



# SOUTHWEST CHILDREN'S CENTER

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_  
(LEGAL NAME) \_\_\_\_\_  
 Last First Middle  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  Male  Female  \_\_\_\_\_

Address  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Ethnic Group\*:  Hispanic or Latino  Non-Hispanic or Latino  Patient Declined Information

Race\*:  American Indian  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  
 White  Alaskan  Patient Declined Information  Other Race: \_\_\_\_\_

Language:  English  Spanish  Arabic  Chinese  Mandarin  Cantonese  Japanese  
 Russian  Hebrew  Korean  Other Language: \_\_\_\_\_  Patient Declined Information

Patient's Primary Physician:  Tina Boylston, M.D.  Shelly McNair, M.D.  Shannon Austin, M.D.  Krista Vizuete, M.D.  
 Karalin Root, D.O.  Gregory Hanson, D.O.  Tiffany Ponzio, M.D.  Liz Vazquez Smith, M.D.  
 Sarah Alpini, D.O.  Elizabeth Yust, M.D.  Kimberly Henrichs, M.D.  Rachel Gravel, M.D.

\*Indicates optional information requested under the Affordable Care Act, including Ethnicity (Hispanic or Non-Hispanic) and Race (Caucasian, Hawaiian, Pacific Islander, Black, American Indian, Alaskan, Asian)

**PRIMARY PARENT/ GUARDIAN NAME (1):** \_\_\_\_\_  
 Last First Middle  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's Lic. #: \_\_\_\_\_  
 Relationship to patient:  Mother  Father  Legal Guardian  Other: \_\_\_\_\_ Authorized to bring patient to visit:  Yes  No

Primary Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  Cell  Home  Work  
 Secondary Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  Cell  Home  Work  
 Email address: \_\_\_\_\_ @ \_\_\_\_\_ Note: Patient portal will be set up using primary phone number.

Address: Same as patient?  Yes  No, complete below  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_  
 Occupation: \_\_\_\_\_

**PRIMARY PARENT/ GUARDIAN NAME (2):** \_\_\_\_\_  
 Last First Middle  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's Lic. #: \_\_\_\_\_  
 Relationship to patient:  Mother  Father  Legal Guardian  Other: \_\_\_\_\_ Authorized to bring patient to visit:  Yes  No

Primary Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  Cell  Home  Work  
 Secondary Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  Cell  Home  Work  
 Email address: \_\_\_\_\_ @ \_\_\_\_\_ Grant portal access?  Yes  No

Address: Same as patient?  Yes  No, complete below  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_  
 Occupation: \_\_\_\_\_

**PRIMARY (and mailing)**  
 5282 Medical Drive, Suite 310  
 San Antonio, Texas 78229  
 Tel: 210-614-8687 | Fax: 210-614-7529

**SATELLITE LOCATION:**  
 7903 Calle Rialto  
 San Antonio, Texas 78257



# SOUTHWEST CHILDREN'S CENTER

**SECONDARY PARENT/ GUARDIAN NAME (1):** \_\_\_\_\_  
 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Driver's Lic. #: \_\_\_\_\_  
 Relationship to patient:  Mother  Father  Legal Guardian  Other: \_\_\_\_\_ Authorized to bring patient to visit:  Yes  No  
 Primary Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  Cell  Home  Work  
 Secondary Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  Cell  Home  Work  
 Email address: \_\_\_\_\_@\_\_\_\_\_ Grant portal access?  Yes  No  
 Address: Same as patient?  Yes  No, complete below  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_  
 Occupation: \_\_\_\_\_

**SECONDARY PARENT/ GUARDIAN NAME (2):** \_\_\_\_\_  
 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Driver's Lic. #: \_\_\_\_\_  
 Relationship to patient:  Mother  Father  Legal Guardian  Other: \_\_\_\_\_ Authorized to bring patient to visit:  Yes  No  
 Primary Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  Cell  Home  Work  
 Secondary Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  Cell  Home  Work  
 Email address: \_\_\_\_\_@\_\_\_\_\_ Grant portal access?  Yes  No  
 Address: Same as patient?  Yes  No, complete below  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_  
 Occupation: \_\_\_\_\_

