PF-100 New Patient Information

Patient's Name

First: _____Middle Initial____ Last: _____
Date of Birth: _____Gender: Male / Female
Address: _____
City:_____State: _____Zip: _____
Cell Phone:(_____)_____-_____

Policy Holder's Information

First Name: _____Last Name _____
Date of Birth: _____Social Security Number: _____
Address:_____
City:_____State: _____Zip: _____
Employer: _____
Employment Address: _____
City:_____State: _____Zip: _____
Insurance Company: _____
Group Number: _____Policy Number: _____

Father's Name

First: _____Last: _____Occupation:_____
Address: _____
City:_____State: _____Zip: _____
Cell Phone: (____)_____Work Phone:(____)_____ ext:_____
Email Address:_____

Mother's Name (if different than Insured Name)

First: _____Last: _____Occupation:_____
Address: _____
City:_____State: _____Zip: _____
Cell Phone:(____)_____Work Phone:(____)_____ext:_____
Email Address:_____

Information Release Authorization

I authorize BestNest Pediatrics to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to BestNest Pediatrics. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician to access my chart for utilization management review.

First (Print): _____Last: _____

Signature: _____Date: _____

BestNest® Pediatrics
Stacy L. Terry MD/Laura Harn MD/Mee Yung Knapp MD/Laurie Hingle MD
4040 Legacy Drive #201 Frisco, TX 75034
972-668-6705 tel 972-668-7308 fax
www.bestnestpediatrics.com

PF-500 Request to Transfer Medical Records

TO: Name of Practice: _____
Name of Physician: _____
Address: _____
City, _____State_____
Fax: _____

Please Fax or Mail a copy of:
____ my complete medical record
____ copy of examination notes and problem lists
____ Other:_____

TO: Best Nest Pediatrics
ATTN: Stacy L. Terry MD
Laura Harn MD
Mee Yung Knapp MD
Laurie Hingle MD

4040 Legacy Dr., Suite 201
Frisco, TX 75034

972-668-7308 fax

Patient Name: _____
Patient DOB:_____
Address: _____
_____
Phone: _____

Thank you for your prompt attention.

_____ _____
Signature of Patient or Guardian Date

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PF-1000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

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, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, 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.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. 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.

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 to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

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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
- ❑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

Practice Duties
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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. 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 address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
Stacy L. Terry, MD
4040 Legacy Dr., Suite 201
Frisco, TX 75034
972-668-6705

Effective Date
This Notice is effective on or after April 14, 2003.

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PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

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PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

_____ all Information In my files, or

_____

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:

___ education, discussion of treatment plan, medical decision making, or

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

BestNest Pediatrics, and

_____
Name of person/organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____

Name of person/organization

_____

Name of person/organization

Expiration Date of Authorization
This authorization is effective unless and until revoked by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual
- ❑You may inspect or copy information used or disclosed under this authorization.
- ❑You may refuse to sign this authorization.

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Effect of Refusing Authorization
If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____
Treatment conditioned on authorization

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative Date

_____
Relationship of Patient Representative to Patient

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