PEDIATRIC NEUROLOGY OF DALLAS
Mahshid Moein, M.D.
7777 Forest LN, Suite A-317 Dallas, TX 75230
972/566-5656 Fax 972/566-5627

Please Complete this Page and Bring to your Appointment

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____INITIAL___NICKNAME_____

SEX_____BIRTH DATE_____SSN#_____HOME PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____COUNTRY_____

FATHER'S NAME_____DOB_____HOME #_____CELL #_____

ADDRESS (*if different)* _____CITY_____STATE_____ZIP_____SSN#_____

FATHER'S EMPLOYER_____WORK PHONE_____

MOTHER'S NAME_____DOB_____HOME #_____CELL #_____

ADDRESS (*if different)* _____CITY_____STATE_____ZIP_____SSN#_____

MOTHER'S EMPLOYER_____WORK PHONE_____

LEGAL GUARDIAN(*if different from above)*_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____COUNTRY_____

EMERGENCY CONTACT (**OTHER THAN PARENT**)_____PHONE_____

REFERRING PHYSICIAN_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____COUNTRY_____

PRIMARY CARE PHYSICIAN_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____COUNTRY_____

INSURANCE CO_____INSURED_____

DOB(*if different from above)*_____ID#_____GROUP #_____

PHARMACY_____ADDRESS_____

I UNDERSTAND PEDIATRIC NEUROLOGY OF DALLAS DOES NOT ACCEPT MEDICAID.

I AUTHORIZE ***PND*** TO DISCLOSE/PROVIDE INFORMATION AT ANY OF THE PHONE NUMBERS LISTED BELOW.

I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY OF ANY CHANGE IN THESE NUMBERS.

BY SIGNING BELOW, I UNDERSTAND ***PND*** IS AUTHORIZED TO LEAVE A MESSAGE IF I CANNOT BE REACHED DIRECTLY.

I AUTHORIZE ***PND*** TO DISCLOSE THE FOLLOWING PROTECTED INFORMATION TO THE NUMBERS INDICATED BELOW: LAB RESULTS, TEST RESULTS, APPOINTMENT REMINDERS, PROCEDURES AND OTHER HEALTHCARE SERVICES.

LIST IN ORDER OF PRIORITY WHICH NUMBER WE CAN CONTACT YOU AND/OR LEAVE A MESSAGE

PREFERRED CONTACT MOM _____HOME _____WORK _____CELL

DAD _____HOME _____WORK _____CELL

SIGNATURE_____ DATE_____

BRING YOUR REFERRAL AND INSURANCE CARD OR A COPY

OF INSURANCE INFORMATION TO EACH APPOINTMENT

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Acknowledgement of Receipt for Notice of Privacy Practices and General Consent for Medical Treatment

I hereby give my consent to the Physicians of Pediatric Neurology Dallas to use the medical information of my child for the purposes of treatment, payment, or health care operations. I understand that should my child's physician be absent, this consent is transferable to the physician covering the practice. Assignment of Benefits: I request that payments of medical benefits be made to Pediatric Neurology of Dallas. I authorize release of medical information necessary to provide treatment, payment of claim, or health care operations: A photo static copy is as valid as the original.

My signature below verifies I have received a copy of the "Notice of Privacy Practices" for Pediatric Neurology of Dallas (7777 Forest Lane, Suite A-317, Dallas, Texas 75230) and that I have been provided with a copy of the office policy. I understand fees are payable at the time services are rendered and I understand the Physicians of Pediatric Neurology of Dallas do not accept Medicaid or Medicare.

_____ _____

Parent Name (please print) Patient Name (please print)

_____ _____

Parent Signature (Please print) Date

For Office Use Only

We attempted to obtain written acknowledge and receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining acknowledgement

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other - Please specify: _____

_____

Initial and Date:

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Disclosure Agreement

Patient's Name: _____

Reason for Office Visit:

☐ New Patient Neurological Exam
☐ Follow-up Neurological Exam

FOR **NON-INSURED PATIENTS:**

I/my child does not have any form of medical/healthcare insurance including Medicare or any form of Medicaid (initials)_____

IF WE ARE CONTRACTED WITH YOUR INSURANCE AND WE ARE FILING WITH YOUR INSURANCE FOR YOUR OFFICE VISITS:

Check appropriate box(es)

☐ My insurance plan covers New Patient Neurological Exams.
☐ My insurance does not cover New Patient Neurological Exams.
☐ I do not know if my insurance plan covers New Patient Neurological Exams.
☐ My insurance plan covers Follow-up Neurological Exams.
☐ My insurance does not cover Follow-up Neurological Exams.
☐ I do not know if my insurance plan covers Follow-up Neurological Exams.

