Pediatric Orthopedic & Scoliosis Center of South Texas

CONSENT FOR TREATMENT

Pediatric Orthopedic & Scoliosis Center of South Texas, provides pediatric orthopedic care including diagnosis and treatment of injuries or illnesses. A Physician provides services at this office. I authorize and consent to diagnostic testing and treatment of my child's condition. I authorize Pediatric Orthopedic & Scoliosis Center of South Texas employees to carry out the instructions of my child's physician with respect to the procedures and treatment they have ordered.

The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically attended and treated by Pediatric Orthopedic & Scoliosis Center of South Texas.

_______________________________________ _______________________________________

Printed Patient Name Signature Parent/Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Pediatric Orthopedic & Scoliosis Center of South Texas, reserves the right to modify the Privacy Practices outlined in the notice. I have read a copy of the Notice of Privacy Practices for Pediatric Orthopedic & Scoliosis Center of South Texas.

_______________________________________ _______________________________________

Printed Patient Name Signature Parent/Legal Guardian

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 of disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals 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 a 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 Pediatric Orthopedic & Scoliosis Center of South Texas. For example, information on the services you receive 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, without your permission 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.

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 request a copy of 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.

Pediatric Orthopedic & Scoliosis Center of South Texas

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 so that they conform to federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a corm to request access to your records by contracting our office.

Contact Person for Complaints or Additional Information
If you would like to inquire further about our privacy practices, or if you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPAA Privacy Officer
Pediatric Orthopedic & Scoliosis Center of South Texas
18626 Hardy Oak Blvd., Suite 320
San Antonio, TX 78258
210.497.4186
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 same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Pediatric Orthopedic & Scoliosis Center of South Texas

18626 Hardy Oak Blvd., Suite 320 San Antonio, TX 78258

Patient Information

Name of Minor/Child:

Last Name	First Name	Initial

Sex ☐ M ☐ F Date of Birth / /	Home Phone:
Parents Cell Phone: ☐ Mother ☐ Father	Parents Cell Phone: ☐Mother ☐ Father
Home Address:	City: State: Zip:
Father/Guardian Name:	Mother/Guardian Name:
Employer:	Employer:
Employer Phone:	Employer Phone:
Occupation: Date of Birth: / /	Occupation: Date of Birth: / /
Email address:	Email address:

Emergency Contact:

Name: Phone Number:

PCP/Referring Physician:

Appointment of Agent

I, ____ hereby appoint the following person(s) listed below of lawful age as
(Name of Parent/Guardian and relationship to child)
my agent and representative for the purpose of authorizing and consenting to medical care and treatment of my child for any illness or injury that may occur while such person is in the care or custody of the agent, while I am away on vacation or otherwise not immediately available to give such consent.

1.	Relationship:
2.	Relationship:
3.	Relationship:
4.	Relationship:

Release and Assignment

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I certify that my child is covered by insurance with________________________________and assign directly to Jeffrey R. Warman, M.D., P.A. dba Pediatric Orthopedic & Scoliosis Center of South Texas, all insurance benefits, if any, otherwise payable to for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent and/or Legal Guardian	Date

Pediatric Orthopedic & Scoliosis Center of South Texas

We wish to notify you of our policies associated with services rendered to your child or a member of your family. Your clear understanding of our policies is important to our professional relationship.

Please Initial

_______**MINORS:** A PARENT or LEGAL guardian MUST BE PRESENT for each visit, unless the parent or legal guardian has indicated on the initial registration form an alternate person(s) who has permission to accompany the child. Any person assigned as an alternate or parent accompanying the child will be **required to present his/her legal photo identification** at the time of each appointment. In the event an alternate is not listed at the time of registration the practice will accept a **notarized** letter from the parent or guardian stating an individual other than themselves has permission to accompany their child to the appointment. This legal document will be kept in the patient's file. **Without legal documentation or photo identification the patient will not be seen and asked to reschedule to another date and time when the authorized individual and/or documents are available.**

________**Financial Agreement**: I agree that in return for the services provided by Pediatric Orthopedic & Scoliosis Center of South Texas, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS for payment. I hereby direct assignment of payment of medical benefits to PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS for services rendered. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plan not to be covered or applied to a co-pay, coinsurance or deductible. If you need to make special arrangements for payment, you may notify our staff to determine an alternate payment plan. Acceptance of any partial payment shall not extend any time period, cure any default, or be deemed to satisfy any remaining balance due. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. If my account is deemed to be in default I understand it will be sent to an agency for collections, I agree to pay an additional 35% collection fee. A monthly statement will be mailed to the address listed for any outstanding balances.

________**Insurance Participation**: PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS will be happy to file a claim to your primary/secondary insurance carrier on your behalf. We will not however become involved in any disputes you may have with your insurance carrier. Our practice does not bill to any third party (e.g. school or auto insurance). You are responsible for knowing your insurance policy. You will be responsible for any charges if your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services, and you have not obtained such an authorization or referral; your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan; or your health plan coverage has lapsed or expired at the time you receive services; or you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier.

_______**Financial Responsibility:** As your child's advocate, PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS will not intervene in any custody dispute or financial responsibility dispute between you and your former spouse or other responsible party. By executing this document you accept full financial responsibility for all charges whether or not paid by your health insurance carrier. PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS will send statements for any remaining balance only to the address provided at time of registration.

_______**Payment for Services:** PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS accepts payment for services by cash, credit card, or check and CareCredit. When you pay by credit card to be held on file to make monthly payments, you agree to keep the credit card information current, and you authorize PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS to securely store your credit card information, and only charge it as agreed upon in your payment plan. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last five digits of your credit card are viewable by PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS personnel. Please be advised that payment by check binds you to a contractual agreement that holds you responsible for any and all service fees, and incidental damages allowable by law if the check is returned unpaid. Returned checks, state fees, and incidental fees may be debited from your account electronically or by paper draft. Payment by check constitutes your acceptance of these terms.

_______**Fees:** PEDIATRIC ORTHOPEDIC & SCOLIOSIS CENTER OF SOUTH TEXAS charges the following service fees: **Missed Appointments $40 (unless a 24 hour notice is provided)**, Medical Records $6.50, School/Sports/Camp forms $5 (free at time of appointment), FMLA paperwork $25 minimum.

_______**Shorts:** Some examinations require that the patient wear gym shorts (no metal buttons, or zippers). After the initial visit, if the patient does not bring their own shorts, a fee of $2.00 (not billable to the insurance, and payable at the time of service) will be incurred for shorts provided by our office.

_______**Non Compliance**: We reserve the right to discontinue care for non-compliance with any of the above policies and/or physician instructions.

______ **Durable Medical Items:** All durable medical items are considered non-returnable, & non-refundable.

The undersigned, having read and expressed understanding of this, hereby agree and will abide by ALL the above mentioned policies.

______________________________________ ____

Printed Patient Name Signature Parent/Legal Guardian Date