



Welcome to Kessler Pediatrics!

Dear Parent,

Thank you for choosing Kessler Pediatrics as your child's medical home. We are honored to partner with you in caring for your child from birth through adolescence.

Our goal is to provide high-quality, personalized pediatric care in a warm and supportive environment. We believe that the best care happens through strong partnerships with families, open communication, and a coordinated team approach. In addition to care provided in our office, we collaborate with trusted specialists and community resources when needed to support your child's overall health and well-being. If your child receives care outside of our office, please notify us so we can ensure appropriate follow-up and maintain an up-to-date medical record. For non-emergency concerns, we encourage you to contact our office before visiting urgent care or the emergency room.

We follow the recommended immunization schedule established by the American Academy of Pediatrics to ensure the safety and health of all patients in our practice.

Office Hours:

Monday–Thursday: 8:30 AM – 4:30 PM
Friday: 8:30 AM – 4:00 PM

We also offer after-hours nurse triage support for urgent concerns.

Please complete all required forms prior to scheduling your first appointment. Forms may be submitted via the patient portal, email, or fax. We are excited to care for your family and look forward to building a lasting relationship with you.

Warmly,

Kessler Pediatrics



Kessler Pediatrics Patient Registration Information

Form Completed by _____

Date: _____

Relationship to Patient: _____

Patient

Patient Name: _____ DOB: _____ Sex: _____

Address: _____

City _____ State: _____ Zip Code: _____ Phone Number: _____

Have you or any immediate family member been seen here before? ☐ Yes ☐ No

Sibling(s)

Sibling #1: _____ DOB: _____

Biological ☐ Half-biological ☐ Step ☐ Adopted ☐

Sibling #2: _____ DOB: _____

Biological ☐ Half-biological ☐ Step ☐ Adopted ☐

Sibling #3: _____ DOB: _____

Biological ☐ Half-biological ☐ Step ☐ Adopted ☐

Sibling #4: _____ DOB: _____

Biological ☐ Half-biological ☐ Step ☐ Adopted ☐

Sibling #5: _____ DOB: _____

Biological ☐ Half-biological ☐ Step ☐ Adopted ☐

Responsible Party

☐ Parent/Guardian #1: _____ DOB: _____ ☐ Mother ☐ Father ☐ Guardian

Biological ☐ Step-parent ☐ Adoptive ☐ Other ☐

Occupation: _____ Employer: _____

DOB: _____ Home Address: _____

SS#: _____ Phone #: H _____ C: _____ W: _____

Email Address: _____

Preferred method of Contact: Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐

May we leave a Voicemail? Yes ☐ No ☐ If Yes: Home Phone ☐ Cell Phone ☐ Work Phone ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐



☐ Parent/Guardian #2: _____ DOB: _____ ☐ Mother ☐ Father ☐ Guardian
Biological ☐ Step-parent ☐ Adoptive ☐ Other ☐
Occupation: _____ Employer: _____
DOB: _____ Home Address: _____
SS#: _____ Phone #: H _____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐
May we leave a Voicemail? Yes ☐ No ☐ If Yes: Cell Phone ☐ Work Phone ☐
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

☐ Parent/Guardian #3: _____ DOB: _____ ☐ Mother ☐ Father ☐ Guardian
Biological ☐ Step-parent ☐ Adoptive ☐ Other ☐
Occupation: _____ Employer: _____
DOB: _____ Home Address: _____
SS#: _____ Phone #: H _____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐
May we leave a Voicemail? Yes ☐ No ☐ If Yes: Cell Phone ☐ Work Phone ☐
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

☐ Parent/Guardian #4: _____ DOB: _____ ☐ Mother ☐ Father ☐ Guardian
Biological ☐ Step-parent ☐ Adoptive ☐ Other ☐
Occupation: _____ Employer: _____
DOB: _____ Home Address: _____
SS#: _____ Phone #: H _____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐
May we leave a Voicemail? Yes ☐ No ☐ If Yes: Cell Phone ☐ Work Phone ☐
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

If Guardian or Other, please explain relationship to Patient:

