San Antonio
Pediatric Surgery Associates

Patient Information

Patient Name: _____ Home Phone #: (____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: ____/____/____ Sex: ☐Female ☐Male SS #:_____

Guarantor/Responsible Party

Father's Name: _____ Cell Phone #: (____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: ____/____/____ SS #:_____ e-mail: _____

Employer: _____ Wk Phone #: (____)_____

Employer Address: _____ City:_____ Zip: _____

Mother's Name: _____ Cell Phone #: (____)_____

Address: _____ City:_____ Zip: _____

Date of Birth: ____/____/____ SS #:_____ e-mail: _____

Employer: _____ Wk Phone #: (____)_____

Employer Address: _____ City:_____ Zip: _____

Insurance Information

*Primary Insurance Company: _____ ID #:_____ Group #:_____

Insurance Co Phone #:(____)_____ Policy Holder: _____ Relationship to Patient: ☐Child ☐Self ☐Other

*Secondary Insurance: _____ ID #:_____ Group #:_____

Insurance Co Phone #:(____)_____ Policy Holder: _____ Relationship to Patient: ☐Child ☐Self ☐Other

Name of Referring MD/Pediatrician: _____ Phone #: (____)_____

Address: _____

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

How well do you speak English? _____ Very Well _____ Well _____ Not Well _____ Not At All Pref Lang _____

Ethnicity: Hispanic or Not Hispanic Race: Asian Black White Other _____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

YOU MUST BE PREPARED TO PAY YOUR COPAY AND DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT

San Antonio
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4499 Medical Drive, Suite 347, San Antonio, Texas, 78229
210.615.8757 Fax: 210.615.8789

Please fill-in the following Medical History Sheet to the best of your knowledge.
Use back of page if more space is required.

Patient's Name:_____ **Birth Date:**_____ **Sex: M F**
Referred By:_____ **Phone Numer:**_____

Reason for Visit or Referral: _____

Past Medical History: List past and current medical conditions.

1.
2.
3.
4.

Past Surgical History: List previous operations and dates.

1.
2.
3.
4.

Any problems with surgery or anesthesia in the past? No Yes >> Explain:_____

Current Medications: List all current medications, timing and dosage.

1.
2.
3.
4.

Does patient have any allergies to medications? No Yes >> Explain:_____

Diet:_____

Family/Social History: If any of the following apply, please circle and explain below: Chronic illness in parent, brother or sister. Problems with anesthesia in family. Problems with bleeding in the family. Smoker in the house. Significant family stress. Other.

Continue on next page

Patient's Name:_____

Review of Systems

Below is a list of symptoms or complaints related to different parts of the body. Circle any that apply to the patient and explain why below by number.

1. **Constitutional:** Frequent fever, Weight loss, Other
2. **Eyes:** Double vision, Blurred vision, Blindness, Surgery, Other
3. **ENT:** Frequent ear infections, Tubes, Deafness, Nose bleeds, Difficulty swallowing, Surgery, Other
4. **Cardiovascular:** Hurt murmur, Chest Pain, Palpitations, Surgery, Other
5. **Respiratory:** Trouble breathing, Asthma, Shortness of breath, Frequent pneumonia's, Surgery, Other
6. **Gastrointestinal:** Food allergies, Frequent vomiting, Reflux disease, Vomiting blood, Rectal bleeding, Surgery, Other
7. **Genitourinary:** Bladder infections, Kidney infections, Urinary infections, Kidney stones, Frequent urination, Surgery, Other
8. **Musculoskeletal:** Broken bones, Painful joints, Surgery, Other
9. **Skin/Breast:** Burns, Lumps, Nipple discharge, Surgery, Other
10. **Neurologic:** Seizures, Numbness, Weakness, Surgery, Other
11. **Psychiatric:** Attention deficit disorder, Hyperactivity, Hospitalization
12. **Endocrine:** Thyroid problems, Adrenal problems, Diabetes, Pancreas problems
13. **Hematologic/Lymphatic:** Anemia, Sicklecell, Swollen lymph nodes
14. **Allergic/Immunologic:** Drug allergies, Seasonal allergies, Immunizations up to date

