



12600 Hill Country Blvd, Suite R-103  
Bee Cave, TX 78738

## PEDIATRIC DEMOGRAPHICS

### Parent/Guardian Information

1. Legal Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Single (\_\_\_\_) Married (\_\_\_\_) Divorced/Single (\_\_\_\_) Divorced/Remarried (\_\_\_\_) Widowed (\_\_\_\_)

Previous Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ D.L. # and State: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

2. Legal Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Single (\_\_\_\_) Married (\_\_\_\_) Divorced/Single (\_\_\_\_) Divorced/Remarried (\_\_\_\_) Widowed (\_\_\_\_)

Previous Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ D.L. # and State: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Children (Full Legal Names/Nickname) (Please check the box next to the children that are here for an appointment today)

- Name \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_
- Name \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_
- Name \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_
- Name \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_
- Name \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

Type of Home: House \_\_\_\_\_ Apartment \_\_\_\_\_ Year built \_\_\_\_\_

Previous physician name \_\_\_\_\_ Practice Name \_\_\_\_\_ office  
# \_\_\_\_\_

Preferred pharmacy \_\_\_\_\_ address \_\_\_\_\_

phone # \_\_\_\_\_

Insurance Information:

Insurance Company Name: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Claim Address \_\_\_\_\_

Policy Holder (Last, First, Middle) \_\_\_\_\_ DOB \_\_\_\_\_

Address: SAME?

Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Home Work Cell/Other \_\_\_\_\_

SSN \_\_\_\_\_ Employer \_\_\_\_\_

Payment is due at the time services are rendered. By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Premier Family Physicians (PFP) HIPAA privacy notice at any time and understand that I may request a copy.

Initials: \_\_\_\_\_

PFP Medical Care Agreement

I authorize the physicians of PFP to administer medical treatment as deemed necessary. I understand that there will be a \$25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that PFP will not verify insurance coverage. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits to otherwise payable to me to Premier Family Physicians, LLP

Initials: \_\_\_\_\_

Medical Care Agreement

I authorize the physicians of PFP to instruct their Physician Assistant /Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care. I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner... I acknowledge that it is my responsibility to inform the staff of PFP that I wish not to see the Physician Assistant/Nurse Practitioner and be scheduled with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

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

Electronic Communication

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication.** I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

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

How did you hear about us?

Word of Mouth  Yelp  Web Search  Facebook  Health Grades  Community Newsletter

Insurance Company  \_\_\_\_\_ Other \_\_\_\_\_



In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Clinical Pathology Laboratories (CPL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by CPL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

- \$12 Controlled substance prescriptions without an appointment
- \$15 Transfer of entire medical record, notary service, school forms with an appointment, disability forms
- \$25 Medical Records (purpose of life/medical insurance, attorney requests)
- \$35 Attending physician statement
- \$50 Physician dictated letter
- \$75 Physician narrative

Thank you for your cooperation.

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Date of Birth

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

\_\_\_\_\_  
Date