****PLEASE PROVIDE ALL LEGAL DOCUMENTS PERTAINING TO CUSTODY AND/OR GUARDIANSHIP****



Primary Insurance Information

Insurance Company Name _____ HMO ☐ PPO ☐ Other ☐ Self Pay ☐
Insurance Address _____ City _____ State _____ Zip Code _____
Name of Insured _____
Insurance ID# _____ Group Number _____

Secondary Insurance Information

Insurance Company Name _____ HMO ☐ PPO ☐ Other ☐ Self Pay ☐
Insurance Address _____ City _____ State _____ Zip Code _____
Name of Insured _____
Insurance ID# _____ Group Number _____

Emergency Contact Information

Name of Person to Contact Other than Parent: _____ Relationship: _____
Address _____
Home Phone _____ Work Phone _____

Registration Acknowledgement

I verify that this information is correct and up-to-date. I agree to update Kessler Pediatrics of any changes to the above information. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If Kessler Pediatrics is unable to collect from my child's insurance company using the information I have provided today or on any occasion, I accept full responsibility for the payment of my child/children's bills. I also understand that if my insurance recoups payments I am responsible for all charges, even if more than a year has passed since the date of service. I also understand that if there is a legal contract in a divorce situation in which one parent is responsible for medical bill payments, that contract is not a contract between us and Kessler Pediatrics. I acknowledge that whichever parent accompanies the patient for the visit is responsible for all copay, coinsurance, out of pocket expenses, or deductibles incurred on the date of service and remaining balance in the system.

Parent/Guardian (print name): _____ Date: _____
Signature: _____



Patient History Questionnaire

Patient Name _____ DOB: _____ Date: _____

Household

List all members in the primary household (where this child spends most of their time)

HOUSEHOLD

PLEASE FILL OUT THE FOLLOWING TABLE ACCORDING TO THE HOUSEHOLD MEMBERS ONLY

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

Are there any Siblings not living in the household? **YES** **NO**

If you answered yes, please list their name, age, and where they live.

What is the patient's living arrangement if not living with both biological parents?

If one or both parents are not living in the home, how often does the child see the parent (s) not in the home?

Are biological parents: ☐ Married ☐ Divorced ☐ Together, but not married ☐ Not together ☐ Not known

If parents are not together: ☐ Joint Custody ☐ Single Custody ☐ One or both parents not involved

Explain: _____

☐ Lives with adoptive parents. If adoptive: is child aware that he or she is adopted? ☐ yes ☐ no

☐ Lives with foster family

(Please provide all legal documents for above custody arrangements)



Patient History Questionnaire

Birth History ☐ Don't know Birth History

How many weeks was patient in the womb? _____ Birth weight: _____

Delivery type: ☐ Vaginal ☐ C-section ☐ Vacuum ☐ Forceps List

problems during pregnancy

(☐none): _____

During pregnancy, did the biological mother use ☐tobacco ☐alcohol ☐illicit drugs ☐prenatal vitamins

☐ other medications: _____

List problems during labor (☐none): _____

List problems during delivery (☐none): _____

Mom treated for Group B Strep? ☐ Yes ☐ No

Did your child go to the NICU or special care nursery? ☐no ☐yes, please give details: _____

General History

Do you consider your child to be in good health?

Yes ____ No ____

Does your child have any medical conditions?

Yes ____ No ____

Has your child had any surgery?

Yes ____ No ____

Has your child ever been hospitalized?

Yes ____ No ____

Is your child allergic to any medication, food, or substance?

