7103 South Peek Road
Unit E500
Richmond
Texas 77407

NEW PATIENT INFORMATION

Patient Name: Patient Name:	Gender: M/F Date of Birth:____/__ /____ Gender: M/F Date of Birth: ___/____ ____
Address: Apartment #:	Mobile Phone #: Alternative Phone #:
City/State/Zip Code:	Email Address:
Referred By:	Pharmacy Name, Address and Phone Number:
Name of Mother or Legal Guardian: Date of Birth:	Name of Father or Legal Guardian: Date of Birth:
Driver's License #:	Driver's License #:
Occupation: Employer: Work #:	Occupation: Employer: Work #:
Insurance Co. Name: Policy/ID #: Group #:	Secondary Insurance Co. Name: Policy/ID #: Group #:

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

Person Responsible for Payment: Address and Contact #:

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel authorization any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Security Code : _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature **Date**

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file to insurance as a COURTESY: however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans. **It is your responsibility to:**
   - **Bring your insurance card and photo ID to every visit.**
   - **Pay your co-pay and/or deductible at each visit.**
   - Pay in full for any medical care/services that are not covered by your insurance.
2. If your child has insurance that we do not accept, or your child does not have insurance, payment is due in full at the time of service provided. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP or PCM (Primary Care Provider or Primary Care Manager). You will need to select Dr. D. Deoskar as your child(s) PCP or PCM. If your insurance card lists another physician's name, we will see your child, but you will be notified to update the PCP or PCM.
4. *Secondary Insurance:* **It is your responsibility to update the COB with your primary and secondary insurance.**
5. **You are financially responsible for any amount not covered by your child's insurance**.
6. If you have questions about your insurance, you may contact our office. However, specific benefit(s) questions should be directed to your insurance provider. If the payment is denied, it is the parent(s) responsibility to contact the insurance provider.
7. **If you fail to make a payment in full for services that are rendered, your outstanding balance will be sent to a third-party collection agency.** Accounts are considered past due after 90 days. You will be responsible for any fees associated with your collection of outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
8. To protect your child's records, we ask you to provide our office with a valid driver's license or other photo ID. Annually, or as changes occur, we will ask to sign our financial policy and update your registration information. We will check these documents prior to release your child(s) records.
9. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child(s) account.

Late Arrival/No-Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back into the schedule at a later time. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you do not show up to three times, we reserve the right to discharge your child from the practice. Appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time there will be a No-Show fee of $25.00.

ADVANCED BENEFICARY NOTICE: These services may NOT be covered by your insurance provider. The purpose of this list is to help you make an informed choice about whether you choose for your child to receive certain services. The face that your insurance provider does not cover a service does not mean that you should not receive that service, it means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance provider, you will be financially responsible for the balance on your account.

We will not provide medical care to children whose parents/guarantors refuse to sign and comply with our financial policy. Signature of Understanding: I have read and understand the above stated financial policy.

Child's Name	**Date of Birth**	**Child's Name**	**Date of Birth**

Patient or Parent/Guardian if Patient is under 18 years of age Date

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CONSENT TO TREAT

I, _____ the parent and legal guardian of

_____hereby give my consent for and authorize the administration and performance of all medical care, treatment and diagnostic procedures which in the judgement of the licensed physicians, nurses and health care professionals of Legacy Pediatrics are believed to be medically necessary. I understand that all services will be provided according to generally accepted standards of pediatric medical care and in accordance with applicable state law.

Included among the medical care services provided will be the administration of immunizations as required by law and generally recommended by the American Academy of Pediatrics and Center for Disease Control (CDC).

I acknowledge that I may revoke or change this Consent in writing addressed to Legacy Pediatrics.

PRIVACY PRACTICE AND OFFICE PROTOCOL ACKNOWLEDGEMENT

1. I hereby acknowledge that I have been presented with a copy of Legacy Pediatrics Notice of Privacy Practices.

2. I hereby acknowledge that I have been presented with a copy of Legacy Pediatrics Office Policies and understand my responsibilities.

Name: _____

Parent/Legal Guardian Signature: _____ _____

Date Signed: __ _____

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CIRCUMCISION

(0-29 DAYS OF AGE)

1. I understand and agree that I am financially responsible for all charges for all services rendered. This includes any medical service or visit done by the provider.
2. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
3. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.
4. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.
5. I agree to pay a fee of $100 for the surgical supply that the doctor uses to perform the surgery.
6. I understand I am financially responsible for any amount not covered by my dependent's health insurance plan. If the claim is denied by my dependent's health insurance, I am responsible for the full amount of $350.00.
7. I understand that there is a refund processing fee of $15.00.

Printed Patient Name

Print Name of Patient's Representative

Signature of Parent or Guardian

Today's Date

Legacy Pediatrics

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CONSENT FOR CIRCUMCISION

I understand that a circumcision is a procedure in which the foreskin (fold of skin that covers the end of the penis) is surgically removed. Many parents are interested in having circumcisions done for ethnic, cultural, religious or social reasons; but there is still some medical controversy about the need for the procedure. The nature of a circumcision, and the benefits to be reasonably expected compared with alternative approaches have been explained to me.

I understand that there is a chance of risks, or complications related to the circumcision may occur. These complications may include, but are not limited to the following:

Minor Problems are short-term:

a) Slight oozing or slight bleeding may be noted at the surgical site.
b) Infection of the circumcision site or at the tip of the penis can occur.
c) Irritation of the exposed tip of the penis (glans) as a result of contact with stool or urine is not uncommon and usually responds to cleansing with water.

Long-Term Minor Problems can include:

a) The urethra, which leads from the bladder to the tip of the penis, can be damaged at its point of exit.
b) Scarring of the penis can occur.
c) Unintended removal of the outer skin layer (or layers) of the penis can occur.
d) An opening that is too small for the foreskin to retract over the penis can occur if too little foreskin is removed.

Major Problems are very uncommon but can include:

a) Complete removal of the skin covering the shaft of the penis has rarely been reported.
b) Significant bleeding may occur, requiring stitches to stop the bleeding.
c) Serious, life-threatening bacterial infection can occur.
d) Partial or full removal (amputation) of the tip of the penis has also been rarely reported.

_____ MD/NP will perform the procedure. The procedure may also involve the participation of a resident physician, fellows and/or physician assistants. My physician will determine when it is necessary for others to participate in the circumcision of my child.

I understand that blood or other specimens removed for necessary diagnostic or therapeutic reasons may later be disposed of by the hospital. These materials also may be used by BWH or other academic or commercial entities, for research, educational purposes (including photographing), or other activity, if in furtherance of the hospital's mission.

The above risks and benefits have been explained to me. I have had an opportunity to fully inquire about the risks and benefits of a circumcision and the alternatives. I consent to the circumcision of my child.

Date _____ **Time** _____ **AM/PM** _____

Signature of Parent/Guardian

Date _____ **Time** _____ **AM/PM** _____

Signature of Physician (MD/NP)