Welcome to Plum Pediatrics! Here are a few office policies and agreements that we would like for you to be aware of to facilitate a good relationship between you and your pediatrician:

Office Hours: Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Thursday and Friday 8:00 a.m. to 3:00 p.m.

Appointments: Patients are seen by **appointment only**. Each child needing examination by the doctor should have an individual appointment.

In general, well examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. In addition, well examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the well examination, but can see your child for his/her illness during the scheduled appointment. This also applies to other conditions that require a significant amount of time for the physician to effectively manage the condition (i.e., asthma, ADHD). We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep the appointment. Absences from school will only be excused by our office if your child has been seen in the office for the illness.

Walk Ins and Late Arrivals and No Shows: Rescheduling may be necessary if you are more than 15 minutes late for your appointment. We will try to work you in if time allows. If you cannot keep your appointment we ask that you cancel 24 hours prior to appointment time. If you "no show" three times we reserve the right to discharge your child(ren) from the practice.

Each well visit and or ADHD evaluation appointment missed and not cancelled prior to 24 hours before scheduled appointment time will be assessed a $25 fee to the patients account.

Financial Agreement: Fees, Insurance and Health Plans: A Parent/Guardian must notify the office of changes in address, telephone number or insurance. You must bring your insurance cards to every visit. The person who brings the child to the office will be expected to pay at the time of service**. You will be responsible for payment of charges from services rendered if we are unable to verify benefits with your insurance company. Insurance companies require collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not yet been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always question your insurance company regarding your benefits first if you have any questions about covered services or bills**.

WE ARE NOT RESPONSIBLE FOR CHECKING BENEFITS/COVERAGE OF YOUR POLICY.

Plum Pediatrics files primary insurance only for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services and deductibles are the responsibility of the patient and payable at the time of service. Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. **Proof of insurance is not a guarantee of payment**. Patients without insurance or covered under an insurance plan in which we are not contracted are financially responsible for all charges incurred at the time of service. In the event that payment for a service performed is erroneously denied by the insurance carrier, it is the patient's responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier. Patients must verify plan participation with our office.

If your child(ren) has insurance that we do not participate with or if your child(ren) does not have insurance we do offer a Private Pay discount.

Below is a list of services that may NOT be covered by your insurance carrier or the charges will be applied to your deductible. This will allow you to make a decision whether or not you choose to receive these services considering you may be financially responsible if it denied by your insurance.

Service	**CPT Code**
Visual Acuity Screen (Vision Test)	99174
Pure-Tone Hearing Test	92251
30 Month Checkup *(recommended by AAP but may not be covered by all insurance plans)*	99382 New Patient 99392 Established Patient
Newborn Screening	99385 New Patient, 83788, S3620
Well Checkup over 18 years of age	99385 New Patient 99395 Establish Patient

Balances are due at time of appointment. Financial arrangements will be required for balances greater than 60 days outstanding and prior to appointment.

We accept cash, checks, Visa, MasterCard, and Discover. **There is a $25 fee for returned checks**.

I request release of payment information to Plum Pediatrics by third party payers when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to Plum Pediatrics and I authorize payment of those benefits directly to that provider.
Medical Records: Medical records can be faxed to another physician's office free of charge upon release of the medical record. Patient copies of the medical record can be obtained for a $25 fee. Copies of the medical record will be provided within 2 business days with a prepayment. Immunization Records are also available on the Patient Portal. IF YOU TRANSFER TO ANOTHER MEDICAL PRACTICE, WE RESERVE THE RIGHT TO NOT ALLOW YOU TO RETURN AS A PATIENT.
Medication Refills: Patients on medication for ADHD will be seen for medication check-ups every 3 months. Refills for ADHD medications will be provided only if these appointments are kept.

Parents/Guardians may send a message via patient portal to request a refill for ADHD medications. These prescriptions will be available for pick-up 48 hours after the request has been made during our regular business hours.

Controlled substance medications (ADHD medications) must be picked up by a parent/guardian and filled within 21 days of the date the prescription was written. In the event, the prescription is not picked up and filled, a $15.00 charge will be applied for rewrites.

Medication refills can be requested on the patient portal to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies), as long as the patient is established and has been seen for the condition within the past 6 months. Refills will not be provided after hours or on the weekends. Please allow 48 business hours for these refills to be completed.

Vaccination Policy: As medical professionals we feel strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If your child has received any vaccinations at any place other than our office, you must provide us with proof of vaccination. ***If you should absolutely refuse to vaccinate your child despite our efforts, we will ask you to find another healthcare provider who shares your views***. Please understand that by refusing to vaccinate your child you are putting your child at an unnecessary risk for life threatening illnesses, disability and even death.

If the parent chooses an alternate vaccine schedule other than the one recommended by our physician, there is a $20 fee each nurse visit.

Patient Portal: Our nurses/medical assistants are always available during business hours to serve your needs..

We highly encourage using the patient portal for non-urgent issues.