Yes ____ No ____

Current Medical Conditions	Approximate age at diagnosis

Medication, Food, or Substance Allergy	Reaction

Has your child been prescribed an EpiPen: Yes ____ No ____ If yes, why? _____

List all prescribed medications

Medication	Strength	Dose	Frequency	Reason

Girls,

Started her period? If yes, what age _____ Any problems with periods? _____



Patient History Questionnaire

Patient Past History

HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW	HAS YOUR CHILD EVER HAD:	YES	NO	DON'T KNOW
CHICKENPOX				SLEEP PROBLEMS; SNORING			
FREQUENT EAR INFECTIONS				CHRONIC OR RECURRENT SKIN PROBLEMS			
PROBLEMS WITH EARS OR HEARING				FREQUENT HEADACHES			
NASAL ALLERGIES				CONVULSIONS OR OTHER NEUROLOGIC PROBLEMS			
PROBLEM W/ EYES OR VISION				OBESITY			
ASTHMA, BRONCHITIS, BROCHOLIOTIS, OR PNEUMONIA				HISTORY OR SERIOUS INJURIES/FRACTURES/CONCUSSIONS			
ANY HEART PROBLEM OR HEART MURMUR				USE OF ALCOHOL OR DRUGS			
ANEMIA OR BLEEDING PROBLEM				TOBACCO USE			
BLOOD TRANSFUSION				ADHD/ANXIETY/MOOD PROBLEMS/DEPRESSION			
FREQUENT ABDOMINAL PAIN				DEVELOPMENTAL DELAY			
CONSTIPATION REQUIRING DOCTOR VISITS				DENTAL DECAY			
RECURRENT URINARY TRACT INFECTIONS AND PROBLEMS				HISTORY OF FAMILY VIOLENCE			
KIDNEY DISEASE OR UROLOGIC MALFORMATIONS				HAS YOUR CHILD EVER TESTED POSITIVE FOR TB SKIN TEST			
BED-WETTING (AFTER 6 YRS OLD)				OTHER			

Biological Family History

DOES ANY FAMILY MEMBER HAVE:	YES	NO	DON'T KNOW	RELATIONSHIP TO CHILD
CHILDHOOD HEARING LOSS				
NASAL ALLERGIES				
ASTHMA				
TUBERCULOSIS				
HEART DISEASE (BEFORE AGE 55 YRS OLD)				
HIGH CHOLESTEROL/TAKES CHOLESTEROL MEDICATION				
ANEMIA				
BLOOD DISORDER				
HIGH BLOOD PRESSURE				



Patient History Questionnaire

BONE/JOINT DISORDER				
SKIN DISORDERS				
THYROID DISEASE: ☐ HYPOTHYROIDISM ☐ HYPERTHYROIDISM ☐ THYROID CANCER				
CANCER (BEFORE AGE 55 YRS OLD)				
LIVER DISEASE				
KIDNEY DISEASE				
DIABETES (BEFORE AGE 55 YRS OLD)				
BED-WETTING (AFTER 10 YRS OLD)				
OBESEITY				
ADHD				
MIGRAINES				
EPILEPSY OR CONVULSIONS				
ALCOHOL ABUSE				
DRUG ABUSE				
MENTAL ILLNESS/DEPRESSION				
DEVELOPMENTAL DISABILITY				
IMMUNE PROBLEMS, HIV OR AIDS				
TOBACCO USE				
ADDITIONAL FAMILY HISTORY				

Exposure History

Daycare: ☐ No ☐ Yes

Exposure to smokers: ☐ No ☐ Yes

Pets: ☐ No ☐ Yes

Guns: ☐ No ☐ Yes

***If yes, guns are locked away and kept separate from ammunition? ☐ Yes ☐ No

Pool/Bodies of water: ☐ No ☐ Yes

***If your home has a pool or body of water nearby, is it surrounded by a 4-sided fence or other precaution to keep your child safe from accidental drowning? ☐ Yes ☐ No



Patient History Questionnaire

Additional Information

Please use this space to provide additional information for any of the above questions:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform Kessler Pediatrics of any changes in my child's medical status or changes in my family's history. I authorize the healthcare staff to perform necessary healthcare services my child may need.

