

# KID CARE PEDIATRICS

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Choose your Primary Office Location:

230 N. Rufe Snow Drive  
Keller, TX 76248  
Phone: 817-337-5503  
Fax: 817-337-0110

6618 Fossil Bluff Dr #116  
Fort Worth, Texas 76137  
817-847-6420  
Fax: 817-847-6412

PLEASE PRINT

## PATIENT REGISTRATION

<b>Patient's Full Name:</b> _____	<b>Nick Name:</b> _____
Date of Birth: ____/____/____	Patient Social Security #: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Mother's Name:</b> _____	Social Security #: ____/____/____
Date of Birth: ____/____/____	Employer: _____ Work # _____
Home Address _____	City _____ State _____ Zip _____
Home Phone #: _____	Mobile Phone # _____ Pager# _____
<b>Father's Name:</b> _____	Social Security #: ____/____/____
Date of Birth: ____/____/____	Employer: _____ Work # _____
Home Address _____	City _____ State _____ Zip _____
Home Phone #: _____	Mobile Phone # _____ Pager# _____

## INSURANCE INFORMATION

<b>Primary Insurance Company:</b> _____	<b>Name of Insured:</b> _____
<b>Insurance Phone #:</b> _____	<b>ID # or Policy #:</b> _____ <b>Group #:</b> _____
<b>Secondary Insurance Company:</b> _____	<b>Name of Insured:</b> _____
<b>Insurance Phone #:</b> _____	<b>ID # or Policy #:</b> _____ <b>Group #:</b> _____

Kid Care Pediatrics has my permission to examine and administer treatment as deemed necessary to my child(ren). I agree that all services are rendered on a paid basis only. If my account is referred to the collection process, I will pay all fees including attorney fees. I authorize the release of information to my insurance if requested.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**A. BIRTH HISTORY**

- 1. Birthplace \_\_\_\_\_
- 2. Birthdate \_\_\_\_\_
- 3. Was pregnancy normal? \_\_\_\_\_
- 4. Was delivery normal? \_\_\_\_\_
- 5. Was baby full term? \_\_\_\_\_
- 6. Birthweight \_\_\_\_\_
- 7. Birth length \_\_\_\_\_
- 8. Any nursery problem? \_\_\_\_\_

**B. GROWTH AND DEVELOPMENT**

- 1. Ages when first:
  - Sat \_\_\_\_\_ Crawled \_\_\_\_\_
  - Rolled \_\_\_\_\_ Walked \_\_\_\_\_
  - First Teeth \_\_\_\_\_ Toilet Trained \_\_\_\_\_
- 2. School History:
  - Year in school \_\_\_\_\_ Nursery \_\_\_\_\_
  - Grades averaged \_\_\_\_\_
  - School name \_\_\_\_\_
  - School problems? \_\_\_\_\_
  - Attends special school or classes? \_\_\_\_\_
  - \_\_\_\_\_
  - Discipline or behavior problem? \_\_\_\_\_
  - \_\_\_\_\_
  - Ever seen by Psychologist, Speech Therapist, or Special Teachers? \_\_\_\_\_
  - \_\_\_\_\_

**C. PAST MEDICAL HISTORY**

- 1. Any problems with:
  - Sleeping? \_\_\_\_\_ Betwetting? \_\_\_\_\_
  - Weight/Height? \_\_\_\_\_ Nail Biting? \_\_\_\_\_
  - Nightmares? \_\_\_\_\_
- 2. Diet
  - Nursed or Bottle Fed? \_\_\_\_\_
  - Any Colic problems? \_\_\_\_\_
  - Use special diets? \_\_\_\_\_
  - Taking vitamins? \_\_\_\_\_
  - Taking Fluoride? \_\_\_\_\_
- 3. Contagious Diseases (What age?)
  - Measles \_\_\_\_\_ Mumps \_\_\_\_\_
  - Chickenpox \_\_\_\_\_ Scarlet Fever \_\_\_\_\_
  - Rubella (German Measles) \_\_\_\_\_
  - Any other? \_\_\_\_\_
- 4. Immunizations (Shots)– Please give ages and/or dates
  - DPT series \_\_\_\_\_ Boosters \_\_\_\_\_
  - Polio series \_\_\_\_\_ Boosters \_\_\_\_\_
  - Smallpox \_\_\_\_\_ Boosters \_\_\_\_\_
  - Measles \_\_\_\_\_ Mumps \_\_\_\_\_
  - TB (Tine) Test \_\_\_\_\_
  - Rubella (German Measles) \_\_\_\_\_
  - Others \_\_\_\_\_
- 5. Medications (Does Your Child Take Any Now?)
  - \_\_\_\_\_

