Angel's Star Wellness Center

PEDIATRIC PATIENT REGISTRATION INFORMATION

Please complete all sections of this form

LAST NAME _____ FIRST NAME _____ M.I. _____

DATE OF BIRTH _____ /_____ /_____ GENDER ❑ M ❑ F SOCIAL SECURITY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL _____

RACE ❑ White ❑ Black ❑ Asian ❑ Native Hawiian/Pacific Islander ❑ Hispanic
❑ American Indian/Alaskan Native ❑ Other

ETHNICITY ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unreported/Refuse

PREFERRED LANGUAGE ❑ English ❑ Spanish ❑ Other _____

SCHOOL NAME _____

GUARANTOR INFORMATION

Name _____ Relationship to Patient _____

Phone _____ Email _____ Employer _____

Date of Birth _____ /_____ /_____ Social Security _____

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

In the case of an emergency when the parent/guarantor cannot be reached, please provide someone we may contact on behalf of the patient.

Name _____ Phone_____ Relationship to Patient _____

How did you hear about our office? _____

PATIENT REGISTRATION INFORMATION (CONT.)

Financial Agreement for Assignment of Benefits

I authorize Angel's Star Wellness Center P.A. to release such information from my patient records as is required in order to receive reimbursement for any billings rendered relating to my treatment. I hereby give authorization for payment of insurance benefits to be made directly to Angel's Star Wellness Center P.A. for all services provided to me. In making this agreement, I understand that I am financially responsible for all charges not covered by insurance, including patient co-payment, deductible, non-covered services and cancellation fees.

➢_____ _____

Signature of Patient or Legal Guardian Date

Acknowledgement of Medical Personnel

I acknowledge that residents, interns or medical students and other health care professional students may participate under the supervision of the physicians at Angel's Star Wellness Center P.A. If in the case I do not wish to be seen by a resident, intern or medical student, I acknowledge that I must notify the medical staff promptly.

➢_____ _____

Signature of Patient or Legal Guardian Date

Notice of Financial Policy

I acknowledge that the **Financial Policy** of Angel's Star Wellness Center P.A. was provided for me and I authorize my understanding of this policy which delineates the clinic's financial policies. As a patient I understand that a copy of this financial policy can be provided to me upon request at any time.

➢_____ _____

Signature of Patient or Legal Guardian Date

INSURANCE INFORMATION	
Primary Insurance _____	Secondary Insurance _____
Member # _____	Member # _____
Policy Holder/ D.O.B _____	Policy Holder/ D.O.B _____
Relationship to Insured _____	Relationship to Insured _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

General Consent for Treatment

I, the parent or legal guardian of _____ , a minor child, do hereby consent to any diagnosis or treatment rendered under the general or specific instructions of the physicians at Angel's Star Wellness Center.

This consent is given in advance of any specific diagnosis or treatment being required, which is given to encourage those persons who have temporary custody of my child, and said physician(s), to exercise their best judgement as to the requirements of such diagnosis or medical treatment. This consent shall remain effective until revoked in writing and delivered to Angel's Star Wellness Center P.A., the said persons entrusted with the custody, care and control of said minor child.

➢_____

Printed Name of Legal Guardian

➢_____ _____

Signature of Legal Guardian Date

Authorization for Treatment without Guardian Present

I, _____ , the legal guardian of _____ , do hereby consent and authorize the providers and staff of Angel's Star Wellness P.A. to examine and/or treat my child in my absence. I affirm I have the legal right to provide this consent and understand this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I give the providers and staff of Angel's Star Wellness Center P.A. the permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate.

I understand that I will be contacted for a verbal consent if treatment plan includes vaccinations, and the best number to reach me for this is: _____.

I authorize the following individuals to seek medical treatment for the following minor patient in my absence:

_____

Name/Relationship Phone Number

_____

Name/Relationship Phone Number

➢_____

Printed Name of Patient

➢_____ _____

Signature of Legal Guardian Date

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

Reason for being seen today: _____

Where has your child gone for check-ups or physicals until now? _____

Last check up was: _____/_____/_____ Date of last dental check-up: _____/_____/_____

Allergies:

Is the patient allergic to any medications? ❑ Yes ❑ No If yes, please list all.

Do you have any other allergies? ❑ Yes ❑ No If yes, please list all.