Signature of Parent/Guardian

Date

Print Name of Parent/Guardian



Authorization for Release of Medical Records

☐ I Hereby Authorize Kessler Pediatrics to **REQUEST** information **FROM**:

Clinic Name _____ Clinic Address _____

Clinic Phone # _____ Fax # _____

☐ I Hereby Authorize Kessler Pediatrics to **RELEASE** information **TO**:

Clinic Name _____ Clinic Address _____

Clinic Phone # _____ Fax # _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Records to be released:

- ☐ All Health Information (including growth charts and immunization records)
- ☐ History/Physical ☐ Laboratory Reports ☐ X-Ray Reports ☐ Progress Notes
- ☐ Office notes for past 2 years (includes all items above)
- ☐ Other (specify dates of service) _____

I authorize the release of information relating to:

- ☐ Alcohol/Drug Abuse Evaluation/Treatment ☐ HIV/AIDS testing/Treatment
- ☐ Psychiatric Evaluation/Treatment

Purpose of Release:

- ☐ Continuing care for on-going treatment ☐ Transfer of Care ☐ Insurance ☐ Personal (copy and retrieval fees may apply)

Statement of Authorization:

- This authorization expires (1) year after the date of my signature.
- I understand that Kessler Pediatrics will not condition my treatment, payment, enrollment, eligibility, or benefits on my signing of this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is sent as specified in this authorization, Kessler Pediatrics, and their employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I understand that if I am transferring care to another provider Kessler Pediatrics is unable to complete any forms or provide any additional care once my records are transferred to my new provider.

Signature of legally authorized representative/patient

Date

Print Name

Phone Number

Relationship to Patient



Kessler Pediatrics Office Policies

Welcome to Kessler Pediatrics! We are extremely pleased that you have chosen us to provide pediatric care for your child and strive to make your experience with our office a pleasant one. We look forward to having a long relationship with you and your family. This sheet will provide a general overview of our office policies. Please read carefully. We are happy to answer any questions you may have regarding our policies.

Office Hours

Our office is open for patient care Monday through Thursday from 8:30 a.m. to 4:30 p.m. and Friday from 8:30 a.m. to 4:00 p.m. We are closed for lunch from 1:00 p.m. to 2:00 p.m. daily.

After Hours

We are available to assist you during our regular office hours and encourage you to call with any questions during that time. For concerns that arise after the office is closed, we are pleased to offer access to our after-hours nurse triage line. Experienced pediatric nurses are available to provide guidance, and a physician is always on call to support any issues that require additional medical oversight.

For after-hours nurse advice, please call our main office number at 214-941-6691, and you will be connected to our nurse advice line.

Scheduling Appointments

Our reception team is available beginning at 8:30 AM, Monday through Friday, to assist with scheduling appointments. Kessler Pediatrics sees patients by appointment only. We are not a walk-in clinic, and we strongly encourage families to call ahead to schedule care. Walk-in patients will not be seen immediately and will be offered the next available appointment. For life-threatening emergencies, please call 911 immediately.

Well-Child Visits

Regular well-child visits are essential to monitoring your child's growth, development, and overall health. We recommend visits at the following ages: newborn, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and 3 years, followed by annual visits beginning at age 3. Because these appointments fill quickly, we strongly recommend scheduling well visits 2–3 months in advance. Well visits are not scheduled automatically and must be arranged by the parent or guardian. Due to the time required for comprehensive preventive care, well-child exams cannot be completed during sick visits. ADHD evaluations should ideally be scheduled at least 3 months in advance.

Sick Visits

Same-day sick visits are scheduled on a first-call, first-served basis. While we make every effort to accommodate urgent needs promptly, same-day appointments are subject to schedule availability. If our schedule is full, we will offer the next available appointment, often the following day. Our team is committed to seeing sick patients as quickly as possible based on medical need and scheduling capacity.



Scheduling for Multiple Children

Appointments are reserved only for the child for whom the visit was scheduled. If more than one child needs to be evaluated, each child must have a separate appointment. Please call in advance if you would like an additional child seen during a scheduled visit. While we will do our best to accommodate sibling appointments, consecutive appointment times cannot be guaranteed. A “quick look” at an unscheduled sibling is considered a medical visit and may require additional charges.

Caregivers Bringing Children to Appointments

If your child will be accompanied by someone other than a parent or legal guardian (such as a grandparent, nanny, or other caregiver), please notify our office in advance and provide written authorization for that individual to consent to care, receive medical information, and communicate the treatment plan. Caregivers should also be prepared to provide payment, including co-pays, at the time of service. All patients under age 18 must be accompanied by an authorized adult.

