Welcome to Kessler Pediatrics!

Dear Parent,

Thank you for choosing Kessler Pediatrics as your child's medical home! We are pleased you have chosen us for your pediatric services and welcome the opportunity to care for your child. Kessler Pediatrics offers complete medical service to patients from birth to the age of 18.

Our goal is to partner with you to achieve optimum health for your child. It is our priority to establish an open, cooperative relationship with our patients. Together with our staff of pediatricians, we offer personalized medical care in a friendly courteous environment. We strive to provide easy access to the practice through readily available appointments and numerous avenues of communication including phone, email, and our patient portal. In addition to the care provided by our staff, we will coordinate care with various specialists as deemed appropriate and help you identify the resources available to you.

Working together as a team is central to the success of this care. Please call the office before you decide to go to the Urgent Care or Emergency Room for non-life-threatening health issues and notify the office immediately in the event that your child receives any care outside the practice. This communication enables us follow up with you and make necessary updates to the medical record.

Please note that Kessler Pediatrics is dedicated to the health and safety of all our patients and will not accept any children into the practice whose parents have made the choice not to vaccinate. We follow the vaccine schedule considered to be the standard of care by the CDC, American Academy of Pediatrics, and the Advisory Committee of Immunizations Practices. Children who are not up-to-date with their vaccines will be asked to quickly obtain the necessary vaccines in order to become up-to-date.

For your convenience, the office is open on Monday-Thursday from 8:30 am to 4:30 pm and Friday from 8:30 am to 4:00 pm. We also provide after-hours care through our partnership with Children's Health.

Please review and complete the forms within this packet. Upon completion, please return your completed forms to our office via email (info@kesslerpediatrics.com), fax (214-941-0437), or the Patient Portal. These forms must be completed prior to scheduling your first appointment. Please let us know if you have any questions or need any assistance in completing these forms.

We are glad to have you join us at Kessler Pediatrics!

Kessler Pediatrics Patient Registration Information

Form Completed by: _____ Date: _____
Relationship to Patient: _____

Patient

Patient Name: _____ DOB _____ Sex: _____
Address: _____
City _____ State: _____ Zip Code: _____ Phone Number: _____
Have you or any immediate family member been seen here before? ☐ Yes ☐ No

Sibling (s)

Sibling #1: _____DOB: _____
☐ Biological ☐ Half-biological ☐ Step ☐ Adopted

Sibling #2: _____DOB: _____
☐ Biological ☐ Half-biological ☐ Step ☐ Adopted

Sibling #3: _____DOB: _____
☐ Biological ☐ Half-biological ☐ Step ☐ Adopted

Sibling #4: _____DOB: _____
☐ Biological ☐ Half-biological ☐ Step ☐ Adopted

Sibling #5: _____DOB: _____
☐ Biological ☐ Half-biological ☐ Step ☐ Adopted

Responsible Party

☐ Parent/Guardian #1: _____ DOB: _____
☐ Mother ☐ Father ☐ Guardian ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Other
Occupation: _____ Employer: _____
Home Address: _____
SS#: _____ Phone #: H_____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell ☐ Work ☐ Email
May we leave a Voicemail? ☐ Yes ☐ No If Yes: ☐ Home ☐ Cell ☐ Work
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Parent/Guardian #2: _____ DOB: _____
☐ Mother ☐ Father ☐ Guardian ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Other
Occupation: _____ Employer: _____
Home Address: _____
SS#: _____ Phone #: H_____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell ☐ Work ☐ Email
May we leave a Voicemail? ☐ Yes ☐ No If Yes: ☐ Home ☐ Cell ☐ Work
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Parent/Guardian #3: _____ DOB: _____
☐ Mother ☐ Father ☐ Guardian ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Other
Occupation: _____ Employer: _____
Home Address: _____
SS#: _____ Phone #: H_____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell ☐ Work ☐ Email
May we leave a Voicemail? ☐ Yes ☐ No If Yes: ☐ Home ☐ Cell ☐ Work
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Parent/Guardian #4: _____ DOB: _____
☐ Mother ☐ Father ☐ Guardian ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Other
Occupation: _____ Employer: _____
Home Address: _____
SS#: _____ Phone #: H_____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell ☐ Work ☐ Email
May we leave a Voicemail? ☐ Yes ☐ No If Yes: ☐ Home ☐ Cell ☐ Work
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Parent/Guardian #5 _____ DOB: _____
☐ Mother ☐ Father ☐ Guardian ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Other
Occupation: _____ Employer: _____
Home Address: _____
SS#: _____ Phone #: H_____ C: _____ W: _____
Email Address: _____
Preferred method of Contact: Home Phone ☐ Cell ☐ Work ☐ Email
May we leave a Voicemail? ☐ Yes ☐ No If Yes: ☐ Home ☐ Cell ☐ Work
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If Guardian or Other, please explain relationship to Patient: _____
_____

