Name ______ Birth Date ______ Date First Seen ______

Race ______ Sex ______ Referred By ______

Hospital ______ Obstetrician ______

Father's Name ______ Date of Birth ______

Mother's Name ______ Date of Birth ______

Address ______ Home Phone ______

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? ______

Is the child yours by ☐ birth ☐ adoption ☐ stepchild ☐ other

Pregnancy complications ______

Delivery by ☐ vaginal ☐ c-section

Reason for c-section ______

Complications ______

Was your child premature ☐ No ☐ Yes, born at ______ weeks

Complications ______

Apgar scores 1 minute ______ 5 minutes ______

Birth weight ______ Length ______

Other problems in the newborn period ______

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease ______
- ☐ Wheezing or bronchiolitis ______
- ☐ Seasonal allergies or eczema ______
- ☐ Food allergy ______
- ☐ Recurrent ear infections ______
- ☐ Pneumonia ______
- ☐ Urinary tract infections ______
- ☐ Genetic syndrome ______
- ☐ Seizures ______
- ☐ Anemia ______
- ☐ Broken bone ______
- ☐ Mental retardation or learning disability ______
- ☐ Depression/anxiety ______

Other chronic medical conditions ______

Has your child ever been hospitalized ☐ No ☐ Yes (explain)

Previous surgeries and dates ______

Please list any specialist your child is currently seeing and reason:

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

Current medications and dose: ______

Vitamins ______

Herbal supplements ______

Over-the-counter meds ______

Development/Nutrition

At what age did your child: Sit alone ______

Walk alone ______ Say words ______

Toilet train (day) ______ 1st period (females) ______

Was your child breastfed ☐ No ☐ Yes, how long? ______

Has your child had any unusual feeding/dietary problems? Explain.

Current milk intake: Type ______ Amount ______ oz/d

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad ☐ Siblings (# ______) ☐ Grandparents ☐ Other ______

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) ______

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV ______ Computer ______ Video games ______

Child's school name ______ Grade ______

Any concerns about school performance? ☐ No ☐ Yes, explain

Any concerns about peer or teacher relationships? ☐ No ☐ Yes

Sports/excercise: Type ______

How often? ______ How long ______ min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
______	☐	☐	☐	☐

Please explain all positives: ______

Review of Systems *(Check all that apply)*

Constitutional
- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat
- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory
- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal
- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye, skin, blood)
- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleed

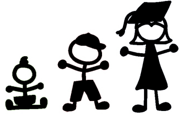
Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular
- ☐ Chest pain, palpitations
- ☐ Tires easily with exertion
- ☐ Fainting

Genitourinary
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic
- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
- ☐ Anxiety/stress ☐ Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity



INWOOD VILLAGE PEDIATRICS

5470 Lovers Lane, Suite 330
Dallas, Texas 75209
Phone: (214) 956-7337
Fax: (469) 364-8724

Demographics

Date: __________________ Primary Doctor: ❍**Browning** ❍**Deuber** ❍**Hamner** ❍**Hubbard** ❍**Khouri** ❍**Linderman**

Patient Information

(*Please include full **legal** names for each patient.*)

Legal Name	Date of Birth	Male	Female
1.			
2.			
3.			
4.			
5.			
6.			

Address: ____________________

Primary Contact Name: ____________________ **Phone #:** (_____) ____________________

Preferred Pharmacy: ____________________ **Phone #:** (_____) ____________________

Pharmacy Location: ____________________ **Fax #:** (_____) ____________________

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: ____________________

Emergency Contact

(Local Emergency Contact Person NOT A PARENT OR GUARDIAN)

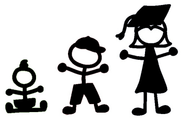
Legal Name: ____________________ Relationship to Patient: ____________________

Address: ____________________

❍ Home #: (____) ____________________ ❍ Cell #: (____) ____________________ ❍ Work #: (____) ____________________

I attest that all information is true and accurate. ____________________ ____________

Signature of Patient or Legal Guardian Date



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ACKNOWLEDGEMENT OF THE RECEIPT OF INWOOD VILLAGE PEDIATRICS' NOTICE OF HEALTH INFORMATION PRACTICES, OFFICE, AND FINANCIAL POLICIES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Inwood Village Pediatrics is furnishing you with the attached notices, which provides information about how Inwood Village Pediatrics may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. You shall also be given a copy of the office and financial policies for Inwood Village Pediatrics. By signing this form, you acknowledge that you have received a copy of Inwood Village Pediatrics' notice of Private Health Information, office, and financial practices and policies.

