

Boerne Pediatrics Patient Information Sheet

Today's Date \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Name of Sibling(s) \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_, \_\_\_\_\_, TX, \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Preferred Cell \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Preferred Email \_\_\_\_\_

Boerne Pediatrics is a paperless office, please circle preferred email address. Email will be used for appointment confirmation. No private medical information will be transmitted via email. Email address will not be distributed to others.

Specialists child sees: \_\_\_\_\_

Primary Insured DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Co \_\_\_\_\_ Copy of Insurance card will be required at every visit  
Children under 18 years of age will not be seen unless accompanied by a parent/guardian or a signed note is sent with caregiver. Please complete caregiver authorization form as needed.

Person who may bring child to visits: \_\_\_\_\_

\_\_\_\_\_

1. I certify to the best of my knowledge the above information is correct.
2. I authorize Boerne Pediatrics to review my insurance coverage with my insurance co as indicated.
3. I authorize Boerne Pediatrics to release medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to patient.
4. I further authorize the release to Boerne Pediatrics of such information as may be necessary for the purpose by my insurance company.
5. I permit a copy of this authorization to be used in place of the original
6. I hereby authorize you to pay directly to Boerne Pediatrics benefits due me out of my indemnity under the terms of my insurance company policy.
7. The undersigned agrees that all services are rendered on a paid basis only. If payments are not received within 60 days of visit, collection may become necessary. The undersigned shall pay all costs including attorney's fees.
8. I authorize Boerne Pediatrics to release copies of my medical records to other medical providers who I may be referred to, to further the patient care.
9. I understand that Boerne Pediatrics encourages patients to receive all required immunizations as recommended by the American Academy of Pediatrics and the State of Texas Dept of Health.
10. I understand that Boerne Pediatrics complies with all HIPAA regulations and that a copy of the complete HIPAA policy is available for review upon request.
11. I have read and agree to Boerne Pediatrics Financial Policy
12. I have read and understand Boerne Pediatrics Recommended Immunization Schedule

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian

## IMMUNIZATION SCHEDULE

**Boerne Pediatrics** follows the AAP guidelines for recommended immunizations. Your child will receive the appropriate immunizations as scheduled as part of their Well Child Check-up. From Birth to age 18 your child will receive the following vaccines.

(Diphtheria Tetanus & Pertussis (DTaP)  
(Hib)Haemophilus influenzae type b  
IPV (Inactivated Polio Vaccine)  
Pneumococcal Conjugate Vaccine  
Rotateq (Rotavirus)  
Hepatitis B  
MMR (Measles Mumps Rubella)  
Varicella (Chickenpox)  
Hepatitis A Vaccine  
Meningococcal Vaccine  
Diphtheria Tetanus & Pertussis (Tdap) Adolescent dose

## FINANCIAL POLICY

**1. Payment is due at the time of check-in for service. We accept Visa/MasterCard Cash and Check.**

**Insurance plan policy is reviewed at every service. If proof of insurance cannot be verified at time of service, you will be responsible for payment of all services at time of check-in.**

**2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days from time of service, you will be billed for the balance of the payment. If we later receive a check from your insurer, we will refund any overpayment to you.**

**3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit. Non-payment of visit co-pay is a violation of your insurance company's contract with you.**

**4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.**

**5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.**

**6. Boerne Pediatrics is committed to providing prompt, efficient quality medical care. If you repeatedly miss scheduled appointments, you may be responsible for a missed appointment fee of \$25.00. It is important for your child to receive continuous healthcare to ensure proper growth and development.**

**7. I understand that I am responsible for any customary bank fees charged for returned checks or for insufficient funds.**