Steadman Pediatrics, PLLC

Patient Information

Child's Name (Last Name, First Name, Middle Name): _____
Date of Birth (Month/Day/Year): _____ Male (__) Female (__)
Child's Street Address (City, State, Zip Code): _____
Email: _____ Preferred Pharmacy Name: _____

Race (Please select appropriate group):
(_) American Indian or Alaska Native (_) Asian (_) Black or African American
(_) Native Hawaiian or Other Pacific Islander (_) White or Caucasian (_) Other

Ethnicity:
(_)Hispanic/Latino
(_)Other

Parent/Guardian Information

Mother's/Guardian's Name: _____ Father's/Guardian's Name_____
DOB: _____ Phone#: _____ DOB: _____ Phone: _____
Mother's/Guardian SS#_____ Father's/Guardian's SS#_____
Address_____ Address_____
Employer: _____ Employer: _____

Brothers and sisters:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Insurance Information

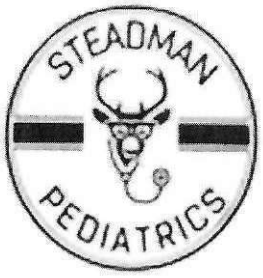
Is the patient covered by insurance? (_) Yes (_) No

Primary Insurance

Insurance Name: _____ Policy Holder's Name (_) Mother (_) Father
(_) Child (_) Other_____
Policy Holder's SS#_____ Policy Holder's DOB: _____

Secondary Insurance

Insurance Name: _____ Policy Holder's Name (_) Mother (_) Father
(_) Child (_) Other_____
Policy Holder's SS#_____ Policy Holder's DOB: _____



Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

Please present you current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit.

If we are your primary care physician, make sure our name and phone number appear on your card. If your insurance company has not been informed that we are your primary care physician as of this date, you may be financially responsible for the visit.

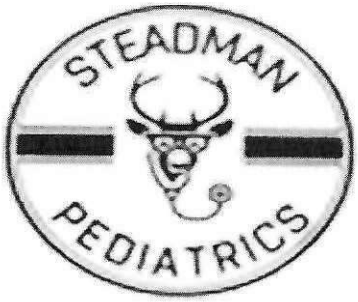
According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances. ***Payment is required at the time of service. We accept cash, check, or credit card.***

For patients with no *insurance*, full payment is required at the time of service.

It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.

I understand it is my responsibility and duty to inform Steadman Pediatrics should any information contained on this change in the future. I understand the balance on my account is my responsibility and promise to pay all balances not covered by my insurance in a timely manner.

_____	_____	_____
Printed Name of Parent/Legal Guardian	**Signature**	**Date**



Consent for Treatment

I, _____ give ***Steadman Pediatrics*** consent to provide medical treatment to (patient's name) _____. I also give permission for ***Steadman Pediatrics*** to release any and all information necessary to other medical specialties for continued care of my child. I also give permission for my child's daycare/school to obtain my child's immunization records.

_____ _____

Signature **Date**

We understand that on occasion, the need may arise for someone other than the parent/legal guardian indicated on file to bring in the child for medical care. Below, please indicate those to whom authorization may be given when you are unavailable.

Name: _____ **Relationship**_____ **Phone#**_____
Name: _____ **Relationship**_____ **Phone#**_____
Name: _____ **Relationship**_____ **Phone#**_____
Name: _____ **Relationship**_____ **Phone#**_____
Name: _____ **Relationship**_____ **Phone#**_____

I authorize the above individuals to consent to any and all medical care/treatment for this child by Steadman Pediatrics. This delegation is valid until I have withdrawn this consent.

_____ _____

Signature: Date:

Consent for Telemedicine

I understand that Steadman Pediatrics, PLLC offers an opportunity for me to connect via telemedine with one of my child's providers at Steadman Pediatrics, PLLC.
I understand the purpose for this service is to seek medical advice and guidance for the care of my child who does not have an emergency condition. I also understand that at any time if I feel I cannot wait for a visit or feel my child's condition has become an emergency than I will call 911 and/or seek emergent care.

I understand that telemedicine is the use of video communication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell in assessing my child's condition. The provider is also unable to use instruments that aid in making a diagnosis.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment but there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

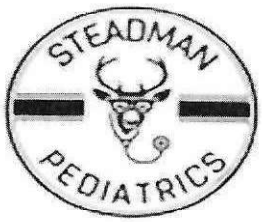
- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment
- Delay in care resulting from communication service or equipment failure
- Inadequate visual resolution resulting in incomplete assessment
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse result.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges for my child's telemedicine visit. I understand that my telemedicine visit may not be covered by my insurance plan.

By signing this form, I indicate that I have chosen to proceed with the telemedicine visit for my child. I understand that the remote provider is a provider at Steadman Pediatrics, PLLC.
I consent to the healthcare provider I am connected with to providing healthcare services to my child via telemedicine.

_____ _____

Signature of Parent or Guardian **Date**



Steadman Pediatrics Policy

No show- We initiate a policy for **NO SHOWS** due to a large percentage of no shows. We will require a call at least 4 hours in advance to the appointment, or it will be considered a no show. If a child has 3 no shows in a year, you will receive a warning letter. Should one more NO SHOW occur, we will no longer be able to keep your child as a patient.
We do not wish to terminate anyone as a patient and we know unforeseen things come up, we just ask that you call and let us know so that other patients that need to be seen can take that time slot. We do not feel it is fair to the other patients, or us to hold spots that are not going to be used.