Child's Name \_\_\_\_\_

Age: \_\_\_\_\_ Date Form Filled Out \_\_\_\_\_

**D. HOSPITALIZATIONS**

(When, Where, Why?) \_\_\_\_\_

**E. SURGERY**

(When, Where, Why?) \_\_\_\_\_

**F. SERIOUS INJURIES**

(When, Where, Why?) \_\_\_\_\_

**G. ALLERGIC REACTIONS**

(Drug, asthma, Hives, Eczema, Hay Fever) \_\_\_\_\_

**H. FAMILY HISTORY**

- 1. Father: Living? \_\_\_ Age now \_\_\_ Health \_\_\_
- 2. Mother: Living? \_\_\_ Age now \_\_\_ Health \_\_\_
- 3. Brothers/Sisters \_\_\_\_\_ How Many? \_\_\_\_\_
  - Ages \_\_\_\_\_ Healthy \_\_\_\_\_
- 4. Any Family History of:
  - Diabetes \_\_\_ Allergies \_\_\_ Convulsions \_\_\_
  - Heart Disease \_\_\_ TB \_\_\_ Cancer \_\_\_
  - Other? \_\_\_\_\_

**I. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?** \_\_\_\_\_

**WHERE DID YOU LIVE BEFORE COMING TO THIS AREA?** \_\_\_\_\_

**J. GENERAL SURVEY**

Has your child had any unusual problems with The following?

- Head \_\_\_\_\_ Eyes \_\_\_\_\_
- Ears/Nose/Throat \_\_\_\_\_
- Chest/Heart/Lungs \_\_\_\_\_
- Stomach \_\_\_\_\_
- Kidneys \_\_\_\_\_
- Bladder \_\_\_\_\_
- Bones, Muscles, Joints \_\_\_\_\_
- Skin \_\_\_\_\_ Blood \_\_\_\_\_

When was your child's last blood test? \_\_\_\_\_

When was your child's last urine test? \_\_\_\_\_

**K. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?** \_\_\_\_\_

**L. YOUR LAST DOCTOR WAS:**

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

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

**KID CARE PEDIATRICS  
AUTHORIZATION FOR THE RELEASE OF INFORMATION  
AND/OR MEDICAL RECORDS**

I consent and authorize Kid Care Pediatrics to release information contained in any financial or medical records, including but not limited to: diagnosis and treatment, information concerning communicable disease, drug or alcohol abuse, psychiatric diagnosis and treatment, medical history, lab results progress notes, and other related information to insurance companies and its agents, Medicaid or Medicare, or any other entity responsible for paying or processing payment, utilization management, or consulting and/or follow-up care.

Kid Care Pediatrics is hereby authorized to release any information or records and reports regarding patient care and health status as required by law or regulation.

Information may be transmitted by mail, facsimile, or other electronic medium.

I understand that I may revoke this authorization in writing at any time, except to the extent that action is already in progress.

**The undersigned certifies that he or she has read, understands, and accepts this authorization form, and is the legal parent, guardian, or representative of the patient(s).**

\_\_\_\_\_  
Signature of Parent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Legal Representative

\_\_\_\_\_  
Relationship

# KID CARE PEDIATRICS

## CONSENT TO TREAT AND FINANCIAL AUTHORIZAITON

### CONSENT TO TREAT:

The undersigned consents to any examination or medical treatment, and or services rendered to the patient by the Dr. Omar Gomez in his best judgment during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

### FINANCIAL RESPONSIBILITY:

It is agreed that regardless of any and all assigned benefits and or monies the undersigned agree to be responsible for the total charges for services rendered. I agree that any amount that may be my responsibility are due upon request, payable to Kid Care Pediatrics. Should this account become delinquent, I agree to pay all expenses including attorney fees. If this account has a credit balance at any time, I agree that it will be applied to any previous outstanding balance prior to any monies being refunded.