______________________________ ______/______/______
Patient's Name Patient's Date of Birth

______________________________ ______________________________
Signature of Patient or Legal Guardian Date

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to Inwood Village Pediatrics to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship	Contact Information
____________	____________	____________
____________	____________	____________
____________	____________	____________

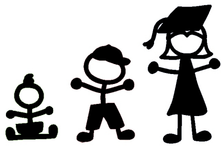
❍ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Reach Primary Contact (Please check all that apply; this is for the primary contact on the Demographic page.)

_____ OK to leave a message on my HOME PHONE with detailed information.
_____ Leave a message on my home phone with a call-back number only.
_____OK to leave a message on my WORK PHONE with detailed information.
_____ Leave a message on my work phone with a call-back number only.
_____ OK to leave a message on my CELL PHONE with detailed information.
_____ Leave a message on my cell phone with a call-back number only.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

______________________________ ______________________________
Signature of Patient or Legal Guardian Date



INWOOD VILLAGE PEDIATRICS

5470 Lovers Lane, Suite 330
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Celia Browning, M.D.
Christina Deuber, M.D.
Jane Hamner, M.D.
Susan Hubbard, M.D.
Grace Khouri, M,D.
Julie Linderman, M.D.

Medical Treatment of a Minor Authorization Form

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Full Legal Name: ____
Home Address: ____
Date of Birth:____________________________

Place of Treatment:
Inwood Village Pediatrics 5470 Lovers Lane, Suite 300 Dallas, Texas 75209 214-956-7337

Information for Medical Treatment

Please note **all** conditions for which the child is currently receiving treatment:
____
____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for ____ (hereafter “Designated Adult”) to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: ___________________.

Signed this _________day of_____________, 20________.

Parent / Legal Guardian Signature: ____

Printed Name: ____

(NOTE ONE FORM PER CHILD)

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OFFICE AND FINANCIAL POLICIES FOR INWOOD VILLAGE PEDIATRICS

Payment is due at the time of service:
For patients without insurance, payment is due at time of service for both sick and well visits. Copays and balances are expected at time of service. After 90 days, outstanding balances will be referred to a collection process. Contact the billing office for any problems with your account.

Should your insurance company deny payment for services performed, it is the insured's responsibility to pursue the issue. Billed services not covered by insurance are the insured's responsibility, including vaccine charges. If correct insurance information is not provided in a timely manner and causes a delay in insurance processing, the patient will be responsible for charges.

The patient or adult person presenting with the patient is responsible for satisfying the copay.

Regardless of court decision concerning health care in the case of divorced parents, prompt payment is expected from the presenting parent.

It is the responsible party's responsibility to be familiar with the patient's insurance benefits.
Patient balances should be paid in full or have a payment plan arranged before medical records are sent to another pediatrician's office.

General Office Fees:
- There is a $50.00 charge for no-shows for well checks and sick visits scheduled
- There is a $50.00 charge for cancellations of well checks with less than a 24-hour notice
- There is a $30.00 return check fee, and future payments must be rendered by means other than a check.
- There is a $30.00 fee to reprocess a refund check that is lost or destroyed

Clinical Fees:
- There is a $20.00 admin fee to sent a RX outside of an office visit. (This includes controlled drug RX, filling medications when the patient is out of town, and after hour calls to the physician when a prescription must be called in.)
- Any communication with your physician outside of an office visit may incur a fee starting at $25.00

Form Completion Fees:
- There is a charge of $10.00 dollars to fill out forms. Payment must be made before returning the forms to the patient or legal guardian.

