Hello,

On behalf of everyone here at Stonebriar Pediatrics, we would like to welcome you to Stonebriar Pediatrics!

We know you have choices in your choice for a Pediatrician and we appreciate that you are here. We are a multi-provider practice that work diligently towards a common goal: the well-being of your family. Our multi-provider selection allows for flexibility for all appointments. We look forward to watching your family grow!

Attached you will find our office policies and valuable resource references on childcare.

Poison Control: 1-800-222-1222

After Hours Number (emergencies only): 972-668-7110 option

Books:

What to Expect the First Year, by Arlene Eisenberg

Caring for Your Baby and Young Child, by American Academy of Pediatrics

Baby and Child Health; the Essential Guide from Birth to 1, by American Academy of Pediatrics, Jennifer Shu, MD

Parenting with Love and Logic, by Foster Cline

Positive Discipline, by Jane Nelson

Websites:

www.aap.org (American Academy of Pediatrics)

www.cdc.gove (Centers for Disease Control)

Like us on Facebook for weekly updates: Stonebriar Pediatrics

Office Hours by Appointment
Monday - Friday 8:00 am – 5:00 pm
Saturday 9:00 am – 12:00 pm
www.stonebriarpediatrics.com
2840 Legacy Drive #210 Frisco, TX 75034
Phone: 972-668-7110 | Fax: 972-668-7135

INFANTS | CHILDREN | ADOLESCENTS

Schedule of Well Child Exams & Immunizations

Birth - 2 Weeks 1	Newborn Screen # 2
Month	Physical Exam
2 Month	Pediatrix (DTaP, Pollo, Hepatitis B), Prevnar 13, Hib, Rotarix
4 Month	Pediatrix (DTaP, Polio, Hepatitis B), Prevnar 13, Hib, Rotarix
6 Month	Pediatrix (DTaP, Polio, Hepatitis B) & Prevnar 13
9 Month	Hemoglobin Screen (Check for anemia)
12 Months	MMR, Varicella & Hib
15 Months	Prevnar, Hepatitis A
18 Months	DTaP
2 Years	Hepatitis A, Hemoglobin Screen (Check for Anemia)
3 Years	Vision Screening
4 Years	MMR, Varicella, Kinrix (DTaP & Polio), Hearing and Vision, Urine Dip
5 Years	Hearing and Vision Screening
6- 10 Years	Hearing and Vision Screening & Scoliosis Screening
11 Years	Menveo, Boostrix (TDaP & Pertussis), Gardasil , Hearing and Vision Screening
12-17 Years	Hearing and Vision Screening & Scoliosis Screening; Menveo & Bexsero at age 16

The flu vaccine is recommended annually and is offered to the whole family. *Please schedule well child exams as early as possible to accommodate any requested as our appointments fill up quickly. In the need to cancel your child's appointment, please contact out office as least 24 hours in advance if possible.

Patient Registration Form

Todays Date: _____

Patient Information

Name: _____ _____ _____

DOB: _____ Gender: _____ Male _____ Female

Mother's Information:

Name: _____ _____ _____

Social Security Number: _____ DOB: _____

Email Address: _____

Address: _____

_____

_____

Home # _____ | Work # _____ | Cell # _____

Father's Information:

Name: _____ _____ _____

Social Security Number: _____ DOB: _____

Email Address: _____

Address (if different from above): _____

_____

_____

Home # _____ | Work # _____ | Cell # _____

Guarantor Information:

Name: _____ _____ _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Email Address: _____

Address (if different from above): _____

_____

Home # _____ | Work # _____ | Cell # _____

Name of Insurance: _____

Medical Claims Address (listed on back of card): _____

_____

_____

Member ID Number: _____ | Group Number: _____ | __PPO __HMO

Name of all other siblings seen by this practice :

_____ _____

_____ _____

Financial Policy

_____ **Insurance**: We have arrangements with many insurance plans to accept an assignment of benefits. All persons will pay their office co-pay (if applicable) at the time of the visit, and the remainder will be billed to your insurance company. If the insurance company does not pay, you will be responsible for the remaining balance, not covered by insurance.