### ASSIGNMENT OF BENEFITS AND INSURANCE REQUIREMENTS:

In consideration of goods and services rendered or to be rendered, I irrevocably assign and transfer to Kid Care Pediatrics all right, title and interest in benefits or monies payable for goods or services. I understand that in the event that Kid Care Pediatrics files a claim on my behalf that the same does not impose any contractual obligation upon Kid Care Pediatrics, and that I remain responsible for instituting suit within the applicable statue of limitations. I authorize pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of the patient (and or parent or guardian), or legal agent. I authorize payors listed herein and any other payors to release any and all information requested and or related to my claims to Kid Care Pediatrics.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND ACCEPTS THE CONSENT TO TREAT AND AUTHORIZATION, AND IS THE LEGAL PARENT OR GUARDIAN OF THE PATIENTS, OR THE LEGAL REPRESENTATIVE OF THE PATIENTS.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**KID CARE PEDIATRICS  
TEXAS-WIDE IMMUNIZATION REGISTRATION  
IMMTRAC CONSENT**

I agree that the record of giving each vaccine (past, present or future) can be given to the Texas Department of Health Immunization Tracking System, and to other health care providers, schools, or places that provide child care.

I hereby authorize the Texas Immunization Registry to release such information concerning my child's immunizations to any public health district, local health department, child's healthcare providers, insurance companies, school or child care center, as well as the Texas Department of Human Services.

The above entries to re-release such information in order to promote the availability of accurate, complete and up-to-date immunization records to those entities and individuals who administer and promote immunizations.

I am aware that I may withdraw this consent at any time by contacting:

The Texas Department of Health  
Immunization Registry  
1100 West 49<sup>th</sup> Street  
Austin, TX 78756

YES

NO

---

Signature of Parent or Legal Representative of the Patient

---

Relationship

---

Date

*Records with "No" consent will not be forwarded to the State-wide Immunization Registry (ImmTrac).*



## CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Legal Guardian's Printed Name: \_\_\_\_\_

I hereby authorize the following person(s) to seek medical care and make decisions in relation to advice rendered from Kid Care Pediatrics and/or its employees for my child in my absence:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

For the following period:

\_\_\_\_\_ through \_\_\_\_\_

Until such time as this authorization is revoked in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date



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### Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- a) **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and will other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan;
- b) **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies).
- c) **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consents is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible.

\_\_\_\_\_  
Patient's Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (or guardian, if a minor)

\_\_\_\_\_

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

## HOW DID YOU FIND OUT ABOUT US AND/OR WHO MAY WE THANK FOR REFERRING YOU TO KID CARE PEDIATRICS?

CHECK ALL THAT APPLY

Are you a previous patient of Dr. Gomez?     Yes     No                      Dr. Leffel?     Yes     No

- Friend(s) or Relative(s): \_\_\_\_\_ (Name of Relative/Friend)
- Discovered the practice while driving by
- Bench Ad on US 377 & Starnes (by EECU)
- Newspaper
  - Keller Citizen                                       Westlake     Roanoke     Argyle     Rhome
  - Ft. Worth Star Telegram (NE Metro Section)     Justin     Haslet     Ponder     Newark
  - Trophy Club
- Fort Worth Child Magazine
- Phonebook
  - Verizon     North East Tarrant Phonebook
  - Southwestern Bell                                       Yellow Pages
- Physician Referral: \_\_\_\_\_ (Name of Physician)
- Neighborhood Newsletter:
  - Voices of Park Glen                                       Summerfield's Newsletter
  - West Park Glen Mom's Club Newsletter     East Park Glen Mom's Club Newsletter
  - Heritage Newsletter                                       Keller Chamber of Commerce
  - PID 6 Newsletter     Woodland Springs Newsletter
  - Parkwood Hill Newsletter
- Keller Parks & Recreation Events/Community Activities:
  - Breakfast with Santa                                       Keller Spring Festival
  - Easter Egg Hunt
- St. Elizabeth Ann Seton Church Bulletin                                       Tarrant County Medical Society Referral Line
- School Folder/Advertisement/Sponsorships                                       Baylor Referral Line
- Harris Methodist Referral Line                                       Baylor Grapevine Physician and Services Directory
- Insurance Company
- Internet: \_\_\_\_\_ (which site)
- Other: (Business Cards, Flyer, Daycare, Pharmacy, etc.) \_\_\_\_\_