PLEASE PROVIDE ALL LEGAL DOCUMENTS PERTAINING TO CUSTODY AND/OR GUARDIANSHIP

Primary Insurance Information

Insurance Company Name_____ ☐ HMO ☐ PPO ☐ Other ☐ Self Pay
Insurance Address _____City _____ State ____ Zip Code _____
Name of Insured _____
Insurance ID# _____ Group Number _____

Secondary Insurance Information

Insurance Company Name_____ ☐ HMO ☐ PPO ☐ Other ☐ Self Pay
Insurance Address _____City _____ State ____ Zip Code _____
Name of Insured _____
Insurance ID# _____ Group Number _____

Preferred Pharmacy

Name of Pharmacy: _____
Address _____
Phone: _____ Fax: _____

Emergency Contact Information

Name of Person to Contact Other than Parent: _____ Relationship: _____
Address _____
Home Phone: _____ Work Phone: _____

Registration Acknowledgement

I verify that this information is correct and up-to-date. I agree to update Kessler Pediatrics of any changes to the above information. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If Kessler Pediatrics is unable to collect from my child's insurance company using the information I have provided today or on any occasion, I accept full responsibility for the payment of my child/children's bills. I also understand that if my insurance recoups payments I am responsible for all charges, even if more than a year has passed since the date of service. I also understand that if there is a legal contract in a divorce situation in which one parent is responsible for medical bill payments, that contract is not a contract between us and Kessler Pediatrics. I acknowledge that whichever parent accompanies the patient for the visit is responsible for all copay, coinsurance, out of pocket expenses, or deductibles incurred on the date of service and remaining balance in the system.

Parent/Guardian (print name): _____ Date: _____
Signature: _____

KESSLER Pediatrics

Patient History Questionnaire

Patient Name _____ DOB: _____ Date: _____

Household

List all members in the primary household (where this child spends most of their time)

HOUSEHOLD
PLEASE FILL OUT THE FOLLOWING TABLE ACCORDING TO THE HOUSEHOLD MEMBERS ONLY

Name	Relationship to Child	Birth Date	Health Problems

Are they any Siblings not living in the household? ☐ YES ☐ NO

If you answered yes, please list their name, age, and where they live.

_____

What is the patient's living arrangement if not living with both biological parents?

_____

If one or both parents are not living in the home, how often does the child see the parent (s) not in the home?

