

## PATIENT INFORMATION

Please print clearly

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for visit \_\_\_\_\_

Current Medications \_\_\_\_\_

Does the patient have any known drug allergies? No \_\_\_\_\_ Yes \_\_\_\_\_

Name of drug(s) \_\_\_\_\_

Are immunizations up to date? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ SSN \_\_\_\_\_

Work Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

## INSURANCE & BILLING INFORMATION

Name of individual responsible for this account \_\_\_\_\_

Name of Insurance Company to be Billed \_\_\_\_\_

Member ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber Birthdate \_\_\_\_\_ Subscriber SSN \_\_\_\_\_

Subscriber Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Subscriber Address (*if different from patient's*) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have a secondary insurance? No \_\_\_\_\_ Yes \_\_\_\_\_

Name of secondary insurance company \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Member ID number \_\_\_\_\_

**EMERGENCY CONTACT** Name \_\_\_\_\_ Number \_\_\_\_\_

## TO BE COMPLETD BY OFFICE STAFF

Co Pay Collected \_\_\_\_\_ Check # \_\_\_\_\_ VISA/MC \_\_\_\_\_ BILLING SUBMITTED \_\_\_\_\_

PN COMPLETED \_\_\_\_\_ Phy LETTER COMPLETED \_\_\_\_\_ Dictated \_\_\_\_\_ TIME \_\_\_\_\_

**CONSENT TO USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I understand as part of my healthcare, Pediatric Infectious Disease Specialists of Houston, PA. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

***I understand that this information serves as:***

A basis for planning my care and treatment.

A means of communication among the many healthcare professionals who contribute to my care.

A source of information for applying my diagnosis and surgical information to my bill.

A means by which a third party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

***I understand that I have the right:***

To object to the use of my health information for directory purposes.

To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**I request the following restrictions to the use or disclosure of my health information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No restrictions

Parent or Patient:

\_\_\_\_\_  
Signature of Patient or Legal Representative Of  
Consent to Use and Disclosure of Protected Health  
Information for Treatment, Payment or Healthcare  
Operations

\_\_\_\_\_  
Date

# PEDIATRIC INFECTIOUS DISEASE SPECIALISTS OF HOUSTON, PA

---

## Memorial City

1140 Business Center Dr. 300  
Houston, Texas 77043

## Cy-Fair

11302 Fallbrook, 110  
Houston, Texas 77065

## Sugarland

15551 Southwest Frwy  
Sugarland, Texas 77478

## Clear Lake

250 Blossom Suite 350  
Webster, TX 77598

## Katy

21308 Provincial Blvd.  
Katy, TX 77450

## Financial Policy

Welcome and thank you for choosing Dr. Amaya as your child's pediatric subspecialist. Your child has been referred to Dr. Amaya for evaluation and treatment of a complex infectious disease condition. Our practice is committed to providing you with quality medical care and our professional fees have been determined through careful consideration. We believe these fees are reasonable and reflect the service and expertise provided by a medical specialist. In order to prevent any misunderstandings and to serve you better, we ask that all parents read and sign our Financial Policy. If you have any questions, please ask to speak to a representative from our business office.

As a courtesy, we will verify your insurance eligibility and benefits prior to or at your initial visit and any time you notify us of a change in your coverage. However, we cannot guarantee that the information we receive is accurate (at the time of verification or for later visits) or that the insurance company will process the claim in accordance with the information they provide. You as the holder of the insurance policy are ultimately responsible for knowing what your plan does and does not cover (such as an evaluation by a specialist) and the administrative rules (authorizations and referrals). You are also responsible for verifying that Dr. Amaya is participating in your insurance plan. Although our practice has made a determined effort to enroll in every insurance plan available in the Houston area, in some situations Dr. Amaya may not be contracted by your insurance plan and would file the claim as an out-of-network provider. Any amounts not covered by your plan, except for contractual fee discounts, are your responsibility.

**Please read and initial each item below.**

1. \_\_\_\_\_ **CO-PAYMENTS/COINSURANCE AND BILLING FEES.** I understand that at the time of my appointment any copayments that are required by my insurance will be paid in full. Cash, checks, Visa, and Mastercard are accepted. The fees charged by Dr. Amaya will be submitted to my insurance company. I will be responsible for any balances as determined by the insurance company and I will be billed directly.
2. \_\_\_\_\_ **BALANCE DUE PER THE EXPLANATION OF BENEFITS (EOB).** After my insurance plan has processed the insurance claim, any balance is due upon receipt of the bill from the office. If I disagree with the amounts due per the EOB, it is my responsibility to immediately contact Dr. Amaya's billing office (281-412-2494) and my insurance plan for resolution of the problem. I understand that I may not withhold payment to Dr. Amaya pending resolution of insurance problems. If the insurance corrects the problem, I understand I will be promptly refunded any overpaid amounts.
3. \_\_\_\_\_ **INSURANCE COMPANY PAYMENT.** I understand that this practice allows 90 days from the date a claim is filed by the office for the insurance company to pay. If despite proper submission of the claim, the insurance carrier has not paid within this time, I will be responsible for the entire balance and I will be billed directly. Furthermore, I understand that the office will not become involved in disputes between myself and my insurance company regarding deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges" other than to supply factual information when necessary. I understand I will be promptly refunded any amount the insurance carrier subsequently pays.