Well Visit vs. Sick Visit – Understanding the Difference

A well-child visit is a preventive visit designed for children who are healthy and focuses on growth, development, routine screenings, immunizations, and age-appropriate guidance. These visits allow your pediatrician to monitor your child’s overall health and identify concerns early.

A sick visit is focused specifically on evaluating and treating illness, injury, or medical concerns. Because these visits are structured differently, chronic medical issues, behavioral concerns, or new illnesses requiring significant evaluation may need to be addressed separately from a well-child exam.

If a significant medical problem is identified or addressed during a well visit that falls outside routine preventive care, your insurance may classify that portion of the visit as diagnostic or problem-focused, which may result in an additional co-pay or out-of-pocket expense. Insurance coverage varies, and families are encouraged to verify their benefits directly with their insurance provider.

Late Arrival Policy

We value your time and make every effort to see your child as promptly as possible. We kindly ask that you extend us the same courtesy by arriving on time for your scheduled appointment. If you anticipate being late, please contact our office as soon as possible so we can determine whether accommodations can be made within the day’s schedule. Patients arriving more than fifteen (15) minutes late may need to be rescheduled for the next available appointment time. While we will always do our best to accommodate you on the same day, please understand that the next available appointment may occasionally be on a different day.

No Show Policy

We understand that unexpected emergencies and scheduling conflicts can arise. If you are unable to keep your appointment, we kindly ask that you notify our office as soon as possible. Advance notice allows us to offer that appointment time to another patient in need of care.



Appointments that are not canceled or rescheduled at least 30 minutes prior to the scheduled appointment time will incur a \$75 missed appointment fee. Please note the following exceptions for early and midday appointments:

- **8:30 AM appointments** must be canceled before the office closes on the business day prior to the appointment.
- **2:00 PM and 2:15 PM appointments** must be canceled before the office closes for lunch at 1:00 PM on the day of the appointment.

We appreciate your understanding and cooperation in helping us serve all families efficiently.

Immunization Policy

At Kessler Pediatrics, we strongly believe in the importance of vaccinations as a critical part of preventive healthcare. We require all patients to follow the immunization schedule recommended by the American Academy of Pediatrics (AAP), which represents the current standard of care. We understand that parents may have questions or concerns, and we are always happy to discuss vaccine safety, efficacy, and recommendations to support informed decision-making.

To ensure children remain on schedule with recommended preventive care, vaccines are administered during regularly scheduled well-child visits only. We do not accommodate alternate or delayed vaccine schedules and do not schedule separate nurse-only visits for vaccines outside of the standard schedule.

Prescription Refills

Prescription refill requests are handled during regular office hours only and may be submitted by phone or through the Patient Portal. Refills are provided only for medications prescribed by our office for chronic medical conditions that have been evaluated within the past year. We are unable to provide refills for medications prescribed for new conditions, medications not prescribed within the past year, medications previously prescribed for acute or short-term conditions, or medications originally prescribed by providers outside our practice.

When requesting a refill, please have the medication name, dosage, pharmacy name, and pharmacy phone number available. For ADHD medications, patients must have been seen for an ADHD evaluation or follow-up within the past three months to be eligible for refills. Please allow up to three (3) business days for all prescription refill requests to be processed.

Referral Requests

Specialist referrals are provided only for conditions that have been evaluated in our office and when deemed medically appropriate by our physicians. For ongoing (chronic) conditions, patients must be seen in our office at least every six (6) months to maintain active referrals.

Please contact our office prior to your specialist appointment to request a referral. Allow up to seven (7) business days for referral processing. We do not process last-minute, same-day, or backdated referral requests. We also encourage families to verify referral requirements directly with their insurance provider before scheduling a specialist appointment.



When requesting a referral, please be prepared to provide all necessary information, including but not limited to:

- Specialist/Physician name
- Office location
- Office phone number
- Physician NPI number
- Appointment date

Your insurance company may require additional information. Referrals cannot be processed without complete and accurate details, and it is the parent or guardian's responsibility to provide all required information. Once completed, referrals will be sent directly to the specialist's office. Our practice is legally required to process referrals in accordance with insurance guidelines and Texas state regulations.