_____

Are biological parents: ☐ Married ☐ Divorced ☐ Together, not married ☐ Not together ☐ Not known

If parents are not together: ☐ Joint Custody ☐ Single Custody ☐ One or both parents not involved
Explain: _____

☐ Lives with adoptive parents. If adoptive: is child aware that he or she is adopted? ☐yes ☐no
☐ Lives with foster family
(Please provide all legal documents for above custody arrangements)

KESSLER Pediatrics

Patient History Questionnaire

Birth History ☐ Don't know Birth History

How many weeks was patient in the womb? _____ Birth weight: _____
Delivery type: ☐ Vaginal ☐ C-section ☐ Vacuum ☐ Forceps
List problems during pregnancy (☐none): _____
During pregnancy, did the biological mother use: ☐ tobacco ☐ alcohol ☐ illicit drugs ☐ prenatal vitamins ☐ other medications:
_____
List problems during labor (☐none):
_____
List problems during delivery (☐none): _____
Mom treated for Group B Strep? ☐ Yes ☐ No
Did your child go to the NICU or special care nursery? ☐no ☐yes, please give details:

General History

Do you consider your child to be in good health?	Yes ___ No ___
Does your child have any medical conditions?	Yes ___ No ___
Has your child had any surgery?	Yes ___ No ___
Has your child ever been hospitalized?	Yes ___ No ___
Is your child allergic to any medication, food, or substance?	Yes ___ No ___

Current Medical Condition	Approximate age at diagnosis

Medication, Food or Substance Allergy	Reaction

Has your child been prescribed an EpiPen? ☐ Yes ☐ No If yes, why? _____

List all prescribed medications

Medications	Strength	Dose	Frequency	Reason

(Girls) Started her period? If yes, what age _____ Any problems with periods? _____

KESSLER Pediatrics

Patient History Questionnaire

Patient Past History

Has your child ever had	Yes	No	Don't know	Has your child ever had	Yes	No	Don't know
Chickenpox				Sleep problems, snoring			
Frequent Ear Infections				Chronic or recurrent skin problems			
Problems with ears or hearing				Frequent headaches			
Nasal allergies				Convulsions or other neurological problems			
Problems w/ eyes or vision				Obesity			
Asthma, bronchitis, bronchiolitis, or pneumonia				History or serious injuries, fractures, concussions			
Any heart problem or heart murmur				Use of alcohol or drugs			
Anemia or bleeding problems				Tobacco use			
Blood transfusion				ADHD, anxiety, mood problems, depression			
Frequent abdominal pain				Developmental delay			
Constipation requiring doctor visits				Dental decay			
Recurrent urinary tract infections and problems				History of family violence			
Kidney disease or urological malformation				Has your child ever tested positive for TB skin test			
Bed-wetting (after 6 yrs old)				Other			

Biological Family History

Does any family member have	Yes	No	Don't know	Relationship to child
Childhood hearing loss				
Nasal allergies				
Asthma				
Tuberculosis				
Heart disease (before age 55 yrs old)				
High cholesterol, takes cholesterol medication				
anemia				
Blood disorder				
High blood pressure				

KESSLER Pediatrics

Patient History Questionnaire

Bone, joint disorder				
Skin disorder				
Thyroid disease: ☐ hypothyroidism				
☐ hyperthyroidism ☐ thyroid cancer				
Liver disease				
Kidney disease				
Diabetes (before age 55 yrs old)				
Bed-wetting (after 10 yrs old)				
Obesity				
ADHD				
Migraines				
Epilepsy or convulsions				
Alcohol abuse				
Drug abuse				
Mental illness, depression				
Developmental disability				
Immune problems, HIV or AIDS				
Tobacco use				
Additional family history				

Exposure History

Daycare	☐ Yes	☐ No
Exposure to smokers	☐ Yes	☐ No
Pets	☐ Yes	☐ No
Guns	☐ Yes	☐ No
***If yes, guns are locked away and kept separate from ammunition?	☐ Yes	☐ No
Pool/Bodies of water:	☐ Yes	☐ No
***If your home has a pool or body of water nearby, is it surrounded by a 4-sided fence or other precaution to keep your child safe from accidental drowning?	☐ Yes	☐ No

Patient History Questionnaire

Additional Information

Please use this space to provide additional information for any of the above questions:

_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform Kessler Pediatrics of any changes in my child's medical status or changes in my family's history. I authorize the healthcare staff to perform necessary healthcare services my child may need.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Parent/Guardian