## If parents are divorced or separated, please fill out this section:

Are there any **Court Ordered** legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?  Yes  No  NA

**If yes, please provide the office with a copy of any Court Orders or legal paperwork that supports this restriction.**

## NEWBORNS ONLY

Which hospital was your newborn delivered?  Methodist (Medical Center)  Methodist (Stone Oak or Metro)  St. Luke's  
 North Central Baptist  Westover Hills  University  
 Other: \_\_\_\_\_  
 Birth Gestation (weeks pregnant): \_\_\_\_ weeks \_\_\_\_ days Birth Weight: \_\_\_\_ pounds \_\_\_\_ ounces  
 Delivery:  Vaginal  Cesarean, Reason for Cesarean: \_\_\_\_\_  
 Were there any prenatal or neonatal complications:  Yes  No If yes, explain \_\_\_\_\_  
 Was a NICU stay required?  Yes  No If yes, explain \_\_\_\_\_

**PRIMARY (and mailing)**  
 5282 Medical Drive, Suite 310  
 San Antonio, Texas 78229  
 Tel: 210-614-8687 | Fax: 210-614-7529

**SATELLITE LOCATION:**  
 7903 Calle Rialto  
 San Antonio, Texas 78257



## INSURANCE INFORMATION

### Primary Insurance (Co-pays/or coinsurance is due at time of service)

<b>INSURED NAME:</b> _____		
Last	First	Middle
Date of Birth: ____ / ____ / ____ <small>MM DD YYYY</small>		
Company: _____		Subscriber ID #: _____
GRP/Policy#: _____		Effective Date: ____ / ____ / ____
Insurance Address: _____		
City: _____ State: _____ Zip Code: _____		
Insurance Phone: ( ____ ) ____ - ____		

### Secondary Insurance (We do not file secondary for primary co-pays. Primary co-pay must be paid at time of service.)

<b>INSURED NAME:</b> _____		
Last	First	Middle
Date of Birth: ____ / ____ / ____ <small>MM DD YYYY</small>		
Company: _____		Subscriber ID #: _____
GRP/Policy#: _____		Effective Date: ____ / ____ / ____
Insurance Address: _____		
City: _____ State: _____ Zip Code: _____		
Insurance Phone: ( ____ ) ____ - ____		

**Please give the receptionist your insurance card. We do not guarantee benefits. Our office is not responsible for the knowledge of benefits. It is your responsibility to contact your insurance company for what is a covered benefit and what is not. Please advise the office immediately when you change insurance so we can update your files.**

## OTHER INFORMATION:

Former Pediatrician/Office: _____			
Address: _____			
Street: _____		City: _____ State: _____ Zip Code: _____	
Phone: ( ____ ) ____ - ____			
How did you hear about us? <input type="checkbox"/> Sibling is a Patient <input type="checkbox"/> Referred by Family/Friend <input type="checkbox"/> Referred by Physician: _____			
<input type="checkbox"/> SWCC Website <input type="checkbox"/> Google <input type="checkbox"/> WebMD/Vitals <input type="checkbox"/> Other Internet Site: _____		<input type="checkbox"/> Social Media: _____ <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Yelp <input type="checkbox"/> Insurance			
Emergency Contact: _____ Relationship: _____			
Last		First	
Phone: ( ____ ) ____ - ____			
Would you like to receive email notifications and SWCC e-Newsletters? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide preferred e-mail addresses: _____ @ _____			
_____ @ _____			



## AUTHORIZATIONS & ACKNOWLEDGEMENTS

(Initial) \_\_\_\_\_ **Office Policies:** I acknowledge that I received, reviewed, and agree to comply with Southwest Children's Center, P.A.'s Office Policies as listed in this New Patient Packet.