Medical Forms and Immunization Records

Requests for medical records must be submitted in writing and include the signature of a parent or legal guardian. Medical records requested for personal use will incur a fee of \$25 for the first 20 pages and \$0.50 for each additional page. There is no charge for medical records sent directly to another physician's office. Immunization records are available at no cost through the Patient Portal. Requests for printed physical copies of immunization records will incur a \$25 processing fee.

FMLA forms are completed for a fee of \$30. One revision to a completed FMLA form, if requested by the employer, is included. Any additional revisions will require completion of a new set of forms and an additional \$30 fee.

School and camp physical forms are completed at no charge for patients who have had a well-child exam within the past year.

Please allow up to seven (7) business days for completion of all medical record requests, immunization records, and forms.

Cell Phone Etiquette

To help us maintain an efficient, respectful, and focused care environment, we kindly ask that you refrain from using your cell phone while approaching the front desk or during your child's exam. Cell phone use can be disruptive to communication and the flow of patient care. Thank you for your cooperation.

School/Work Excuses

School and work excuses are provided only for patients and/or parents who are seen in our office. At the conclusion of each visit, you will receive documentation reflecting the date of the appointment and the medically appropriate return date for school or work. Please note that our office is unable to provide excuses for absences outside of these guidelines.

Separated/Divorced Families

We ask that separated or divorced parents provide our office with a copy of any legal custody or divorce decrees outlining custody arrangements, decision-making authority, or restrictions related to the child's



medical care. We will comply with all legally documented custody agreements on file. Without court documentation specifying restrictions, we are unable to withhold medical information from either parent and will provide care regardless of which parent or legal guardian presents with the child for the appointment.

The parent or guardian accompanying the child to the visit is considered the consenting party for that date of service and is financially responsible for all applicable charges at the time care is provided, including co-pays, deductibles, and any patient-responsibility balances required by the insurance plan. Please arrive with current insurance information and payment method available. Our office will not contact the other parent for payment or billing arrangements.

If a court order requires one parent to reimburse the other for medical expenses, it is the responsibility of the parent authorizing treatment and payment at the visit to seek reimbursement independently. Kessler Pediatrics will not mediate financial disputes between parents or make special payment arrangements based on custody agreements. Upon request, we are happy to provide receipts or billing documentation to assist with reimbursement between parties.

Failure to comply with this policy may result in dismissal from the practice.

Financial Policy and Patient Obligations

Kessler Pediatrics participates with most major private insurance plans; however, we do not currently participate in Medicaid or other medical assistance programs. If you plan to use insurance for your child's visit, please bring your current insurance card at the time of service. Patients are required to disclose all active insurance plans under which the child is covered, including primary and secondary coverage. Insurance companies routinely coordinate benefits, and failure to provide complete insurance information may result in claim delays, denials, or increased financial responsibility for the parent or guardian.

For families enrolled in HMO plans and certain Choice plans, it is essential that Dr. Donza Rogers Williams be selected as your child's Primary Care Provider (PCP) with your insurance company prior to your visit. Failure to designate the correct PCP may result in higher out-of-pocket costs, claim denials, or reduced insurance reimbursement. We strongly encourage families to verify PCP selection and coverage details directly with their insurance carrier before scheduling appointments.

Depending on your specific insurance plan, you may be responsible for one or more of the following at the time of service:

- **Co-pay:** A fixed amount due at each visit
- **Co-insurance:** A percentage of the cost of care after deductible requirements are met
- **Deductible:** The amount you must pay out of pocket before insurance begins covering eligible services

Questions regarding your benefits, co-payments, co-insurance, deductibles, or covered services should be directed to your insurance provider. All patient-responsibility amounts required by your insurance plan are due at the time services are rendered. Insurance contracts require our office to collect these



fees, and we are unable to waive or bill them later. Failure to provide required payment at the time of service may result in your appointment being rescheduled.