Authorization for Release of Medical Records

☐ I Hereby Authorize Kessler Pediatrics to **REQUEST** information **FROM**:

Clinic Name _____ Address _____

Phone _____ Fax _____

☐ I Hereby Authorize Kessler Pediatrics to **REQUEST** information **TO**:

Clinic Name _____ Address _____

Phone _____ Fax _____

Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____

Records to be released:
☐ All Health Information (including growth charts and immunization records)
☐ History/Physical ☐ Laboratory Reports. ☐ X-Ray Reports ☐ Progress Notes
☐ Office notes for past 2 years (includes all items above)
☐ Other (specify dates of service) _____

I authorize the release of information relating to:
☐ Alcohol/Drug Abuse Evaluation/Treatment ☐ HIV/AIDS testing/Treatment
☐ Psychiatric Evaluation/Treatment

Purpose of Release:
☐ Continuing care for on-going treatment ☐ Transfer of Care ☐ Insurance ☐ Personal
(copy/retrieval fees may apply)

Statement of Authorization:
- This authorization expires (1) year after the date of my signature.
- I understand that Kessler Pediatrics will not condition my treatment, payment, enrollment, eligibility, or benefits on my signing of this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is sent as specified in this authorization, Kessler Pediatrics, and their employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I understand that if I am transferring care to another provider Kessler Pediatrics is unable to complete any forms or provide any additional care once my records are transferred to my new provider.

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Print Name Phone Number Relationship to Patient

Patient Agreement

I acknowledge that I have read and understand the policies and procedures of Kessler Pediatrics as outlined in this document. I agree to adhere to the specific policies of Kessler Pediatrics. I am aware the office policies and protocols will be updated periodically as the practice grows and changes will be made accordingly. These updates will be available on our website as well as in our office. I understand that if I do not comply with above stated guidelines, Kessler Pediatrics reserves the right to terminate care with the office.

Parent/Guardian Name: _____
Signature: _____
Patient(s) Name (s): _____
Date: _____

Kessler Pediatrics Patient Portal

We are pleased to provide our patients with the convenience of our Patient Portal. Our patient portal will allow you to:

- View upcoming appointments for your child
- Review a visit summary for your child's appointments, including
    - Diagnoses
    - Vitals (height, weight, etc.)
    - Screening results (vision, hearing)
- Receive lab results
- Download and print a copy of your child's immunization record
- Send messages requesting non-urgent medical advice
- Request non-same day appointments (check-ups, follow-up appointments)
- Request prescription refills

Messages received via the Patient Portal are responded to during normal business hours and may take up to 72 hours for a reply. You will receive a notification at the email address you provided that a new message is waiting for you in the patient portal. In using this Patient Portal, please make sure that our office has your most current email address and that all of your demographic information has been updated within the last 6 months.

You may access the Patient Portal by going to our website www.kesslerpediatrics.com and clicking on the Patient Portal icon located on the top right-hand corner of the website. You must receive a unique link from us in order to log-in and complete the set-up of your Patient Portal. Please do not contact us via Patient Portal with any urgent questions.

KESSLER Pediatrics

Patient Portal Registration

Email address: _____
First name: _____
Last name: _____
Phone number: _____

Patients to add to account:

Name	Date of Birth

Once your account is created, you will receive an email with a temporary password that is active for week. You will need to sign into the portal in order to complete your account set-up. Be sure to verify that your name appears correctly and that the names of the patients you have requested access to appear on the screen.

Please be aware that when a patient turns 18, the record for that patient automatically becomes **private**. Messages can still be sent in regards to the patient, but information in the chart cannot be viewed. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by completing and signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the physician.