You can send a message with any questions that you may have. All messages received prior to 3:00 p.m. will be returned on that business day; however, depending on the daily schedule, these messages may not be returned until the end of the day, and they will be returned in order of urgency. Messages received after 3:00 p.m. will be returned the next business day.

If you feel your child needs to be seen you should speak with someone in the front office to schedule an appointment, as the schedule fills quickly.

In general, antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen.

In case of an emergency, call 911 or take your child to the nearest hospital emergency room.

After Hours Services: Office line and follow prompts

By signing below you acknowledge that you have read and understand the office policies and financial policies. I accept the financial terms noted above and certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility to present Plum Pediatrics with valid insurance information at each visit and inform Plum Pediatrics should any information on this form change at any time in the future.

Signature of Parent/Legal Guardian _____ **Date:** _____

PLUM PEDIATRICS Phone:
469-864-7586 Fax: 469-864-7571
Pediatric Health History Intake Form

Date: _____ ☐Initial Visit ☐ Update of Information

Patient's Name: _____ Address:_____Gender: Male Female

Mother's Name: _____ DOB: _____ Email: _____Cell:_____

Father's Name: _____ DOB: _____ Email: _____Cell:_____

Sibling:_____ DOB: ___/___/___ ☐Male ☐Female Health Problems: _____

Sibling:_____DOB: ___/___/___ ☐Male ☐Female Health Problems: _____

Sibling:_____DOB:___/___/___ ☐Male ☐Female Health Problems: _____

Sibling:_____DOB:___/___/___ ☐Male ☐Female Health Problems: _____

Birth Weight: _____ Gestation Age of Delivery: ☐Early <38 wks ☐Term 38-42 wks ☐Late > 42 wks
Prenatal/Delivery Complications: ☐none_____
List all medical problems, serious illness, injury, hospitalizations and/or surgeries below: Date of diagnosis, hospitalization, or surgery
_____
_____
_____

Medications: Name Dosage Frequency
_____
_____
_____
_____

List any known **drug allergies/reactions**: _____
List any known **food or other allergies/reaction**: _____
Have there been any deaths in the family prior to age 50? ☐No ☐Yes: Please list relationship and reason: _____

Pets: ☐No ☐Yes:_____ ☐Daycare ☐School, Grade: _____ Exposure to smokers: ☐No ☐Yes:_____
List everyone that lives with patient:_____
Parents: ☐Married ☐Divorced ☐Separated ☐Together, but not married ☐Other: Guns in Home: ☐No ☐Yes

FAMILY HISTORY (Do any relatives have the following, please indicate who using D=dad, M=mom, MGM=mom's mom, MGF=mom's dad, PGM=dad's mom, PGF=dad's dad, B=brother, S=sister, MA=mom's sister, MU=mom's brother, PA=dad's sister, PU=dad's brother)

Condition	***Relative***	***Condition***	***Relative***
ADHD	_____		
Alcohol Abuse/Addiction	_____	Heart Disease	_____
Allergies	_____	High Blood Pressure	_____
Anemia	_____	High Cholesterol	_____
Asthma	_____	HIV / AIDS	_____
Bed-wetting	_____	Kidney Disease	_____
Birth Defects	_____	Lung Disease (other than asthma)	_____
Blood Disorder (other than anemia)	_____	Migraines	_____
Bone/Joint Disease	_____	Mental Retardation / Developmental Disorder	
Cancer	_____	Muscle or Orthopedic Issues	_____
Dermatologic / Skin Issues	_____	Neurologic Issues (other than seizure)	_____
Cystic Fibrosis	_____	Psychiatric Issues	_____
Diabetes	_____	Rheumatic Fever	_____
Drug Abuse	_____	Rheumatologic Issues	_____
Ear Disorders / Hearing Impairment	_____	Seizures / Epilepsy	_____
Eye Disorder / Vision Impairment	_____	Thyroid Disorders	_____
Genetic Disorders	_____	Tuberculosis	_____
Gastrointestinal Disorder	_____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status.

Signature of Parent: _____ Date: _____
rev. 04/2021

Plum Pediatrics

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

I am providing Plum Pediatrics with all known health insurance information. I understand that if MY PRIMARY INSURANCE FINDS OTHER HEALTH INSURANCE, they may deny paying any office visit claims. I understand that I will be completely responsible for all charges and will pay in full. **ALL INSURANCE CARDS MUST BE PRESENTED in order for us to file claims. This form is NOT CONSIDERED valid to file claims with your insurance company.**

Primary Insurance Information

Primary Insurance :_____

Name of Policy Holder:_____

Date of Birth of Policy Holder:_____

Policy Holder Address:_____

Policy Holder Phone Number:_____

Policy Number:_____Group Number:_____

Claims Address:_____

Insurance Phone Number:_____

Signature:_____Date:_____

Plum Pediatrics

Consent for Treatment
Authorization for Release of Information

I authorize Plum Pediatrics to administer such care and treatment that is medically necessary and as is set forth in the development plan of treatment. I also authorize Plum Pediatrics to release any medical information acquired in the course of my child's examination or treatment, to any facility (including other physicians, laboratory, hospital or ancillary providers) to which my child may need to be referred. I further authorize Plum Pediatrics to release any medical information determined in the course of my child's examination or treatment required to process medical claims to my insurance carrier.

