let our office know to request a referral to be processed prior to the specialty appointment.

Evening, Weekend, and Holiday Code

Please be aware, we report all evening, weekend, and holiday visits to your insurance carrier. This code may or may not be covered by your insurance.

[1]This policy does not apply to patients with Medicaid and Medicaid HMO Insurance.

I acknowledge that I have read, understand, and agree to the policies outlined in this document.

Signature: _____ Date: _____

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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 Bright Beginnings Pediatrics is a participating provider. Necessary forms will be completed to file for the 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 Bright Beginnings 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 Bright Beginnings Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my independent's illness and treatments; (2) process insurance claims generated based on patient 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 Bright Beginnings 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 on 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): _____

_____

BrightBeginnings
PEDIATRICS

Waiver

We pride ourselves on providing only the highest quality care for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidence-based clinical outcome information.

However, many insurers rarely keep pace with guidelines, or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests, and non-covered services as we, your trusted providers of care, deem necessary.

Following is the list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Vision Screening

- **Snellen Testing**. This is a simple screening performed with the use of a Snellen eye chart used to measure visual acuity on older children.
- **Visual Evoked Potential Testing** (VEP). This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia ('lazy eye') occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye.

As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount. For Snellen tests the discounted price is only $15, and for VEP tests the discounted price is $30.

Developmental Testing

Developmental screening (including standard pediatric developmental screening done at well-visits, Connor forms, Edinburgh post-partum depression screening, etc.) are very important in the assessment of any developmental delays or potential problems. As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $10 per test.

Ear Piercing

In addition to screenings and lab tests, we also offer ear piercing which is not a covered service by your insurance company. We charge $50 including a pair of studs.

Please sign the following waiver indicating that you are aware that these charges may apply if your insurance company does not cover these services.

Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, if my insurer does pay for these services.

Patient Name(s):

Responsible Party's Name: _____

Responsible Party's Signature: _____

Date: _____

Notice of Privacy Practices Acknowledgement of Receipt

I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

Signature: _____ Date: _____

Race and Ethnicity

To help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

☐ Caucasian
☐ Black
☐ Hispanic
☐ Asian
☐ Native American or Alaskan Native
☐ Other Race or Ethnicity
☐ Race Not Reported - Refusal
☐ Race Not Reported – Don't Know

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Consent to Treat Minor

I hereby give consent to Dr. Handley and Bright Beginnings Pediatrics to perform lab testing, examination, local anesthetic, medical diagnosis, and/or treatment, minor surgical treatment, and/or hospital care as deemed advisable by a licensed physician or nurse practitioner, as well as any assistant on the staff of Bright Beginnings Pediatrics under the supervision of Dr. Handley.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to all diagnoses, treatments, and hospital care which a licensed physician at Bright Beginnings Pediatrics recommends.

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

Signed: _____

Print Name: _____

Date: _____

Relationship to Patient: _____