_____

_____

_____

_____

_____

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AUTHORIZATION FOR OBTAINING AND DISCLOSING
PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient Name: Birthdate: Social Security No. (optional):

Provider's Name: Recipient's Name:

Provider's Address: Recipient's Address:

Provider's Phone Number: Provider's Fax Number: Recipient's Phone Number: Recipient's Fax Number:

This authorization will expire on the following (Fill in the date or event but not both):

Date: Event:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description: Date(s):

All PHI in medical record

Intake form

Dictation reports

Laboratory reports

Description: Date(s):

Diagnostic tests

Special test/therapy

Monitoring strips

Itemized bill:

Description: Date(s):

HCFA-1500:

Other:

Other:

I understand that:
I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requester or receiver is not a health plan, health care provider, healthcare clearing house or business associate of such health plan, health care provider or health care clearing house are the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
I may receive a copy of this form after I sign it.

Section B: The request of PHI is for the purpose of marketing

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? Yes No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative: Date:

Print Name of Patient's Representative: Relationship to Patient:

Indicate authorized representative's authority to act on the patient's behalf: (circle one)

Parent/Legal guardian Limited Power of attorney

General power of attorney Other (Please describe):_____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____
2. _____
3. _____
4. _____

THE PRACTICE STAFF HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my: (Please check all that apply)

___Home Voice Mail or Answering Machine Home Phone number:_____

___Cell phone Cell phone number:_____

___Work Voice Mail Work phone number:_____

___NO INFORMATION: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____
Print Name of Patient *Print Name of Authorized Representative

_____ _____
Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

___Parent/legal guardian ___Power of Attorney

*Evidence of authority must be provided and on file with the practice.

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Child's Name_____

Date of Birth_____

Notice #1

The surgeons of San Antonio Pediatric Surgery Associates perform operations at a number of facilities in San Antonio. We are required to inform you that our surgeons have a financial interest (partial ownership) of the Methodist Ambulatory Surgery Center located on Ewing Halsell Drive

Notice #2

The surgeons of San Antonio Pediatric Surgery Associates are actively involved in teaching and training medical students and surgery residents (trainees). Very often, students and residents are in the operating room observing and assisting your surgeon during your child's surgery. Students and residents are always under the direct supervision of your surgeon. Your surgeon is always in attendance during your child's surgery. If you have any concerns about the teaching and training of medical students and surgery residents please discuss them with your surgeon.

By signing below I have acknowledged that I have read and understand the above notices.

Signature_____

Print Name_____

Date_____

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Health Insurance Portability and Accountability Act (HIPAA) Consent

General

In seeking medical advice or receiving medical care in this practice Protected Health Information (PHI) will be generated on you (your child). This information includes your medical information (past, present, and future) and personal information such as your name, address and social security number.

This information will be used for the Treatment of your medical condition(s), obtaining Payment from your insurance company and for Healthcare Operations (TPO) within the practice.

Privacy Practice Notice

For more complete description of how your PHI may be used and disclosed, you may review this practice's "Notice of Privacy Practices". A copy of our notice is available at the reception desk. You may keep the copy of the notice for your records if you like.

Individual Rights

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on reliance of this consent.

You have the right to sign this consent.

This practice has the right to refuse to treat you if you refuse to sign this consent of if you, at any time, revoke this consent.

Your signature below acknowledges:

- You have read and understand this consent
- You have agreed to have your PHI used by this practice for the purpose of your treatment, to secure payment for your treatment, and for this practice's healthcare operations
- Prior to signing this consent, you were given a copy of this practice's Notice of Privacy Practices
- You are aware that you may now or at any time request restrictions to the use and disclosure of you PHI
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent

_____ _____

Child's Name (please print) Signature of Parent or Legal Guardian

_____

Date