Hello,

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

We appreciate your decision in choosing a pediatrician and are delighted to have you here. As a multi-provider practice, we are committed to a common goal: ensuring the well-being of your family. Our diverse team offers flexible appointment options, tailored to your convenience. We eagerly anticipate the opportunity to be a part of your family's journey and growth!

Below, you will find our office policies helpful childcare resources.

Poison Control: 1-800-222-1222

After Hours Number (emergencies only): 972-668-7110 option 0

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)

Friend 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 and Immunizations

Birth – 2 weeks	**Newborn Screen #2**
1 Month	**Physical Exam**
2 Months	**Pediatrix (DTaP, Polio, Hepatitis B), Prevnar 20, Hib, Rotateq**
4 Months	**Pediatrix (DTaP, Polio, Hepatitis B), Prevnar 20, Hib, Rotateq**
6 Months	**Pediatrix (DTaP, Polio, Hepatitis B), Prevnar 20, Hib, Rotateq**
9 Months	**Hemoglobin Screen (to check for anemia)**
12 Months	**Priorix (MMR), Varicella (For chicken pox), Hepatitis A**
15 Months	**Prevnar 20, Hib**
18 Months	**DTaP, Hepatitis A**
2 Years	**Hemoglobin Screen (to check for anemia)**
3 Years	**Hearing and Vision Screen**
4 Years	**Priorix (MMR), Varicella, Kinrix (DTaP & Polio), Hearing & Vision**
5 Years	**Hearing and Vision Screen**
6-10 Years	**Hearing and Vision Screen, Scoliosis Screen**
11 Years	**Menveo, Boostrix (TDaP & Pertussis), Gardasil, Hearing & Vision**
12-17 Years	**Menveo and Bexsero (at age 16), Scoliosis Screen, Hearing & Vision**

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 our office at least 24 hours in advance.

Patient Registration Form

Today's Date: _____

Patient Information

Name: _____

DOB: _____ Gender: _____ Male _____ Female

Mother's Information:

☐ **Responsible Party for Insurance**

Name: _____

SSN: _____ DOB: _____

Email: _____

Address: _____

_____

Cell #: _____

Father's Information:

☐ **Responsible Party for Insurance**

Name: _____

SSN: _____ DOB: _____

Email: _____

Address: _____

_____

Cell #: _____

Insurance Information

Name of Insurance: _____

Medical Claims Address (listed on back of card):

_____

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

Pharmacy Information

*** We will make every effort to e-scribe your child's prescriptions; however, sometimes 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: _____

Financial Policy

_____ **Insurance:** We have agreements with several insurance plans to accept assignment of benefits. Office co-pays (if applicable) are due at the time of the visit, with the remaining balance billed directly to your insurance provider. Any unpaid amounts not covered by insurance will be your responsibility to settle.

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

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

_____ **Consent to Treatment:** I, as the parent/guardian or authorized representative of _____ (Name of Patient), affirm that there are currently no court orders in effect prohibiting me from providing consent. I hereby request and authorize the doctors and staff at Stonebriar Pediatrics, P.A. to perform necessary services for the child named above. These services may include, but are not limited to, laboratory tests and treatments deemed advisable by the physician, even in instances where I am not physically present during the administration of such treatments.

_____ **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: Married/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:

_____

Please provide details below of any injuries or traumas, including dates, such as broken bones, stitches, surgeries, and hospitalizations.

_____
_____

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:

_____
_____

Inbound Medical Record Release

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

Patient's Name: _____ DOB: _____

Home Address: _____

_____

Cell #: _____

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.

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.

_____ _____

Signature of Patient or Legal Representative **Date**

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

I, _____(Name of legal representative) acknowledge that, as a part of the healthcare provided to _____ (Name of patient), this Practice originates and maintains health records that detail the patient's health history, symptoms, examination and test results, diagnoses, treatment, and any future care or treatment plans. I understand that this information serves the following purposes:

- To guide the planning and management of the patient's care and treatment
- To facilitate communication among the various healthcare professionals involved in the patient's care
- To provide information necessary for billing services, including the application of the patient's diagnosis and surgical details
- To enable third-party payers to verify that billed services were rendered
- To support routine healthcare operations, such as assessing the quality of care and reviewing the performance of healthcare professionals

I acknowledge that I have received a Notice of Information Practices, which provides a comprehensive description of how my information may be used and disclosed. I understand that I have the right to review this notice before signing this consent. I also understand that the organization retains the right to modify its notice and practices, and any revised notice will be mailed to the address I have provided prior to its implementation.

Furthermore, I understand that I have the right to object to the use of my health information for directory purposes. I am aware that I may request restrictions on how my health information is used or disclosed for treatment, payment, or healthcare operations, though the organization is not obligated to agree to these restrictions. Additionally, I recognize that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance upon it.

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.

_____ _____

Signature of Patient or Legal Representative **Date**

Office Policies

Well Child Visits: Routine well-child exams are essential for maintaining your child's overall health and development as we prioritize monitoring growth and developmental milestones. We highly recommend scheduling well-child appointments 6-8 weeks in advance to ensure timely immunizations and comprehensive well-visits.

Sick Visits: Sick visits are accommodated with same-day appointments. Our Saturday morning clinic is designated for emergent illnesses. If symptoms have persisted for several days, we kindly request addressing them during our weekday office hours for thorough evaluation and care.

Walk-Ins: Office visits are scheduled by appointment only. Patients arriving without an appointment and requesting to be seen will be accommodated at the next available appointment time, based on scheduling availability. Patients experiencing distress or requiring emergency services will be triaged promptly.

Late Arrivals: Patients who arrive 15 minutes or more late for their appointment will be asked to reschedule, or they will be accommodated at the next available appointment time if the schedule allows.

Cancellations/No Shows: If you need to cancel or reschedule a visit, we kindly ask for a 24-hour notice or as soon as possible. Please note that our office policy states that after a third no-show, a $25 fee will be billed. Continued no-shows may result in dismissal from the practice.

Telephone Calls: Please limit non-emergency calls, as well as medication refills, to regular office hours. Antibiotics are not prescribed over the phone as our providers prefer to assess and treat during an examination. For emergencies after hours, a provider is available on-call. In case of a life-threatening emergency, please dial 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 NP completes these forms only if your child has had 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. They are also 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 guardian(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