Living Situation:

If not living with both biological parents, the patient is under the custody of:

❑ With Mother ❑ With Father ❑ With Adoptive Parents ❑ With Foster Family

❑ Grandparents ❑ Single Custody ❑ Joint Custody ❑ Other _____

Immunizations:

Are you up-to-date on your vaccinations?	❑ Yes	❑ Yes but only as a child	❑ No not immunized	

Birth History:

Birth weight (lbs): _____ Location of delivery: _____

The delivery was: ❑ Spontaneous ❑ Induced
❑ Vaginal ❑ Cesarean, because _____

Duration of pregnancy was ❑ to term (37-42 wks) ❑ premature (<37 wks) ❑ postmature (>42 wks)

Did mother have an illness or problems with her pregnancy? ❑ No ❑ Yes, _____

Did the baby have any problems after birth? ❑ No ❑ Yes, _____

Did the baby go home with mother from the hospital? ❑ Yes ❑ No because _____

During pregnancy, did mother smoke? ❑ No ❑ Yes If so, how often? _____

During pregnancy, did mother drink? ❑ No ❑ Yes If so, how often? _____

During pregnancy, did mother use prenatal vitamins, drugs or medication? ❑ No ❑ Yes, _____

Was initial feeding ❑ Breast Milk ❑ Formula ❑ Both

Medications:

Are you taking any medications, prescription or over the counter, currently? ❑ Yes ❑ No

If yes, please list all medications. *Please list additional medications on the back of this form*.

Medication Name	Strength	Quantity Taken	Frequency Taken A Day

Medical Conditions: Please select any of the following which applies and onset date if known.

- ❑ AIDS / HIV / Other STD: _____
- ❑ ADHD / ADD
- ❑ Alcohol / Drug Abuse
- ❑ Allergy / Sinus Problems
- ❑ Anemia
- ❑ Anxiety / Depression
- ❑ Asthma
- ❑ Autism or Asperger's
- ❑ Bed Wetting
- ❑ Behavioral Disorder or issue of _____
- ❑ Birth Defects
- ❑ Bladder Issues (includes retention or incontinence)
- ❑ Blood or Bleeding Disorder
- ❑ Bone or Muscle Disease
- ❑ Cancer of _____
- ❑ Chicken Pox
- ❑ Constipation, Chronic
- ❑ Deafness Childhood
- ❑ Dental Caries
- ❑ Developmental Delay: _____
- ❑ Diabetes Type 1 or 2
- ❑ Ear Infections, frequent
- ❑ Endocrine System Disorder
- ❑ Eczema
- ❑ Epilepsy
- ❑ Eye Problems
- ❑ Genetic Disorders
- ❑ Gastrointestinal Problems
- ❑ Growth Issues
- ❑ Headaches
- ❑ Head Injury: _____
- ❑ Hearing Loss
- ❑ Heart Problems: _____
- ❑ Kidney or Liver Disease
- ❑ Kidney Infection
- ❑ Learning Disability: _____
- ❑ Leukemia
- ❑ Lupus (SLE)
- ❑ Measles
- ❑ Meningitis
- ❑ Neurologic Disorder: _____
- ❑ Organ Transplant
- ❑ Physical Impairment
- ❑ Pneumonia
- ❑ Scarlet Fever
- ❑ Short Attention Span
- ❑ Sleeping Problems
- ❑ Speech Delay
- ❑ Stroke
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ UTI
- ❑ Vision Loss
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

Medical Providers:

Please list all other doctors seen on a regular basis, including name and speciality.

History of Surgical Procedures:

Please list all surgeries with approximate dates.

Hospitalization:

Please list all hospitalizations other than for birth with approximate dates.

_____
Patient or Guarantor's Initials

By initialing, I understand that it is the patient's responsibility to notify my doctor of any change in my health condition so that they may better assist me.

Angel's Star Wellness Center PA Medication Policy

*Please **initial** on the blanks below and sign any indicated areas to denote that you have read and acknowledge our clinic's policies regarding medications.*

_____ Effective August 1, 2019, any patient who is taking any controlled substance will be required to have a **random drug screening twice a year**. Controlled substances include, but are not limited to: Xanax, Adderall, Hydrocodone, Morphine, and Oxycodone.

_____ I acknowledge that I am aware of the **Pain Policy** at Angel's Star Wellness Center P.A., which was effective August 1, 2019 and if I am prescribed any controlled pain medication by Dr Chau Pham D.O. or Dr Jennifer Trinh D.O., I will abide by this policy.

_____ For all medication refills, the patient must **allow 72 hours (3 business days)** for the medication to be sent to the pharmacy from the date we receive the request for refill. This refill request can be from the patient or the patient's pharmacy.

_____ Angel's Star Wellness Center P.A. and its physicians reserve the right to **deny medication refills** for non-compliance such as if the patient has multiple missed appointments/ No Show, if it has been greater than 3 months since the patient has been seen by the Doctor, or if the patient has an outstanding balance.

By signing below, I agree to the above communication preferences, medication procedures for refills, and controlled substance procedure at Angel's Star Wellness Center P.A.

➤_____ _____

Signature of Patient or Legal Guardian Date

Thank you for choosing Angel's Star Wellness Center. We look forward to caring for you!

Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you at Angel's Star Wellness Center P.A. about your health care by completing and signing the form below:

❑ Yes ❑ No May we use your first name, last name or both to identify you in the waiting room? If not, how would you prefer to be identified?

_____

❑ Yes ❑ No May we leave a message on your answering machine or personal voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you?

❑ Patient Portal ❑ Cell / Work

_____

❑ Yes ❑ No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

_____

❑ Yes ❑ No Is there another person with whom you give permission for us to disclose or discuss my health care with? If so, please list the name(s) and relationship to the patient.

_____

_____

_____

By signing below, I agree to the above communication preferences, privacy policies and disclosure(s) of information of my health information and any other relevant information by the staff and physicians at **Angel's Star Wellness Center P.A**. I understand if I want to amend any disclosures of my health information or preferences I must do so in writing.

➢_____

Patient Legal Name Printed

➢_____ _____

Signature of Patient or Legal Guardian Date

Angel's Star Wellness Center

Please read and complete the last page of our financial policy

FINANCIAL POLICY

We appreciate payment for all copay, co-insurance and deductibles at the time of service and will accept personal checks, VISA, MasterCard, Discover and cash. Prompt payment helps keep both our costs and fees down.

Our physicians share your concern about the cost of medical care. We strongly believe that the best medical service is based on a friendly, mutual respect and understanding between patient and doctor. We therefore invite you to discuss frankly with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, we encourage you to contact our staff. The earlier we know about a possible problem, the better we are able to develop suitable options for you. *It is never our intention to cause hardship to our patients, only to provide them with the best care possible.*

AGREEMENT

This is an agreement between Angel's Star Wellness Center P.A, as a provider and creditor, and the Patient named on this form. By executing this agreement, you, the Patient, are agreeing to pay for all services that are received.

INSURANCE: Insurance is a contract between you and your insurance company. We will bill your primary insurance (and secondary insurance) if you have provided the correct information. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility. Authorization received by Angel's Star Wellness Center P.A. from your insurance carrier is *not* a guarantee of payment. The patient agrees to pay any portion of the charges not covered by insurance.

REQUIRED CO-PAYMENTS: Any *co-payment* required by an insurance company **must** be paid at the time of service by contract. We cannot bill you for these fees.

PAYMENT OPTIONS WITH NO INSURANCE:

A. All services and procedures are required to be paid in full on the date rendered by the patient. If an extended payment plan is needed, I agree to speak to a billing coordinator to discuss a mutually agreeable payment plan that will at the very least contain the following:
B. In the event of a financial hardship, a modified payment plan can be arranged on a case-by-case basis upon discussion with a financial coordinator. I am aware that discussion regarding a payment plan does not ensure such a plan. I will provide a valid credit or debit card to keep on file to ensure my payment.

PAYMENT WITH INSURANCE: All deductibles, copayments and co-insurances must be paid in full at the time services are rendered. This can be paid with cash, check or credit/debit card. I can choose to pay all services in full and file with my insurance company. If my insurance coverage and plan is one that Angel's Star Wellness PA does not have prior agreement (out of network) with, I understand charges for care and treatment are due at the time of the services rendered.

RETURNED CHECKS: There is a fee of $25 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check. All future visits will need to be paid in another form of payment prior to being seen.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days from the date of service are considered past due. If your account becomes past due, we will take necessary steps to collect this debt.

FINANCIAL AGREEMENT CONT.

DIVORCE: Consistent with Texas statute, in case of divorce or separation, the party responsible for the account prior to divorce or separation will remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. *If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent.*

MISSED APPOINTMENTS: When a patient does not show for an appointment or cancels with less than 24 hours notice, the patient may be subject to a **$50 charge** for all appointments. This fee would be due prior to receiving any future services or appointments.

Good medical care requires a mutual relationship of trust, confidence and respect between the patient and their doctor. Persistent failure to keep scheduled appointments may result in dismissal from the practice.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect this debt. If we are forced to refer your collection balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs.

PERSONAL INJURY / MOTOR VEHICLE ACCIDENT (MVA): We do not bill attorneys or other third party billing services for medical services. All services performed in relation to a personal injury case must be paid in full at the time of service.

- If you are not planning to seek reimbursement, we will file to your primary insurance for a regular office visit. Any information from this visit will not be disclosed to any third party billing or attorneys in the event you should decide to seek further action and reimbursement.

ADDITIONAL SERVICES: Please be aware that there are fees for additional services. Please ask our office staff any questions.

Any photocopy of this consent shall be considered as valid as the original.

ANGEL'S STAR
WELLNESS CENTER, PA

➤_____
Patient Legal Name Printed

➤_____ _____
Signature of Patient or Legal Guardian Date