(Initial) \_\_\_\_\_ **Consent to Treat:** I have the legal right to consent to medical and surgical treatments for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Southwest Children's Center, P.A. believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient of this practice.

(Initial) \_\_\_\_\_ **Financial Policy:** I acknowledge that I received, reviewed and agree to comply with Southwest Children's Center's Financial Policy. I further understand that I am responsible for all expenses for treating my child; that it is my responsibility to make sure that my child's insurance is in order and that I have provided this office with correct and up-to-date insurance information; That payment is due when service is rendered and that I agree to pay for all non-covered expenses (including co-insurances, co-payments, deductibles, and self-pay balances) and that these amount covered or not covered are determined by my insurer and not Southwest Children's Center.

(Initial) \_\_\_\_\_ **Privacy Practices:** I understand that as part of my healthcare, Southwest Children's Center originates and maintains health records describing my health history, symptoms, examination and test results, treatment, and any plans for future care or treatment. I hereby acknowledge that I have received a copy of Southwest Children's Center's Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment. I further understand that Southwest Children's Center reserves the right to change its practices and to make new provisions effective for all protected health information maintained by Southwest Children's Center.

(Initial) \_\_\_\_\_ **Assignment of Benefits:** I hereby authorize payment directly to Southwest Children's Center, P.A., for medical benefits otherwise payable to me. I authorize my insurance to disclose to Southwest Children's Center, P.A., information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third-party payor.

(Initial) \_\_\_\_\_ **Minor Authorization:** I acknowledge that I received, reviewed and completed the Minor Authorization Form for my child. I understand that I have authorized individuals on the form to accompany my child and to serve as my representative. I further understand that medical information may be released to them as a result of this authorization.

(Initial) \_\_\_\_\_ **Credit Card on File Policy:** I understand that by providing my credit card information to Southwest Children's Center, P.A., that I am authorizing it to be charged for unpaid copayments, balances over 60 days under \$100 and all self-pay balances after all insurances on file (if applicable) have been billed and processed.

(Initial) \_\_\_\_\_ **Missed Appointment/Cancellation Policy:** I acknowledge that I received, reviewed and agree to comply with Southwest Children's Center, P.A.'s "Missed Appointment/Cancellation Policy" and agree to pay any fees incurred from failure to comply.

(Initial) \_\_\_\_\_ **E-Prescribing:** I voluntarily authorize Southwest Children's Center, P.A. to allow E-Prescribing for my child's prescriptions, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as this child is a patient at this office.

(Initial) \_\_\_\_\_ **Code of Conduct:** I acknowledge that I received, reviewed, and agree to comply with Southwest Children's Center, P.A.'s Patient/Parent Code of Conduct.

(Initial) \_\_\_\_\_ **Preventative Care Policy:** I acknowledge that I received, reviewed, and agree to comply with Southwest Children's Center, P.A.'s Preventative Care Policy.

(Initial) \_\_\_\_\_ **Divorced or Separated Parents Policy:** I acknowledge that I have received, reviewed and agree to comply with Southwest Children's Center's Policy for Divorced or Separated Parents.

(Initial) \_\_\_\_\_ **Forms Policy:** I understand that I received notice about the fee for all forms to be completed by Southwest Children's Center, P.A. and I agree to pay prior to form completion.