Signature _____Date _____

For office use only

Date account requested	
Date account set up	
Initials	
Temporary password	

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone** ___-___-____

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Acknowledgement of Office Policies

1. Patient Name _____ Date of Birth _____
2. Patient Name _____ Date of Birth _____
3. Patient Name _____ Date of Birth _____
4. Patient Name _____ Date of Birth _____
5. Patient Name _____ Date of Birth _____

Kessler Pediatrics Office Policies:

1) Financial Obligation Policy: I have read, understand, and will comply with the Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or in previous occasions, Kessler Pediatrics is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills. **Parent/Guardian_____**

2) Appointment/Late Arrival/No-Show Office Policies: I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Office Policies regarding appointment scheduling, late arrival, and no-shows and understand my responsibilities. I have read and understand them. **Parent/Guardian _____**

3) Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications: I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications policies and understand my responsibilities. **Parent/Guardian _____**

HIPPA (Health Insurance Portability and Accountability Act): I hereby acknowledge that I have been presented with a copy of Kessler Pediatrics Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand I am not required to agree to Kessler Pediatrics requested restrictions, but if parents agree, then parent is bound to abide by such restrictions. **Parent/Guardian_____**

I acknowledge that I have read this document in its entirety and fully understand it. I will comply with all of Kessler Pediatrics policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, if requested, and I was given the opportunity to ask any questions.

Print Parent/Guardian Name: _____ Date_____
Signature: _____
Print Witness Name: _____ Signature: _____

Kessler Pediatrics Office Policies

Welcome to Kessler Pediatrics! We are extremely pleased that you have chosen us to provide pediatric care for your child and strive to make your experience with our office a pleasant one. We look forward to having a long relationship with you and your family. This sheet will provide a general overview of our office policies. Please read carefully. We are happy to answer any questions you may have regarding our policies.

Office Hours

Our office is open for patient care Monday through Thursday from 8:30 a.m. to 4:30 p.m. and Friday from 8:30 a.m. to 4:00 p.m. We are closed for lunch from 1:00 p.m. to 2:00 p.m. daily.

After Hours

We are always available to assist you during our regular office hours, and we encourage you to call with questions during our opening hours. For questions that arise when our office is closed, we are pleased to provide you with access to our nurse triage after-hours phone line. A physician is always on call to provide backup for any issues that cannot be handled by our nurses. The after-hours number is **855.456. 6976**. This number is only to be used outside of our regular office hours.

Scheduling Appointments

Our receptionists are available beginning at 8:30 am Monday through Friday to schedule appointments. Patients are seen **by appointment only**. We are not a walk-in clinic and strongly discourage patients from walking into our office to obtain an appointment. Walk-ins will not be seen on an immediate basis and will be given the next available appointment time. Life threatening emergencies require EMS notification via 911.

Well-Child Visits are essential in ensuring the proper health and development of your children. Patients should be seen at newborn, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, and 3 years. From 3 years of age, patients should be seen annually for an exam. We recommend scheduling well child exams 2-3 months in advance as these appointments book quickly. We do not automatically schedule well appointments for patients. It is the responsibility of the patient to schedule their well exams. Due to the length of well child exams, we will not be able to perform a well child exam during a sick visit as the time allotted for a sick visit is much shorter than a well exam. ADHD evaluations should ideally be scheduled at least 3 months in advance.

Same day Sick visits are scheduled on a **first-come, first-serve basis**. If our schedule fills for the day, we may not be able to honor all patient requests for a same day sick appointment. If we are unable to schedule a same day sick appointment, we will be sure to schedule an appointment for the next day. We will always do our best to get our sick patients seen as quickly as our schedule permits

In scheduling appointments, please note the appointment is only for the patient for whom the appointment was scheduled. In order to protect your time and that of other patients, please make an appointment for each child you would like to be evaluated by the physician. Be sure to call ahead to make an appointment if you plan to bring an additional child to a previously scheduled visit. Please understand that we may not be able to schedule sibling appointments in adjacent time slots. If you would like the physician to take a “quick look” at a sibling, this "look" constitutes a visit and requires payment for the visit.