☺ ☺ ☺ COME GROW WITH US! ☺ ☺ ☺

Thank you for the opportunity to provide medical care to your child(ren)!

**Please consider telling others about your pleasurable experience here at KID CARE PEDIATRICS.**

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**I hereby authorize the use or disclosure of information from the medical record of:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ (optional)

**I authorize the following individual or organization to disclose the above named individual(s) health information:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/ State/Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax# \_\_\_\_\_

**This information may be disclosed TO and used by the following individual or organization:**

- |  |   |
|--|---|
| <input type="checkbox"/> Kid Care Pediatrics<br>230 Rufe Snow Dr<br>Keller, TX 76248<br>817.337.5503<br>817.337.0110 (Fax) | <input type="checkbox"/> Kid Care Pediatrics<br>6618 Fossil Bluff, Suite 116<br>Ft. Worth, TX 76137<br>817.847.6420<br>817.847.6412 (Fax) |
|--|---|

**Please release the following:**

\_\_\_ Entire Record  
**Or:** \_\_\_ Newborn Hospital Assessment Record      \_\_\_ Laboratory Results      \_\_\_ X-Rays  
\_\_\_ EKG Report      \_\_\_ EEG Reports      \_\_\_ Operative Reports  
\_\_\_ Therapy Reports      \_\_\_ Obstetrical Reports      \_\_\_ Psychological Reports  
\_\_\_ Most Recent History and Physical      \_\_\_ Other (specify) \_\_\_\_\_

**Purpose for the release:**

\_\_\_ Medical Care      \_\_\_ Insurance Purpose      \_\_\_ Legal Purpose      \_\_\_ Other: \_\_\_\_\_

I understand that my medical record may contain information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.

\_\_\_ **YES, I consent**      \_\_\_ **NO, I do not consent to the release of this information**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR-164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I can contact Kid Care Pediatrics.

\_\_\_\_\_  
Signature of Patient or Legal Representative      DL# \_\_\_\_\_      \_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient      \_\_\_\_\_  
Witness

# **KID CARE PEDIATRICS POLICY PAGE**

**We want to welcome you to Kid Care Pediatrics. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about your child's healthcare.**

## **Appointments:**

-Call the office at (817) 337-5503 or (817) 847-6420 twenty four hours prior to an appointment if the appointment is not going to be utilized/if the visit is being cancelled or postponed.

We reserve the right to charge \$25 for no show appointments without 24 hour cancellation notice.

Please be aware patients that arrive more than 5 minutes late for their appointments may be asked to reschedule.

## **Payments:**

We collect all co-pays, deductibles and co-insurance at the time of service according to the benefit quote that our office obtains from your insurance company.

We have a \$30.00 fee for all returned checks.

## **After Hour Calls:**

There is a \$15.00 charge for all after hours urgent nurse triage calls.

For prescription refills, ask the pharmacy to forward a medication refill request to our office. For patients that are seen at the Keller office use (FAX # 817 337-0110) and for patients that are seen at our Fort Worth office use (FAX # 817-847-6412) or call the office for a refill request with 24-48 hours prior notice if possible in order to ensure a timely response. (Keller Phone # 817-337-5503) (Fort Worth Phone # 817-847-6420)

## **Holidays:**

The office is closed for all major holidays. For urgent and emergency care, parents are to use the Cook Children's URGENT CARE and EMERGENCY CARE GUIDELINES.