_____ **Certification of Coverage and Assignment of Benefits:** I certify that I, and /or my dependent(s) have insurance coverage with the above insurance company. I hereby assign to Stonebriar Pediatrics P.A. all insurance benefits, if any, otherwise payable to me for services rendered to myself and/or my dependent(s), and I hereby authorize and direct my insurance carrier to issue payment of such benefits directly to Stonebriar Pediatrics, P.A. I authorize the use of my signature (and a copy thereof) on the insurance submissions.

_____ **Financial Responsibility:** I understand that I am responsible for all charges not paid by insurance. I understand that all co-pays are due at time of services rendered.

_____ **Consent to Treatment**: I am the parent /guardian or person representative of _____(name of patient) and there are no court orders now in effect that prohibits me from signing consent. I do hereby request and authorize the doctor(s) and practice staff of Stonebriar Pediatrics, P:A. to perform necessary services for the child named above, including but not limited to laboratory test and treatment, which are deemed advisable by the doctor, whether I am present when the treatment if rendered.

_____ **Authorization to release Information:** I hereby authorize Stonebriar Pediatrics, P.A. to use my health care information (or that of a dependent) and to disclose such information to insurance companies (and their agents) for the purpose of obtaining payment for services and determining insurance benefits. This authorization will remain in effect until revoked by me in writing.

_____ _____

Responsible Party Signature Date

_____ _____

Responsible Party Name Relationship to Patient

New Patient Information

Patient Name: _____ DOB: _____

Location of birth: _____

___ Vaginal ____ C-Section (list reason) _____

Birth Complications: _____

_____

___ Gava (number of times pregnant ____ Para (number of times given birth)

Birth weight: _____ Birth Length: _____ Head Circumference: _____

Discharge weight: _____ Bilirubin Level: _____ Weeks Gestation: _____

Feedings *(complete if under one year of age)*

Breast/Formula Fed (*circle one*) Type of formula: _____

How often: _____ How many ounces/minutes: _____

Hepatitis B given at hospital: ____ Yes _____ Date ____ No

Circle one

Parents: Marries/Divorced/ Single/ Other _____

Child Care: Home/Daycare/ Relatives

Parents Smoke: Yes/No

Pets in Home: Yes/No

Family History

***If you answer yes, please indicate what family member in the space provided*

Family History of Anemia or blood disorder:	Yes	No	Relation:_____
Family History of Allergies	Yes	No	Relation:_____
Family History of Asthma	Yes	No	Relation:_____
Family history of diabetes:	Yes	No	Relation:_____
Family History of High Blood pressure:	Yes	No	Relation:_____
Family History of Cholesterol:	Yes	No	Relation:_____
Family History of Psychiatric Disorder:	Yes	No	Relation:_____
Family History of Thyroid Disorder:	Yes	No	Relation:_____

Any other pertinent family history: _____

_____

Patient Childhood Illness or Injuries

History of Chickenpox:	Yes	No	Date: _____
History of MMR(measles, mumps, rubella)	Yes	No	Date:_____

Other pertinent illnesses: _____

_____

List any injuries or traumas below, including broken bones, stitches, surgeries, hospitalizations . Please list an approximate date:

_____

_____

Chronic Problems

History of ADD/ADHD:	Yes	No	Onset: _____
History of allergies:	Yes	No	Onset: _____
History of asthma :	Yes	No	Onset: _____
History of strep throat:	Yes	No	Onset: _____
History of ear infections:	Yes	No	Onset: _____
History of sinus infections:	Yes	No	Onset: _____
History of sexual abuse:	Yes	No	Onset: _____
History of substance abuse:	Yes	No	Onset: _____

List any other pertinent history:

_____

_____

Pharmacy Information

*** We will make every effort to e-scribe your child's prescriptions; however, sometime this service may not be available. If this service is unavailable, we will let you know and give you a paper script to take to the pharmacy.*

Name of preferred Pharmacy: _____

City of Pharmacy: _____

Intersection of pharmacy Location: _____

Stonebriar Pediatrics, P.A.

Office Policies

- **Well Child Visits:** Routine well child exams are an important part of your child's medical care. A well child exam focuses on your child's growth & development. We recommend scheduling well child appointments 6-8 weeks in advance to assure that your child has their immunizations & well visit on time.