If your child needs to be brought in by a caregiver (nanny, au pair) or family member (grandparent, sibling etc.) please notify the office and provide written authorization for that caregiver to accompany the child, accept information and prescriptions, and relay the plan of care. **Please plan for the caregiver to bring the payment when bringing the child (co-pays etc.)** The physicians are not able to communicate the care plan to the caregiver and then contact the parents separately to inform them of the care plan as well. Please have an adult accompany all patients under 18 years of age for any visit.

Well Child visit vs Sick visit – What’s the difference?
The Well Child visit is exactly that – a visit for a child who is well. These visits are designed to be a time to follow up on normal growth, check things like hearing, vision and blood pressure, make sure development is on track and get a full head-to-toe examination. These visits are scheduled at intervals that allow the pediatrician to address age-specific issues for each child to make sure everything is alright and if not, to address problems and treat them as early as possible. During a Sick visit, the pediatrician limits the visit to the problem(s) that brought the child to the office. Our physicians want to devote your entire appointment time on the purpose for your visit. Please be mindful of the difference in the type of visits when scheduling appointments. If you have an illness or chronic medical concern that need to be evaluated, please schedule an appointment separate from the Well Child visit so that we may focus on your child’s growth and wellness during their Well Child visit. Sometimes a child being seen for a Well Child visit is found to have a problem that requires treatment at the time of the Well Child visit. This problem is no longer considered part of the Well Child visit and is treated as a Sick visit on the same day. Please note that while the Well Child visit is covered by insurance with no co-pay. A visit that addresses a problem outside the scope of a Well Child visit (a Sick visit) requires a co-pay. This payment is a requirement from the commercial insurance companies, and the practice has to collect the appropriate amount at the time care is given. To help explain, please read this excerpt from Cigna’s website: “If your provider finds a health problem during a wellness exam, you may have to pay. Why? Once a problem is found, your exam is no longer considered preventative-it becomes diagnostic, or non-routine. When diagnostic care is needed, your out-of-pocket costs depend on your coverage and tests for services needed.”

Late Arrival Policy

We value your time and will make every attempt to see your child in a timely fashion. Please extend us the same courtesy and be on time for your appointment. If you are running late for your appointment, please notify our office, and we will attempt to make accommodations within our schedule. Patients who are more than **fifteen (15) minutes late** for their appointment will be rescheduled for the next available time slot. Please be advised that although we will try to accommodate you on the same day, occasionally the next available appointment will not be on the same day of your originally scheduled appointment.

No Show Policy

We are sensitive to unexpected emergencies, which may prevent you from keeping your appointments. However, we ask that you extend us the courtesy of notifying the office when you are unable to make your appointment. This notification allows us to offer your time slot to another patient who needs to be seen. **Failure to cancel or reschedule your appointment at least 30 minutes prior to your scheduled time will result in a fee of $75.** Appointments scheduled for 8:30 am must be cancelled prior to the office closing the day before the appointment to avoid the $75 cancellation fee. **Appointment scheduled for 2:00 pm or 2:15 pm must be cancelled prior to the office closing for lunch (1:00 pm) to avoid the $75 cancellation fee.**

Immunization Policy

Due to our firm belief in vaccines, Kessler Pediatrics requires all parents vaccinate their children according to the recommended schedule considered to be the standard care by the CDC, American Academy of Pediatrics, and the Advisory Committee of Immunizations Practices. We are happy to answer any questions and discuss the safety and efficacy of the vaccines with any parents who may have hesitancy towards vaccines. Vaccines are only provided during Well Visits. We will not schedule any additional nurse visits for vaccines for alternate vaccine schedules.

Prescription/Referral Requests

Prescription refills and specialist referrals may be made during office hours only. These requests may be made by either calling the office or submitting through the Patient Portal. Prescription refills are only provided for medications established as treatment for chronic medical conditions treated in our office within the last year. Requests for prescriptions for medications for new conditions, for medications not prescribed within the last year, or medications prescribed by other providers not in our office will not be granted. When contacting our office for prescription refills, please have the name and dosage of the medication as well as the name and phone number of your pharmacy readily available. Refills on **ADHD medications** will be provided for patients who have been seen within the last three months for their ADHD evaluation and/or follow-up. Please allow up to **three (3) days** for prescription refills to be processed.