(Initial) \_\_\_\_\_ **I understand that I can withdraw my consent at any time by contacting Southwest Children's Center, P.A. in writing at 5282 Medical Drive, Suite 310 San Antonio, Texas 78229. Withdrawal may result in dismissal from the practice.**

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Parent/Guardian Name (Print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Relationship to patient:  Parent  Legal guardian  Other: \_\_\_\_\_

Staff/Witness Signature: \_\_\_\_\_

**PRIMARY (and mailing)**  
 5282 Medical Drive, Suite 310  
 San Antonio, Texas 78229  
 Tel: 210-614-8687 | Fax: 210-614-7529

**SATELLITE LOCATION:**  
 7903 Calle Rialto  
 San Antonio, Texas 78257



## MINOR AUTHORIZATION

I, \_\_\_\_\_, parent or legal guardian of:

Printed Parent/Legal Guardian Name

\_\_\_\_\_  
Printed Child's Name

Child's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

hereby authorize in my absence, medical treatment for the child named above, and I authorize the individual(s)[named below] to accompany my child and to serve as my representative. I agree to allow the physician to release medical information to representatives mentioned below:

Full Name <small>(First MI Last)</small> :	Relationship to Child:	Address:	Phone:
_____	_____	_____	( ____ ) ____ - ____
_____	_____	_____	( ____ ) ____ - ____
_____	_____	_____	( ____ ) ____ - ____
_____	_____	_____	( ____ ) ____ - ____

**I understand I have the right to:**

1. Revoke this authorization by sending a written notice to Southwest Children's Center, P.A. and that revocation will not affect this office's previous reliance on the uses of disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Parent/Auth. Rep. Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Auth. Rep. Signature: \_\_\_\_\_



**SOUTHWEST  
CHILDREN'S  
CENTER**

**CREDIT CARD AUTHORIZATION FORM**

I authorize Southwest Children's Center to charge my credit card listed below for my family's account for:

- unpaid co-payments
- work-in charges and/or balances over 60 days due under the amount of \$100.00
- self-pay visit balances (due at time of service)

This authorization will remain in force on each of my child's accounts until they are no longer patients of Southwest Children's Center or until a written request by the cardholder instructing the practice to remove the authorization.

**Account Holder to Complete**

**Patient(s) Name**

First	Last	Date of Birth
		____ / ____ / ____ <small>MM DO YYYY</small>
		____ / ____ / ____ <small>MM DO YYYY</small>
		____ / ____ / ____ <small>MM DO YYYY</small>
		____ / ____ / ____ <small>MM DO YYYY</small>

**Account Holder to Complete**

**Credit Card Information**

- VISA    Mastercard    Discover    American Express

Card Holder's Name		Credit Card Number <b>DO NOT ENTER- WILL BE COLLECTED AT THE OFFICE</b>	
Card Expiration Date <b>DO NOT ENTER- WILL BE COLLECTED AT THE OFFICE</b>	Zip Code	3 or 4* Digit V Code (Back of Card) <b>DO NOT ENTER- WILL BE COLLECTED AT THE OFFICE</b>	
E-Mail Address		Phone Number	

\* American Express has 4 digits

Our office will send a courtesy text message the day we charge your credit card and will email a receipt once the payment is processed.

I understand and agree that I am financially responsible for the payment of all services received in the amount stated above. I authorize Southwest Children's Center, P.A. to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment date(s) falls on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that this authorization will remain in effect until the debt is fully discharged or I cancel it in writing, whichever comes first, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the payments of this authorization with my credit card company, so long as this transaction corresponds to the terms indicated in this form. I authorize Southwest Children's Center, P.A. to keep my credit card on file and to charge payments to the credit card provided above. I further understand that payments shall be deemed delinquent if not received at the payment date. If any scheduled payment related to this agreement is deemed delinquent during the term of this agreement, the agreement shall be considered to be in default. Default of payment will result in possible dismissal from the practice and the account sent to a collection agency.

Card Holder Name: \_\_\_\_\_

Card Holder Signature: \_\_\_\_\_

Date: \_\_\_\_\_

N/A Verbal Authorization

Billing Team Member Name: \_\_\_\_\_

Billing Team Member Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PRIMARY (and mailing)**  
5282 Medical Drive, Suite 310  
San Antonio, Texas 78229

**SATELLITE LOCATION:**  
7903 Calle Rialto  
San Antonio, Texas 78257

Tel: 210-614-8687 | Fax: 210-614-7529