Patient Name:_____DOB:_____
Patient Name:_____DOB:_____
Patient Name:_____DOB:_____
Patient Name:_____DOB:_____

CONSENT FOR CARE FORM

I, _____ give permission for:

(Parent's Name)

_____ _____

(Name) (Relationship to Child)

_____ _____

(Name) (Relationship to Child)

_____ _____

(Name) (Relationship to Child)

_____ _____

(Name) (Relationship to Child)

to bring my child(ren), _____, for his/her appointments.

Please give them any instructions and/or prescriptions that may be needed.

In case of emergency, I can be reached at _____.

Parent Signature_____ Date_____

Plum Pediatrics

Newborn State Screen Waiver

The Newborn State Screen is a mandatory screening conducted by the STATE OF TEXAS. The first screen is completed after 24 hours of life in the hospital, and the second screen is done after day 7 of life. Due to the addition of Cystic Fibrosis Screening, the cost of the screening cards has increased significantly. The insurance companies are not fully reimbursing for this procedure. Therefore, our office now offers two options for getting the second newborn screen completed for your baby.

PLEASE CHECK THE OPTION THAT YOU AGREE TO:

I _____ AGREE TO PAY $70.00 FOR THE NEWBORN STATE SCREEN TO BE COMPLETED AT PLUM PEDIATRICS.

I_____ agree to take my baby to the lab designated by my physician to have the Newborn State Screen completed. The lab will bill the screen to my insurance. I understand that once I leave the office, it is my responsibility to make sure the MANDATORY Newborn State Screen is done.

Patient Name:_____

Signature of Parent:_____

Date:_____

Acknowledgment by Individual or Personal Representative of Receipt of Notice of Privacy Practices

I acknowledge receiving a copy of the Notice of Privacy Practices given to me by Plum Pediatrics and understand that Plum Pediatrics reserves the right to modify the privacy practices outlined in the notice.

I understand this Notice explains how Plum Pediatrics is permitted to Use and Disclose my Protected Health Information.

Plum Pediatrics may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations as described in our Notice of Privacy Practices (NPP).

Plum Pediatrics may call my home or other designated location and leave a message on voicemail or in person in to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

Plum Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards, and patient statements.

Plum Pediatrics may email any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

If I refuse to sign this consent or if I revoke an already signed consent I understand that Plum Pediatrics will continue to provide treatment to my child.

I understand I should keep the Notice and refer to it if I have questions. This agreement is in effect without any expiration unless I revoke my consent at any time in writing. Revoking my consent does not apply to the Protected Health information that has already been disclosed for normal agreed upon practice operations. I also understand that Plum Pediatrics reserves the right to refuse requested restrictions. I also understand I should call Plum Pediatrics at 469-864-7586 if I have a question or concern about my privacy rights.

_____
Print name of Patient

_____
(If applicable) Print name of Individual's Personal Representative and Relationship to Individual

_____
Signature by Individual or Individual's Personal Representative

_____
Date

OFFICE STAFF USE ONLY IF ACKNOLWEDGMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgment of Receipt:

☐ ☐ NPP given to Individual, who refused to sign.

☐ ☐ NPP was mailed to Individual's home address as stated in records.

☐ ☐ NPP was mailed to an alternate address, at Individual's request.

☐ ☐ NPP was faxed or emailed to Individual, at Individual's request.

Other reason(s) why written acknowledgment not obtained:

_____
_____

_____ _____
Signature of Person attempting to obtain signed Acknowledgment Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO: PLUM PEDIATRICS

PATIENT'S NAME:_____**DOB:**_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:
___Continuation of Care___Insurance Application___Billing Records
___History & Physical___Other (description) _____

Specific Description of the Information to be Used or Disclosed:
Last two Sick Visits
Last Well Visit
Immunization Record
Problem List
Medication List
Diagnostic Tests/Labs

Reason For Records Release: _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: PLUM Pediatrics

The above information may be released **FROM:** (specify name of individual or organization from which records are being released)

_____
(Doctor, Hospital, Insurance Company, Self, etc). **Phone Number**

_____
Address (Street, City, State, Zip) **Fax Number**

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Plum Pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by Plum Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.

_____
Print Name of Patient's Representative

_____ _____ _____
Signature of Parent or Guardian Relationship to Patient Date

Office Representative Initials_____ Completed Date_____

PLUM PEDIATRICS
270 S Collins Rd #300 Sunnyvale, TX 75182
Phone: 469-864-7586 Fax: 469-864-7571 www.plumpeds.com