4. \_\_\_\_\_ **LAB TESTING.** I understand that as the policy holder, it is my responsibility to be aware of the coverage for lab testing. Although the office will ensure that I am sent to a contracted lab, specific tests may not be paid by my insurance. I am encouraged to verify that the requested labs are covered prior to performing these tests. All unpaid balances are the responsibilities of the policy holder.
  
5. \_\_\_\_\_ **NEW INSURANCE INFORMATION** must be provided before my child is seen. Failure to provide correct insurance information may result in the entire bill being my own responsibility.
  
6. \_\_\_\_\_ **INSURANCE REQUESTS FOR ADDITIONAL INFORMATION** necessary to process claims must be responded to by me immediately. These include requests to verify if other insurance coverage exists, details of accidents/injuries etc. Failure to provide this information in a timely manner may result in the entire bill being my own responsibility.
  
7. \_\_\_\_\_ **UNACCOMPANIED MINORS.** A minor must have written authorization for medical treatment signed by a parent or guardian. The parent or guardian is responsible for providing current insurance information for the patient and payment of copay or balances.
  
8. \_\_\_\_\_ **BILLS ARE SENT MONTHLY.** I agree to contact the billing office immediately (281-412-2494) if I have questions regarding a bill I receive. I understand that bills are not sent out for informational purposes only. If I receive a bill, it means payment is expected from me.
  
9. \_\_\_\_\_ **BALANCES OVER 90 DAYS OLD:** Unless prior payment arrangements have been agreed upon, I understand that if I allow my account balance to exceed 90 days, the account will be turned over to a collection agency and may be reported to the major credit bureaus.
  
10. \_\_\_\_\_ **RETURNED CHECKS** will incur a \$25 fee. The check will be redeposited the first time it is returned from the bank. If it is returned a second time and additional \$25 fee will be posted to the account and I will be asked to pay the entire balance by cash, money order or credit card within 10 days of notification of the problem.
  
11. \_\_\_\_\_ **CREDIT CARD FILE.** We require you to leave a credit card number on file. For your convenience, the credit card on file will secure any copays/deductibles/co-insurances for any office location. In the event that there are any patient balances after claims are processed, this credit card will be used for this purpose only. **Your credit card will not be charged unless we get a verbal consent prior to transaction.**

Type of CC: \_\_\_\_\_ Exp. \_\_\_\_\_

CC#: \_\_\_\_\_

Signature on card \_\_\_\_\_ Date: \_\_\_\_\_

Again, we thank you for choosing Dr. Amaya to care for your children. We appreciate your trust and look forward to serving you. If you have any questions regarding the above policies, please do not hesitate to ask. We will make every reasonable effort to facilitate your payment. Please sign below to acknowledge your understanding of the entire policy and that you are provided a copy for your records.

\_\_\_\_\_ Please print name of Patient

\_\_\_\_\_ Date of Birth

\_\_\_\_\_ Please print name of Parent or Guarantor

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Parent or Guarantor

## Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Amaya all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Rene Amaya may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

---

Signature of Parent or Guarantor

---

Date

---

Please print name of Parent or Guarantor

---

Relationship to Patient

NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices and understand my rights as a patient of this practice.

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT/ GUARDIAN SIGNATURE

\_\_\_\_\_  
REALATIONSHIP TO PATIENT

PEDIATRIC INFECTIOUS DISEASE SPECIALISTS OF HOUSTON,  
PA  
Rene Amaya, M.D., FAAP

---

RESCHEDULING FEE

In the event that you are unable to arrive on time for a scheduled follow up appointment, we ask that you notify the office 6 hours prior to your appointment so that a new appointment may be arranged.

Failure to contact our office will result in a \$35 rescheduling fee that will be added to your direct charges at the time of your next appointment.

\_\_\_\_\_  
Print: Parent/Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature- Parent/Guarantor

MEDICAL RECORDS

Our office can gladly provide you with a copy of your child's medical records with a written request. Since many of our records are archived in storage, please allow 48-72 hours to honor your request.

Medical records can ONLY be mailed or picked up at our main Memorial City location. The fee for this service is \$15.00 and is to be collected at the time of the initial request and prior to delivery of the records.

\_\_\_\_\_  
Initials