BestNest® Pediatrics
www.bestnestpediatrics.com

GENERAL INFORMATION

REQUESTING PROVIDER: Dr. Melissa Belanger, Dr. Karin Hager, Dr. Laura Harn, Dr. Laurie Hingle, Dr. Mee Yung Knapp, Dr. Jodi Lemeshev, Dr. Danielle Schroeder, Dr. Lori Seibert, Dr. Stacy Terry, Dr. Nadine Wakim

PATIENT 1:	LAST NAME	FIRST NAME	MIDDLE NAME
NICKNAME	DOB _____/_____/_____	SEX (CIRCLE) MALE FEMALE	
RACE ❑ I choose not to specify ❑ Caucasion ❑ Hispanic ❑ Black-Non Hispanic ❑ Asian/Pacific ❑ Other _____		ETHNICITY ❑ I choose not to specify ❑ Hispanic or Latino ❑ Not Hispanic or Latino	

PATIENT 2:	LAST NAME	FIRST NAME	MIDDLE NAME
NICKNAME	DOB _____/_____/_____	SEX (CIRCLE) MALE FEMALE	
RACE ❑ I choose not to specify ❑ Caucasion ❑ Hispanic ❑ Black-Non Hispanic ❑ Asian/Pacific ❑ Other _____		ETHNICITY ❑ I choose not to specify ❑ Hispanic or Latino ❑ Not Hispanic or Latino	

PATIENT 3:	LAST NAME	FIRST NAME	MIDDLE NAME
NICKNAME	DOB _____/_____/_____	SEX (CIRCLE) MALE FEMALE	
RACE ❑ I choose not to specify ❑ Caucasion ❑ Hispanic ❑ Black-Non Hispanic ❑ Asian/Pacific ❑ Other _____		ETHNICITY ❑ I choose not to specify ❑ Hispanic or Latino ❑ Not Hispanic or Latino	

PARENT/GUARDIAN 1:	NAME	DOB _____/_____/_____
PHONE ❑ Ok to leave voice message	EMAIL	
STREET ADDRESS	CITY, STATE	ZIP

PARENT/GUARDIAN 2:	NAME	DOB _____/_____/_____
PHONE ❑ Ok to leave voice message	EMAIL	
STREET ADDRESS	CITY, STATE	ZIP

PRIMARY CONTACT:

PARENT MARITAL STATUS (CIRCLE ONE)	PATIENT(S) LIVE WITH (CIRCLE ONE)
MARRIED SEPARATED	PARENT/GUARDIAN 1 PARENT GUARDIAN 2
DIVORCED OTHER: _____	BOTH OTHER: _____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

GUARANTOR NAME	DOB _____/_____/_____	RELATIONSHIP
INSURANCE COMPANY	MEMBER ID	GROUP #
CLAIMS MAILING ADDRESS (ON BACK OF CARD)		EFFECTIVE DATE

FINANCIAL POLICY

Patients with Insurance:

Parents/guardians of patients are responsible for deductibles, copays, coinsurance, and services not covered by your insurance company. Copays and account balances will be collected at the time of an appointment. If you are unable to pay at the time of service, please inform us before the time of the appointment, so that there is plenty of time to come to a resolution. Once your insurance processes a claim and makes adjustments, we will send a statement with the remaining balance.

While BestNest Pediatrics will make every effort to verify insurance coverage, it is ultimately the responsibility of the insured to verify the plan is in network, know and understand their benefits, and inform the office of any insurance changes before any appointment.

Patient Name/Patient Representative _____

Patient/Patient Representative Signature _____

Date _____

Self-Pay/Uninsured Patients:

A prompt-pay discount is offered to patients who elect to pay for services in full on the date of service and who will not be submitting claims to an insurance carrier. If you have insurance, services received that are included in the prompt-pay discount will not likely not be reimbursed by your carrier or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the prompt-pay discount.

You have requested that this service be coded as self-pay because (initial one):
____ I have no health insurance
____ I have health insurance, but I do not want my insurance billed and want to pay out of pocket.

As a result, I agree to the following:

- Self-pay fees must be paid on the date of service.
- The self-pay amount covers only the professional services provided by the physician. I am financially responsible for all ancillary services, such as labs, x-rays, etc.

Patient Name/Patient Representative _____

Patient/Patient Representative Signature _____

Date _____

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of the practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize BestNest Pediatrics to disclose the following Protected Health Information (PHI):

___ All Information ___ Test Results ___ Appointments ___ Billing/Account information

Names of person(s) authorized to obtain above mentioned information (e.g. physician other than referring doctor, family members other than parents/guardians, nanny, etc)

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Can we leave a detailed message on your voicemail that contains PHI? __ Yes __ No

Patient Name/Patient Representative _____

Patient/Patient Representative Signature. _____

Date _____

MEDICAL AUTHORIZATION FOR MINORS

Name(s) of Child(ren): _____ DOB: _____

_____ _____

_____ _____

_____ _____

I authorize BestNest Pediatrics to provide medical treatment (diagnostic and therapeutic procedures) for my child as requested, and as needed in the event of an emergency.

Patient Name/Patient Representative _____

Patient / Patient Representative Signature _____

Date _____

I authorize the following individuals provide consent for medical treatment for the child(ren) listed above. (e.g. nanny, family member other than parents/guardians, neighbor, etc.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

VACCINATIONS

I acknowledge and agree to the following: BestNest Pediatrics requires patients be vaccinated according to the schedule required by the Texas Education Code and recommended by the Centers for Disease Control and Prevention (CDC). Influenza and COVID vaccines are optional. A modified schedule may be allowed after discussion with your doctor.

I authorize BestNest Pediatrics to email and/or fax my child's immunization records, health statement, or any other requested forms, at my request without written permission.

Patient Name/Patient Representative _____

Patient/Patient Representative Signature _____

Date _____

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 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, text message, 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.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- Right to request restrictions on the use and disclosure of your protected health information (cont'd on next pg.)
- Right to receive confidential communications concerning your medical condition and treatment
- Right to inspect and copy your protected health information
- Right to amend or submit corrections to your protected health information
- Right to receive an accounting of how and to whom your protected health information has been disclosed

- 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 may 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.

I have received, read, and understand the Privacy Practices of BestNest Pediatrics.

Patient Name/Patient Representative _____

Patient/Patient Representative Signature _____

Date _____