Medical Record Fees:
- There is a $30.00 admin fee per chart to have it copied. Fee must be paid in advance.
- Shot Record only is free of charge.

After Hours Triage Service:
- There is a $25.00 fee on any after hour triage calls

Identity Theft Protection:
A copy of all parents' driver's licenses and insurance card must be kept on file for your protection in compliance with HIPAA and Red-Flag. Verification must be done for all new insurance prior to the visit; give all updates to the scheduler when making your appointment.

All demographic information will be updated annually. It is the patient's or legal guardian's responsibility to inform us of address and telephone number changes. We will need these in written form, therefore arrive 15 minutes early for your appointment when needing to update any information.

Office Courtesy:
An appointment reminder call is made one business day in advance as a courtesy only; it is the patient's or legal guardian's responsibility to remember the appointment date and time. If you will be 10 or more minutes late for your appointment, please call as it may be necessary to reschedule your appointment.

Scheduled appointments are for one child only. Do not assume a sibling can be seen at the same time. A call must be made to determine if the doctor's schedule can accommodate an additional child.

All physician office visits are by appointment only.
(Revised 04/14/2022)

Inwood Village Pediatrics is committed to protecting the privacy of our patients' health information. This notice describes our privacy practices.

Notice of Privacy Practices

Uses and Disclosures for Treatment, Payment, and Health Care Operations Treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations

Your health information may be used as necessary to support the day-to-day activities and management of Inwood Village Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. There are some services provided to our organization through contacts with business associates. Examples include auditors and attorneys. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job required and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Uses and Disclosures That Can Be Made Without Your Authorization Law Enforcement

Your health information may be disclosed to law enforcement or other public agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting (including cases of suspected abuse or neglect of a child or disabled individual).

Public health reporting and health oversight

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. We may also disclose your medical information to report reactions to medications or vaccines or problems with products. Additionally, your health information may be disclosed to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications, and inspections that are all government activities undertaken to monitor the health care delivery system and evaluate compliance with laws.

Notification

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointment Reminders and Requests to Contact the Office

We may contact you by mail and/or telephone and may leave messages on your home answering machine to provide appointment reminders or to request you contact the office unless you request confidential communications as described below.

Required by law

We may release your medical information as otherwise required by law.

Other uses and disclosures require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have certain rights under the federal privacy standards. These include:

• The right to request restrictions on the use and disclosure of your protected health information
• The right to receive confidential communications concerning your medical condition and treatment, such as requesting communications by alternative means or at alternative locations
• The right to inspect and copy your protected health information
• The right to amend or submit corrections to your protected health information
• The right to receive an accounting of how and to whom your protected health information has been disclosed
• The right to receive a printed copy of this notice

As permitted by federal regulation, excluding a request for a copy of this notice, we require that requests related to those rights listed above be submitted in writing. You may obtain the appropriate form by contacting the Receptionist or Privacy Officer. We will notify you in writing if we are unable to honor any request pursuant to the rights listed above. Such circumstances are outlined in the federal privacy standards. For example, a request to inspect or copy your health information would be denied if it is determined that releasing that information could cause substantial harm to you or another person.

Duties of Inwood Village Pediatrics

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints

If you would like to submit a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Inwood Village Pediatrics, Practice Manager • 5470 W. Lovers Lane, Suite 330 • Dallas, TX 75209 • (214) 956-7337

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also send a written complaint to the United States Department of Health and Human Services. The contact information for the United States Department of Health and Human Services is:

Office for Civil Rights, Region VI • U.S. Department of Health and Human Services • 1301 Young Street, Suite 1169 • Dallas, TX 75202

You will not be penalized or otherwise subject to retaliation for filing a complaint.

Contact Person

Contact the Office Manager at the address and telephone number above to submit comments or to obtain further information about our privacy practices.

Inwood Village Pediatrics