I recognize that I am responsible for providing my insurance information to Pediatric Neurology of Dallas at the time of service. If I do not have this information, I must pay for the visit and will be provided a statement to file with my insurance carrier myself. (initials)_____

I agree to pay for any and all medical services I receive from the physicians of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason (i.e. non-covered services, terminated coverage, my failure to secure a referral from my primary care physician), I will pay for service upon written/verbal notice of their refusal. Failure by your insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. (initials)_____

_____ _____
Signature of Patient or Responsible Party Date

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DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO FAMILY MEMBERS/FRIENDS

Patient Name_____ Date of Birth_____

In our effort to adhere to HIPAA guidelines, Pediatric Neurology of Dallas (PND) needs your authorization to release medical/financial information connected to your child's/your care. **Please complete the information below so that we may release any necessary information to your family member(s) or friends. If you are over the age of 18, you must give authorization for our physicians/staff to speak to your parents!**

Please check the appropriate box if you do **NOT** wish this information to be released.

☐ Please DO NOT release this information.

I, the undersigned, hereby authorize PND to disclose information from my child/my medical or financial record to the following family member(s) or friends:

Name:_____ Relationship:_____

Contact information:_____

Type of information that PND can provide to them: ☐Medical ☐Financial ☐Both

Name:_____ Relationship:_____

Contact information:_____

Type of information that PND can provide to them: ☐Medical ☐Financial ☐Both

_____

Signature of Parent/Patient (if over 18) Date

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Credit Policy

All services rendered by this association are charged directly to the patient. As a courtesy we will file your insurance claims at no charge and credit their payment to your account. Unless we are contracted with your insurance carrier as a participating provider to accept what they approve, your deductible or the percentage not covered by the carrier is due at the time of service. Managed care co-pays are due at the time of service.

If you do not have insurance, payment is due in full at time of service.

Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.

Fee Disclosure Acknowledgement

We will make available our fee schedule for medical procedures upon request. Most fees are for office and/or hospital procedures. However, fees will also be incurred when you request special services in addition to your regular services. **Fees not covered by your insurance plan.** The following is a brief, non-comprehensive listing of such services:

1)	Appointments cancelled with less than 24 hours notice	$40
2)	No show appointments	$40
3)	Medical records processed to transfer	$35 and up
4)	Form completion	$10-30

Signature _____ Date_____

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OFFICE POLICY

In an effort to answer your questions and improve our efficiency, we have compiled the following office policies:

OFFICE HOURS AND APPOINTMENTS:

Office hours are 8:30 am – 4:30 pm Monday through Friday
Limited Saturday appointments are available.

APPOINTMENTS:

When calling to schedule an appointment please tell the office assistant the reason for the appointment. More acute cases are given priority. Please help us keep on schedule by arriving 30 minutes before your appointment for new patients and 15 minutes for a follow up. If you arrive more than 15 minutes late, we may have to reschedule the visit. If you do not cancel your new patient appointment at least 24 hours in advance, we may not permit you to reschedule.
In addition, there may be a charge for follow up appointments cancelled less than 24 hours in advance.

ROLE OF REFERRING PHYSICIAN:

Since this is a practice in consultative pediatric neurology, it is mandatory that each patient have a primary care physician, be it a general pediatrician or family doctor. You/your child's primary care physician will be kept informed of you/your child's progress and current neurological status. You/your child's primary care physician is the doctor you should contact for routine care.

AFTER OFFICE HOURS:

The phone is answered 24 hours a day, 7 days a week via answering service for emergent calls.
PLEASE DO NOT HAVE THE PHYSICIAN PAGED FOR NON-EMERGENT CALLS (such as prescription refills, follow up appointments). If you subscribe to "caller ID" and "anonymous call rejection", please be advised that most phones utilized by our doctor and staff have caller ID blocking and will reflect "anonymous" or "private" when your phone calls are returned. Be aware this could be a problem if the doctor or staff need to reach you with information regarding your child. There may be a charge for non-emergent after hour phone calls. This will be billed directly to you and will not be filed with your insurance carrier.

MEDICATION REFILLS:

Dr. Moein always prescribes enough medication to last until the recommended follow up visit. However, if a medication refill is needed prior to your follow up appointment, requests for medication refills should be called in during regular office hours. **Please do not request refills for medications after hours or week-ends.** Keep track of your supply of medication and request refills before running out.