If you are not using insurance for your visit, full payment is required at the time of service. Please refer to our office fee schedule for current self-pay rates.

Patient Financial Responsibilities

Payment is due at the time services are rendered. This includes, but is not limited to, co-pays, co-insurance, deductibles, non-covered procedures or treatments, outstanding account balances, and any self-pay charges. These amounts are collected during the check-in process prior to your child's appointment.

For your convenience, we accept cash, checks, MasterCard, Visa, and American Express. Returned checks are subject to a \$30 returned check fee. If a patient disputes a valid credit card charge with their financial institution, Kessler Pediatrics reserves the right to provide documentation necessary to respond to and dispute the claim. If the dispute is resolved in favor of Kessler Pediatrics, an additional \$75 administrative fee may be applied.

Account Balances and Collections

Kessler Pediatrics will make every reasonable effort to help families maintain current account balances. As a courtesy, we will file claims with your insurance company when appropriate; however, please understand that the parent or guardian is ultimately responsible for all charges related to services provided. Insurance coverage does not guarantee payment, and any balance determined to be patient responsibility remains due.

Monthly statements will be provided for outstanding balances. Timely payment of all balances is expected. Failure to maintain a current account may result in additional collection efforts and could affect continued care within the practice.

Patient balances are expected to be paid in full upon receipt of your statement. A finance charge may be applied each month that an outstanding balance remains unpaid and an additional statement is issued. If you are unable to pay your balance in full, we encourage you to contact our office manager promptly to discuss possible payment arrangements and help keep your account in good standing.

Kessler Pediatrics reserves the right to refuse non-emergency care for patients with unpaid balances who do not make satisfactory payment arrangements with our office. Accounts with balances outstanding for more than three (3) months may be referred to a collections agency. Accounts that remain unresolved for more than one (1) year may result in dismissal from the practice.



Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications

The Patient Portal is provided by Kessler Pediatrics as a courtesy for the exclusive use of our patients and their authorized parents, legal guardians, or designated caregivers. By accessing the Patient Portal, you confirm that you are authorized to view and use the information available within the account and agree to use all confidential medical information solely for its intended purpose. Any unauthorized use, sharing, or misuse of protected health information is strictly prohibited.

If you believe your portal account security has been compromised, please notify our office immediately so that your access credentials can be reset.

The Patient Portal is intended for routine, non-urgent communication only. Our typical response time for routine messages is within three (3) business days; however, messages requiring physician review or more extensive medical evaluation may take longer. If your child is experiencing an urgent medical concern or requires immediate attention, please call our office directly or seek appropriate emergency care. The Patient Portal and email are not appropriate for emergencies.

When sending electronic communications, please include a clear subject line and provide the patient's full name, date of birth, and a return phone number to help us process your request efficiently. Certain highly sensitive topics, including but not limited to mental health concerns, HIV-related matters, or other confidential issues, may not be appropriate for portal or email communication and may require direct discussion with our office.

Please understand that communications sent through the portal or email may be accessible to appropriate members of our clinical and administrative staff as necessary to coordinate your child's care. Messages related to diagnosis, treatment, or medical advice may become part of the patient's permanent medical record.

While Kessler Pediatrics makes every reasonable effort to protect your privacy, electronic communication carries inherent security risks. Third parties may potentially gain access despite safeguards, particularly when using employer-based or shared email systems. If you access portal or email communications through a work or shared device, please be aware that your employer or others may have access to those communications.

By signing our Consent Acknowledgement Form and using the Patient Portal, you acknowledge that you have read, understand, and agree to abide by our Patient Portal and Electronic Communication Policy.



Patient Agreement

I acknowledge that I have read and understand the policies and procedures of Kessler Pediatrics as outlined in this document. I agree to adhere to the specific policies of Kessler Pediatrics. I am aware the office policies and protocols will be updated periodically as the practice grows and changes will be made accordingly. These updates will be available on our website as well as in our office. I understand that if I do not comply with above stated guidelines, Kessler Pediatrics reserves the right to terminate care with the office.

Parent/Guardian Name: _____

Signature: _____

Patient(s) Name (s): _____

Date: _____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on **April 14, 2003**.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.