## **Inclement weather:**

For inclement weather office hours, please check our website at [www.kidcarepediatrics.com](http://www.kidcarepediatrics.com). For urgent and emergency care when the office is closed due to inclement weather, please use the URGENT CARE and EMERGENCY CARE guidelines previously listed.

Kid Care Pediatrics physicians see patients from 0 – 18 years of age. Once 18 years of age, patients are referred to physicians that care for adults.

## **Vaccines:**

Kid Care Pediatrics providers believe in the efficacy of vaccines and strongly recommends patients receive state and school mandated immunizations. Elective vaccines are also offered. For families who will be refusing/declining vaccines for their children, Kid Care Pediatrics will kindly refer families to the Tarrant County Medical Society (PH# 817 732-2825) to search for other medical practices in agreement with an anti-vaccine medical philosophy.

Initials \_\_\_\_\_

## BILLING POLICIES

### **Newborns**

- Please be aware that not all plans cover newborns with automatic coverage and patients may be asked to pay for the visit in full if our office staff is not able to verify coverage for the date of service.
- Newborn charges are often put to patient responsibility because the baby has not been added to the health plan. It is the parent's responsibility to contact our office once the baby is added to the policy so that we may submit the charges to the correct insurance and they are processed correctly. If the parent fails to contact the office within filing time limits, the charges will remain patient responsibility. **Please call your insurance to add newborn within 30 days. Failure to add newborn child within 30 days may result in the child being denied coverage until the next enrollment period for the plan.**

### **Well Child Exams**

- Please be aware that a physician may bill a sick office visit (99202-99205, 99212-99215) in addition to a previously scheduled preventative visit. Per CPT coding rules the well child visit code applies only to preventative medical care but does not include any issues related to chronic diseases or acute illness. Insurance companies process these claims according to their policy guidelines and the patient may have a balance due for the unrelated sick office visit.
- All labs, hearing screen and vision screen are billed separate from the preventative office visit. Please be aware that each policy processes these charges according to your benefit guidelines and the patient may receive a bill for these services.

### **Current Insurance**

- We verify insurance benefits prior to your child being seen by our providers. We ask that you present your current insurance card at every visit so that the office staff may copy it. Failure to update our office with correct insurance information on the date of service will result in the charges being billed to the patient. We are not able to bill new insurance if it is not provided to us in a timely manner.
- Our office staff is only given a quote of benefits by your insurance company. It is never a guarantee of payment. We do our best to verify all vaccines and office visit co-pays and deductibles; however ANY portion that is applied to patient responsibility by the insurance company is due in full at the time of service. If you have any questions about your benefits we recommend you contact your insurance company so that they can explain your benefit package to you. Similarly you can ask our staff about the benefits that were quoted.

### **State Vaccines**

- If you are aware that your insurance plan has a max benefit for well care and wish to receive state vaccines, please ask at the check out window to make sure you received state vaccines. If you do not verify and pay for the state vaccines before leaving the office, and private vaccines were given, the balance due for the private vaccines will be patient responsibility.

### **Payment**

- We collect payment (fees, co-pays and deductibles) at the time of service. Statements will be mailed out monthly for any portion due that insurance may apply and payment in full is expected on receipt. Please review statements to insure accuracy from all parties. **We accept cash, personal check and all major credit cards (Amex, Visa, MC and Discover) for your convenience.** Credit card payments can be paid online at [www.kidcarepediatrics.com/payments](http://www.kidcarepediatrics.com/payments)

### **Current Information**

- The parents must update new address and phone information with the front office staff. Failure to do so will result in statements being undeliverable and accounts possibly being sent to collections.

### **Refunds**

- Refunds must be requested from the office for any credit balance you may have on your account. They will not be automatically issued. Please allow ten business days to process. Refund will not be processed by credit card transactions. All refunds will be issued by paper check.

### **Collections**

- Accounts that remain unpaid will be sent to a collection agency for further collection proceedings and will result in patients being dismissed from the practice.
- If you have a question about your account please call our office at 817.337.5503 and speak to someone in the billing department. We are happy to assist you in any way that we can.

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Parent Signature

Date