Nazia Baig, MD • Sonal Jain, MD

Eastside Children's Clinic

311 N. Allen Drive, Allen, TX 75013
Phone: 972-372-0444
Fax: 833-427-1174
Email: doc@eastsidechildrens.com

*Patient Information

Name: _____ **DOB:** ____/_____/_____ **Sex**: Male/Female
Resides with: _____

Name: _____ **DOB:** ____/_____/_____ **Sex**: Male/Female
Resides with: _____

Name: _____ **DOB:** ____/_____/_____ **Sex**: Male/Female
Resides with: _____

Name: _____ **DOB:** ____/_____/_____ **Sex**: Male/Female
Resides with: _____

*Parent/Guardian Information

***Mother's/Guardian Name**:_____ **DOB:** ____/_____/_____
Social Security Number: _____- ____- _____ **Cell Phone**: (_____) _____- _____

***Father's/Guardian Name**:_____ **DOB:** ____/_____/_____
Social Security Number: _____- ____- _____ **Cell Phone**: (_____) _____- _____

*HomeAddress:

_____
City: _____ **Zip Code**: _____

*Insurance:

Policy Holder Name:_____ **DOB:** ____/_____/_____
Policy Name: _____
Member/Subscriber ID: _____**Group #**: _____

*Pharmacy:

Address/Cross Streets:_____
Phone: (_____) _____- _____

All patients will need to complete an updated registration form every 6-12months.

I wish to be contacted in the following manner:

Primary Contact: _____ **Relationship to Child**: _____

Cell Phone: (_____) _____- _____ Leave detailed message: Yes/No & Text: Yes/No

Email: _____ Email message: Yes/No

Secondary Contact: _____ **Relationship to Child**: _____

Cell Phone: (_____) _____- _____ Leave detailed message: Yes/No & Text: Yes/No

Email: _____ Email message: Yes/No

****Text messages will not contain health information. Detailed and email messages may contain health information.****

Medical Consent

The individuals listed below may be contacted **other than parent/guardian** as emergency contacts, to schedule appointments, request medical information and consent to medical treatment related to my child /children.

Name: _____ Relationship to Child: _____

DOB: ____/_____/_____ Phone Number: (_____) _____- _____

Name: _____ Relationship to Child: _____

DOB: ____/_____/_____ Phone Number: (_____) _____- _____

Parent Signature: _____
Date:_____

Request for Release of Medical Records

(Please ask for additional forms if more than one Physician/Practice)

_____

Physician or Practice Name

_____

Address

_____

Phone Number and Fax Number

I request that my child's complete records or specific information as listed below be released to:

Eastside Children's Clinic
311 N. Allen Drive
Allen, TX 75013
Phone: 972-372-0444
Fax: 833-427-1174

Patient Name: _____ **DOB:** ____/_____/_____

Patient Name: _____ **DOB:** ____/_____/_____

Patient Name: _____ **DOB:** ____/_____/_____

Patient Name: _____ **DOB:** ____/_____/_____

Please send all medical records, including immunization records.

By signing this form, I authorize you to release confidential health information about me or my child. I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the facility receiving the revocation. If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed. I have read and authorized the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

Parent Signature: _____

Date:_____

Financial Policy

Insurance:

Copayments, coinsurance and deductible payments are due at the time of service. **There may be an additional balance due after your insurance payments are applied to your account.** Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All outstanding balances greater than 90 days old will be turned over to a collection agency unless prior arrangements have been made with this office. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25 % of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. We have implemented a policy which enables you to maintain your credit card information securely on file with Eastside Children's Clinic, PLLC. In providing us with your credit card information, you are giving Eastside Children's Clinic, PLLC permissions to automatically charge your credit card on file for co-pay for any person you have listed on these forms. If your insurance provider has paid their portion of your bill or for any other person listed and there is a balance owed, Eastside Children's Clinic, PLLC will notify you via phone/mail. If by the final billing notice/90 days, we do not receive a response from you on payment, any balance owed will be charged to your credit card. A copy of the charge will be sent by mail to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. The amount you pay for your office visit depends on several factors including; Type of visit that is scheduled, whether you are a new patient or established, the complexity of your visit and the doctor's examination. (This will not always be known at check out until the physician signs off on the visit notes) Any out of pocket expenses, copays, deductibles and coinsurance is the responsibility of the patient and is due at the time of service.