Specialist referrals will only be provided for conditions evaluated within our office within the last year and as deemed appropriate by physicians. Our office requires that you contact us for referrals prior to your appointment with a specialist. Please allow up to **seven (7) days** for the referral process to be completed. We will not process last minute, same day requests for specialist referrals. Additionally, we will not back date referrals. Be sure to discuss with your insurance company whether or not you will need a referral for the specialist visit prior to the office visit. When contacting our office for a referral request, please have all pertinent information for the referral to be processed. Information needed for your referral includes but is not limited to the Physician's name, Office Location, Office Phone Number, Physician's NPI number, and Date of Visit. Your insurance company may require additional information. We will not be able to process your referral without all needed information. It is your responsibility to provide us with the necessary information to process your requested referral. The referral will be

faxed to the specialist once it has been processed. We are under legal obligation to all insurance companies to process referrals according to Texas State Law.

Medical Forms and Immunization Records

Requests for medical records must be made in writing and contain the signature of a parent or guardian. Medical records requested for personal use will incur a charge of $25 for the first 20 pages and $0.50 for each additional page. There is no charge to send medical records to another physician. Immunizations records are provided at no charge via the Patient Portal. Physical copies of immunization records will incur a charge of **$25**. FMLA forms will be completed at a charge of $30. Physician will make one revision to the completed FMLA form as requested by the patient's employer. Any additional revisions will require the completion of a new set of FMLA forms and an additional payment of **$30.** School and camp physicals are completed free of charge for any patient who has had a well child exam within the last year. Please allow up to **seven (7) business days** for the completion of any requests for forms or medical/ immunization records.

Cell Phone Etiquette

Please do not use your cell phone when approaching the front desk or upon entering the exam rooms. Cell phones can be very disruptive to the flow of patient care.

School/Work Excuses

We are only able to provide school and work excuses for patients and/or parents who are seen within our office. At the end of each office visit, you will be provided with an excuse noting the day that you were seen and the date most appropriate for you to return to school or work. Please do not ask our office to excuse missed days outside of these guidelines.

Separated/Divorced Families

We ask separated/divorced families to provide us with a copy of all decrees outlining divorce and custody arrangements. Divorce/Custody decrees are a contract between two parents and not the physician and the parent. We will follow all the arrangements as outlined legally. We cannot and will not withhold patient information from one parent at the request of the other parent without receiving a copy of the divorce decree verifying full custody and outlining all restrictions. Unless a divorce/custody decree is submitted to the patient's chart, we will provide care for the child regardless of which parent is at the appointment. Financially, the parent bringing the child to the office is authorizing treatment and is, therefore, the parent responsible for payment on the date of service. We will not call or contact the other parent to obtain payment information. Please have the child's payment and insurance information with you when arriving for your office visit. All fees associated with the visit, including but not limited to the co-pay of the child's insurance plan, are due at the time services are rendered. Additionally, all account balances and charges deemed parent responsibility by the contracted insurance plan are due to Kessler Pediatrics by the parent presenting the child for the date of service and authorizing treatment.

If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. Kessler Pediatrics will not make special provisions or act as a mediator in collection of payment. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request to assist in collection of fees from the other parent. Non-compliance with this policy may result in termination of care.