Rudeness- Any act of rudeness to any of our office staff and especially in front of other patients such as demeaning comments, abusive, or inappropriate language in office as well as on Social Media will be grounds for termination as our patient.

Immunizations- We believe in immunizations and believe they are a very important part of a child's overall care. We stand behind them and all of the vast research that has gone into them. We also support the CDC guidelines for giving them. We also believe in parental autonomy and know that there are many opinions on immunizations especially on the internet. Many of these views we do not agree with, but will be happy to discuss these issues with you as they arise. Know that we will strongly encourage you to have your child immunized with the recommended immunizations, but we will be willing to work with you on a possible alternate schedule if we feel these will do no harm to your child.

Late- If anyone is more than 10 minutes late to their appointment, we feel that you need to understand that you may have to wait for those ahead of you who did show up on time. We know things happen and we will do our best to get you in as quickly as possible but we will not make someone wait on you who are here on time. However, on certain days it may be necessary to reschedule your appointment. Thank you for understanding.

Bringing in Siblings- Please let the front office staff know if other siblings are being brought to the appointment or need to be seen. We will make an attempt to see them depending on our schedule. However, if our schedule is full, we will have to schedule for a different time. When we don't know about, it causes all the patients after you to be late. Please notify the front desk out of courtesy to staff and other patients when checking in.

I have read the above policy and understand.

Patient's Name: _____
DOB: _____
Parent/guardian's Name Printed: _____
Parent/guardian signature: _____
Date: _____
Witness (Employee): _____

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.

Purpose of this Notice

Steadman Pediatrics is required by law to maintain the privacy of your protected health information (PHI). This notice applies to all records of the health care and services you received at PAA. This notice will tell you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI. A more detailed version of this notice may be found on PAA's website and a paper copy will be provided upon request.

Steadman Pediatrics Commitment

We are required by law to: (i) make sure that your PHI is kept private; (ii) give you this notice of our legal duties and privacy practices with respect to your PHI; (iii) follow the terms of this notice as long as it is currently in effect (if we revise this notice, we will follow the terms of the revised notice as long as it is currently in effect); (iv) train our personnel concerning privacy and confidentiality; and (v) mitigate (lessen the harm of) any branch of privacy/confidentiality.

How We May Use and Disclose Information about You

The following categories (listed in bold-face print, below) describe different ways that we use and disclose your protected health information (PHI). For each category of uses or disclosures we will explain what we mean and give you some examples, but not every use or disclosure in a category will be listed.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you or providing you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose your PHI to health care providers that are not affiliated with Pediatric Associates who may be involved in your medical care, such as physicians, who will provide follow-up care, physical therapy organizations, medical equipment suppliers, and skilled nursing facilities.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at/by PAA may be billed to (and payment may be collected from) your insurance company or a third party. For example, we may need to give your health plan information about the procedure you received at Steadman Pediatrics so your health plan will pay us or reimburse you for the procedure.

For Health Care Operations. We are permitted to use and disclose your PHI for our business operations. These uses and disclosures are necessary to run PAA and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you.

To Business Associates for Treatment, Payment, and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment of health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for health care services we provide.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative, or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person's involvement in your care. WE also may release information to someone who helps pay for your care. We may tell your family or friends that you are at PAA and what your general condition is.

Other Uses/Disclosures. We may use and disclose medical information: (i) to tell you about health-related benefits or services that may be of interest to you; (ii) to give you information about treatment options or alternatives that may be of interest to you; or (iii) to contact you as a reminder that you have an appointment for treatment or medical care at PAA.

Special Situations: We will disclose your PHI when required to do so by federal, state, or local law. **Public Health Activities:** We may disclose your PHI for certain public health activities (e.g., controlling disease, injury, or disability; reporting abuse or neglect; reporting drug reactions), but only if you agree or when required or authorized by law.

Health Oversight Activities. WE may disclose PHI to a government health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court of administrative order or in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. In certain designated situations, we may release PHI if asked to do so by a law enforcement official.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI: (i) to a coroner or medical examiner to identify a deceased person or to determine the cause of death; or (ii) to a funeral director as necessary to help them carry out their duties.

Other Special Situations. We may use and/or disclose PHI: (i) to organizations that handle or facilitate organ procurement or transplantation; (ii) to law enforcement when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another

person; (iii) as required by applicable military command authorities (if you are a member of the armed forces); (iv) to authorize federal officials for certain national security purposes; or (v) for workers compensation purposes.

When Your Authorization is Required Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with you written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

Your Rights: You have the following rights regarding the PHI we maintain about you:

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for you care. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. We will accommodate all reasonable requests.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Psychotherapy notes may not be inspected or copied. We may deny your request to inspect or receive a copy in certain very limited circumstances.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for PAA. You must include a reason that supports your request. We may deny your request for an amendment in certain limited circumstances.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" that has been made by PAA in the past six (6) years.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice (even if you have agreed to receive this notice electronically). You may ask us to give you a copy of this notice at any time. Changes to this Notice We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on PAA premises and on PAA's website. The notice will contain, in the lower left-hand corner, the effective date. In addition, each time you register at, or are admitted to, PAA for treatment purposes, you may request a copy of the current notice in effect.

Requests, Questions, and Complaints If you have any questions or would like additional information on these rights, you may contact the PAA Privacy Officer at 512-458- 5323. Additionally, if you believe your privacy rights have been violated, you may file a complaint with either PAA's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. You will not be penalized in any way for filing a complaint

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient/Guardian **Date**