(Families with basic medicaid are exempt from this policy)

TeleHealth:

Please note that a TeleHealth visit is equivalent to an office visit. All payments and insurance processing still applies. TeleHealth is considered any phone or virtual visit with the provider. If no TeleHealth visit is made then it is possible that the provider will instruct the Medical Assistant to respond to your call with instructions.

Self-Pay:

Patient(s) that **do not** have insurance will be considered Self Pay patients. Please note that the Self Pay visit cost may not be the only cost you have during your visit. If additional test and/or shots are given, you will be charged for these at checkout. So please make sure you ask the staff first, if any additional test/shots are covered. I understand that this authorization will be valid through the expiration of my credit card, unless I cancel this authorization via written notice.

Parent Signature: _____

Date: _____

Clinic Policy

Appointments:

We ask that you arrive at least 10 minutes before your appointment to complete the necessary paperwork and confirm insurance coverage. Only a certain number of appointments are

scheduled each hour. If your child has a problem that might require extra time (i.e. chronic headaches, recurrent abdominal pain), please convey this to our team when scheduling the appointment. If necessary, please notify our office when you are unable to keep an appointment. Sick appointments should be canceled as soon as possible. Other appointments should be canceled with at least 24-hour notice.

If you have a medical question, your call will be handled by our trained triage medical assistant. (If you wish your child to be seen, please make an appointment. Telehealth are optional and will be called in between in-office appointments.) All phone calls are returned in the order received, unless there is an urgent problem. We strive to answer all calls on the same day they are received. Please note, calls requiring a physician's input may not be returned until after appointments are seen. Eastside Children's Clinic always attempts to confirm appointments the day before the appointment. However, failure to respond to our appointment confirmation your appointment may be offered to another patient. If you need to respond to us after hours to cancel please leave a voicemail and we will check the next morning.

Our telephones are answered Monday-Friday from 8:30-12 and again from 1-5 and on every other Saturday from 8:30-12. Our staff have been instructed to handle all incoming calls to allow the providers to attend to their scheduled patients with a minimal interruption. If you feel you need to speak to the provider during office hours, you will be asked to leave a message with the front office and it will be relayed to the provider. It is possible that the provider will instruct the Medical Assistant to respond to your call with instructions.

Patient Portal:
A patient portal is available to access and save time by sending us a message, viewing vaccines, lab results and much more.

<u>For all emergencies, please call 911 or go to the nearest emergency room.</u>
For non-emergent problems requiring an after-hours office visit, please check with your insurance carrier for recommendations. One local urgent care clinic for pediatric patients only is listed below. We are not affiliated with the clinic, so please ensure that important information is faxed to our office after your visit.

Children's Health PM Urgent Care
Phone: (214) 592-0701

You may also contact Ask A Nurse by Medical City Children's Hospital. Ask a Nurse is a free service for pediatric patients, available 24/7. To reach this service call (972) 318-6752. Many insurance carriers also offer a free nurse service line, please contact your insurance to get further information.

Referrals:
Please note that any referral that the provider recommends to a specialist or therapy will require some time to be worked on, time may range between 3-7 business days unless marked URGENT. Please let us know your preference of contact for referral information. Email/Text/Phone Call
It is the parent responsibility to call and get scheduling information.

Medication Refills:
The quickest way to receive a prescription refill is to call your pharmacy, as they can send an electronic request directly to your child's chart in the electronic medical record. Medication refills can also be requested easily through the patient portal, which also goes directly into your child's chart. Phone refill requests will typically be completed within a few days. Some prescriptions may require pre-authorization from your insurance carrier so please be sure to contact us before your child is completely out of medicine. All refill requests are subject to physician discretion. Minimal turn around time for a refill request can be 48 hours.

Forms:
Any forms needed for any outside facility, like school, daycare etc. will require 7-10 business days to process. It is the parents responsibility to get us any forms needed in a timely manner. Forms will be completed during office hours in between scheduled appointments.

HIPAA Release of Information Agreement:
This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Records may be delivered to any physician that is directly or indirectly responsible for your medical care. We are legally obligated due to compliance with HIPAA, to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. You may speak with the Office Staff to obtain additional information regarding questions you may have concerning this Notice or to receive a printed copy of the Notice.

Treatment Consent:
I agree to allow my child to receive medical care at Eastside Children's Clinic. This consent applies to routine medical care including, but not limited to, physical exams, routine testing office treatments, standard vaccinations and Telehealth visits. I understand that no interventions or treatment will be performed without first discussing with a parent / guardian.

Parent Signature: _____

Date: _____