- **Sick Visits:** Sick visits are scheduled as same day appointments. Saturday morning clinic is for emergent illness. If symptoms have been ongoing for several days, please have this addressed during our weekday office hours.

- **Walk-Ins:** Office visits are by appointment only. Patients who appear in the office without an appointment requesting to be seen will be given the next open appointment time, schedule permitting. Any patients in distress or requiring emergency service, will be triaged asap.

- **Late Arrivals:** Patients who arrive late, by 15 minutes or more, for an appointment will be required to reschedule, or be given the next open appointment if the schedule permits. Please be considerate to other patients by being on time for appointment times.

- **Cancellations/No Shows:** Should you need to cancel or reschedule a visit, please call 24 hours in advance or as soon as possible. Our office policy is after a 3rd No-show, you will be billed a $25 fee. If it continues, No-Shows are grounds *for* dismissal from the practice.

- **Telephone Calls:** We ask that you make all non-emergency calls during regular office hours. We will return your call as soon as possible in the order received, and generally within 1-2 hours. Antibiotics are not prescribed over the phone. The Doctors/Nurse Practitioner prefers to examine your child and tailor treatment to the specific diagnosis. Medication refill requests should be made only during regular office hours. We have a Doctor or Nurse Practitioner on-call after hours for emergency calls only. Should you have a life-threatening emergency occur, call 911.

- **Antibiotic Refills:** Antibiotics are not prescribed or refilled without a physician assessment.

- **Referrals:** Referrals and Authorizations are not given without a physician assessment.

- **School and Camp Forms:** Please be advised that the doctor or nurse practitioner complete these forms only if your child has bad a physical in the past year. Please make your request at least one week in advance. These forms are available for pick-up or can be faxed with a valid records release on file.

- **Minor Patients:** The parent (s), guardian(s), and/or adult(s) accompanying a minor are responsible for providing current insurance information for the minor. The adult accompanying the child is responsible for any co-pays or balances due including past due balances at the time of service. All patients under the age of 18 must be accompanied by a parent(s) or legal guar an(s) for each appointment unless given verbal/written consent to treat.

- **Payments** All co-pays are due when services are rendered unless prior arrangements have been made. Balances are due within 30 days of when the bill is issued. Bills will be issued after the insurance carrier pays its portion of the bill. We accept checks, cash, and credit cards. In addition to paying through the mail, credit card information may also be called to the billing office during business hours at 972-668-7110 option #5
- **NSF Fee:** There will be a $25 return check fee for all returned checks.

- **Nonpayment:** If a balance persists beyond 120 days and you wish to continue treatment by this office, we will require a payment of half the balance before being seen. Our physician will only be able to treat your child on an emergency basis until this matter has been resolved.

I understand the above policies and agree to abide by them:

_____ _____

Parent/Guardian Signature **Date**

HIPAA Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____(name of legal representative) understand that as part of the health care of _____(name of patient), this Practice originates and maintains health records describing his/ her health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning the patient's care and treatment
- a means of communication among the many health professionals who contribute to the patient's care
- a source of information for applying the patient's diagnosis and surgical information to the bill for services .
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I request the following restrictions to the use or disclosure of my health information (list below if any):

_____
_____
_____

Signing below indicated that I have been given a chance to review a copy of the Stonebriar Pediatrics, PA. Privacy Practice Policy. A copy of this policy is available upon request.

Name of Patient: _____

_____ _____

Signature of Patient or Legal Representative Date

Inbound Medical Records Release

I, _____(Name),_____(Relationship), of:

Patient's Name:_____ DOB: _____

Home Address:_____

_____

_____

Best Contact #: _____

Hereby authorize the release if his/ her medical records from:

Name of Provider/Institution:_____

Address:_____

_____

Phone #:_____ | Fax #: _____

To be forwarded directly to:

Stonebriar Pediatrics, P.A.
2840 Legacy Drive, Ste 210
Frisco, TX 75034
Phone: (972) 668-7110
Fax: (972) 668-7135

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

_____ _____

Parent/Guardian Signature Date