Financial Policy and Patient Obligations

Kessler Pediatrics participates with most private insurance companies. We do not currently participate in any Medical Assistance programs, i.e. Medicaid. If you plan to use your insurance for your office visit, please have your insurance card with you at the time of your visit. Be aware that all HMO plans and many Choice plans require that a PCP be selected for the plan. To ensure accurate billing and payment, please be sure to contact your insurance company and select Dr. Donza Rogers as your child's PCP. Failure to select Dr. Rogers as your PCP may result in higher co-pay fees and decreased reimbursement from your insurance company. Depending on your insurance plan, you may have a co- pay, coinsurance, or a deductible due at the time of your visit. A **Co-pay** is a set dollar amount that your insurance company requires you to pay at the time of each visit. A **Co-insurance** is an amount required by some insurance carriers that is above the deductible and co-pay amounts. A **Deductible** is a set amount your insurance company requires you to pay towards your health care costs before your insurance begins paying toward your services. Questions regarding your co-pay, co- insurance, and deductible should be directed to your insurance company. Co-pays, Co-insurance, and Deductible amounts are due at the time services are rendered. Your insurance company contractually requires these payments, and we cannot bill these payments. If you refuse to pay your required amount at the time of service, you may be denied care for that date of service. If you will not be utilizing insurance for your visit, you are required to pay the associated fees for your visit at the time of service. Please see our fee schedule for our current office fees.

Patient Obligations

Payment is due at the time of service. Copays, co-insurance, deductibles, procedures/treatments not covered by an insurance plan, and account balances are collected during the check-in process. We accept cash, checks, MasterCard, Visa, and American Express for payments. Returned checks will incur a $30 returned check fee. If a charge is disputed by the patient with the credit card company used for payment, our office reserves the right to relay information to dispute the claim. If the dispute is settled in favor of Kessler Pediatrics, an additional fee of $75.00 will apply.

Account Balances and Collections

Kessler Pediatrics will make every effort to assist you in keeping your account current with our office. As a courtesy to you, we will file claims with your insurance to obtain payment. However, please remember that you are ultimately responsible for all charges associated with the services we provide to you. We will send you a monthly statement reflecting balances on your account for which you are responsible.

Patient balances are expected to be paid in full upon receipt of the statement. A finance charge will be applied each month a statement is re-sent for payment. If you are unable to pay your balance, please contact our office manager immediately to determine if we can arrange a

payment schedule to keep your account current. We reserve the right to refuse care to any patients who refuse to pay their balance and/or make payment arrangements with our office. Failure to pay account balances older than three (3) months may result in us turning your account over to a collections agency for payment. Failure to pay account balances older than one (1) year may result in dismissal from our practice.

Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications

The Patient Portal is provided by Kessler Pediatrics as a courtesy for the exclusive use of its patients and authorized parents, legal guardians, and/or other caregivers. By logging in, you attest that you are a member of one of the aforementioned groups and will use any confidential medical information that is disclosed to you only for its intended purpose. Any other use is strictly forbidden. If you believe that the security of your account has been compromised, please notify us immediately so we can reset your credentials. The turnaround time for routine patient communication is typically within 3 business days; however, inquiries requiring extensive involvement of the physician may cause a delay in message delivery. Should you require urgent or immediate attention, this medium is not appropriate. When sending an e-mail, please put the subject of the message in the subject line so we may process it more efficiently. Some forms of communication (e.g., HIV and mental health) are not appropriate for emails. Also, be sure to put the name and birthdate of the patient as well as a return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using auto reply feature. Communication relating to diagnosis and treatment will be filed in your medical records. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and that your messages may be monitored. In addition, you should be aware that although an e-mail may be addressed to one person, our entire staff will have access to this information. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Patient Guidelines and Consent for Use of Patient Portal and E-mail Communications.

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.**

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on April 14, 2003.

We are bound to abide by the terms of this notice and reserve the right to revise this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health
information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request.
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction.
- You have the right to receive confidential communications of your protected health information, either directly from us or from us or by alternative means or from alternative locations.
- You have the right to inspect and copy your protected health information.
- You have the right to amend protected health information, however, this request may be denied under certain circumstances.
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you
have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health & Human Services, Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA or to file a complaint contact:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
202.619.0257
Toll free: 877.696.6775

Please contact us for more information Kessler Pediatrics Privacy Officer:

Tracy Sneed
214.941.6691