We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request.
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction.
- You have the right to receive confidential communications of your protected health information, either directly from us or from us or by alternative means or from alternative locations.
- You have the right to inspect and copy your protected health information.
- You have the right to amend protected health information, however, this request may be denied under certain circumstances.
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy.



Officer at our office, or directly to the Department of Health & Human Services, Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA or to file a complaint contact:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
(202) 619-0257
Toll free: (877) 696-6775

Please contact us for more information Kessler Pediatrics Privacy Officer:

Tracy Sneed
214-941-6691

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Kessler Pediatrics Patient Portal

We are pleased to provide our patients with the convenience of our Patient Portal. Our patient portal will allow you to:

- View upcoming appointments for your child
- Review a visit summary for your child's appointments, including
 - Diagnoses
 - Vitals (height, weight, etc.)
 - Screening results (vision, hearing)
- Receive lab results
- Download and print a copy of your child's immunization record
- Send messages requesting non-urgent medical advice
- Request non-same day appointments (check-ups, follow-up appointments)
- Request prescription refills

Messages received via the Patient Portal are responded to during normal business hours and may take up to 72 hours for a reply. You will receive a notification at the email address you provided that a new message is waiting for you in the patient portal. In using this Patient Portal, please make sure that our office has your most current email address and that all of your demographic information has been updated within the last 6 months.

You may access the Patient Portal by going to our website www.kesslerpediatrics.com and clicking on the Patient Portal icon located on the top right-hand corner of the website. You must receive a unique link from us in order to log-in and complete the set-up of your Patient Portal. Please do not contact us via Patient Portal with any urgent questions.



Patient Portal Registration

Email address: _____

First name: _____

Last name: _____

Phone number: _____

Patients to add to account:

Name	Date of Birth

Once your account is created, you will receive an email with a temporary password that is active for 1 week. You will need to sign into the portal in order to complete your account set-up. Be sure to verify that your name appears correctly and that the names of the patients you have requested access to appear on the screen.

Please be aware that when a patient turns 18, the record for that patient automatically becomes **private**. Messages can still be sent in regards to the patient, but information in the chart cannot be viewed. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by completing and signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the physician.

Signature _____ Date _____

For office use only

Date account requested	
Date account set-up	
Initials	
Temporary password	



ACKNOWLEDGEMENT OF OFFICE POLICIES

- | | |
|-----------------------|---------------------|
| 1. Patient Name _____ | Date of Birth _____ |
| 2. Patient Name _____ | Date of Birth _____ |
| 3. Patient Name _____ | Date of Birth _____ |
| 4. Patient Name _____ | Date of Birth _____ |
| 5. Patient Name _____ | Date of Birth _____ |

Kessler Pediatrics Office Policies:

- 1) **Financial Obligation Policy:** I have read, understand, and will comply with the Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or in previous occasions, Kessler Pediatrics is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills. **Parent/Guardian** _____
- 2) **Appointment/Late Arrival/No-Show Office Policies:** I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Office Policies regarding appointment scheduling, late arrival, and no-shows and understand my responsibilities. I have read and understand them. **Parent/Guardian** _____
- 3) **Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications:** I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications policies and understand my responsibilities. **Parent/Guardian** _____

HIPPA (Health Insurance Portability and Accountability Act): I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand I am not required to agree to Kessler Pediatrics requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.
Parent/Guardian _____

I acknowledge that I have read this document in its entirety and fully understand it. I will comply with all of Kessler Pediatrics policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, if requested, and I was given the opportunity to ask any questions.

Print Parent/Guardian Name: _____ Date _____

Signature: _____

Print Witness Name: _____ Signature: _____



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 Sex: ☐ 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)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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 ImmTrac2. 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 § 161.007 (d). <https://statutes.capitol.texas.gov/Docs/HS/btm/HS.161.btm#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 ImmTrac2. Once in ImmTrac2, 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 DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. 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 § 161.00705. <https://statutes.capitol.texas.gov/Docs/HS/btm/HS.161.btm#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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to ImmTrac2. **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