STANDARD MEDICATIONS:

To request a refill for a standard medication, call our refill line at 972/566-5656. Leave you/ your child's name, date of birth, the name and dosage of the medication that you are requesting. All prescription requests are processed Monday – Friday 9am to 4pm. We require 24-hour notice for standard prescriptions. For routine refills from the retail and mail order pharmacies, have the request faxed to our office, 972/566-5627.

CONTROLLED MEDICATIONS:

These medications are strictly controlled by the State of Texas and must be written on specialized prescription forms, referred to in the past as "triplicate but now CII.

Please note the following information:

To request a prescription for these medications, call our prescription line at (972)566-5656. These medications cannot be called into the pharmacy. Please confirm your address with every request.

Upon receiving your prescription, please check the prescription before presenting it to the pharmacy for any potential discrepancy that can occur from changes in physician's directives between office visits, address change or other clerical information that might require updates or corrections. The prescription must be presented to the pharmacy and/or sent into a mail order pharmacy immediately. The written prescription expires 21 days after the date of the prescription. Due to the time involved in the process of CII prescriptions, there is a$15.00 fee for each prescription. This will not be billed to your insurance company. We accept MasterCard, Visa, Discover, American Express and cash. Credit card information is NOT kept on file and must be given at each request for the medication.

MEDICAL RECORDS:

Letters and narrative reports are routinely sent to the primary care physician. We require written consent from a parent or guardian prior to sending medical records to anyone other than your primary care physician. NO INFORMATION REGARDGING THE PATIENTS WILL BE RELEASED TO ANYONE WITHOUT WRITTEN AUTHORIZATION FROM THE PARENT OR GUARDIAN. If you want a copy of your child's records sent to another physician or for any other reason you must provide us with a written, signed authorization with the name and address where you wish the records to be sent. We require 10 working days to process the medical record requests. In addition, there may a fee charged of $25.00 for copying the records.

SCHOOL, CAMPS AND MEDICATION FORMS:

Please bring your forms to us as soon as you receive them. Be sure to fill in your CHILD'S NAME and DATE OF BIRTH along with all the portions designated to be filled out by the parents prior to submitting your form to us. If you are bringing a form with you to your appointment, in most cases, we will be able to complete your form before you leave. There are times when our office is extremely busy and you may be asked to leave the form with us for completion. If you are dropping off, faxing or emailing a form to us, please allow 3 to 5 working days to complete. We will call you when your form is ready to be picked up. There is a $25.00 form fee.

PAYMENT POLICY:

Payment is due when services are rendered. We do not file insurance with companies we are not contracted with. All office staff have been instructed to inform patients of our fee policy when appointments are scheduled. If you have any questions regarding payment you may discuss them with my office staff. We are affiliated with some HMO/PPO plans. If you are enrolled in a plan that we have a contract with you are only required to pay the co-payment/co- insurance and/or deductible at the time of service. For insurance companies we are not contracted with, we provide a receipt that has been specifically designed to enable you to file insurance yourself for reimbursement. The receipt is simply attached to your insurance form and submitted. You will be reimbursed directly according to your plan benefits.

Medicaid assignment is NOT accepted at this office.

YOUR INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO OBTAIN A CURRENT INSURANCE REFERRAL FOR YOUR APPOINTMENT PRIOR TO THE DAY OF THE APPOINTMENT. IF YOU DO NOT HAVE YOUR REFERRAL UPON ARRIVAL, WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT. PAYMENT OF YOUR ACCOUNT IS YOUR RESPONSIBILITY. Billing is automated and accounts over 90 days are automatically turned over to an agency for collection. We accept MasterCard, VISA, Discover and American Express for your convenience. We do not accept checks.

MATTER OF DIVORCED PARENTS:

Payment is the responsibility of the parent who brings the child for treatment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts; we cannot be placed in the middle.

HOSPITALIZATIONS:

Dr. Moein is affiliated with Medical City Dallas Hospital of Dallas.

Thank you for choosing Pediatric Neurology of Dallas and we look forward to working with you and your child!

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_____ _____

Parent Name (please print) Patient Name (please print)

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Parent Signature (Please print) Date

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Initial and Date:

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NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

This Notice Describes How Medical Information About Your Family May Be Used and Disclosed as Well As How You Can Get Access to This Information. PLEASE REVIEW CAREFULLY!

As required by the Privacy regulations created as a result of the Health Insurance Profitability and Accountability Act of 1996, also known as HIPAA, we are required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with the Notice of your privacy practices, our legal duties, and your rights concerning your health information.

Our office is required to abide by the terms of this Notice of Privacy Practices. As time passes our privacy practices and the law related to them may change which may require a change to this notice. The revised notice will be posted in our office. For more information about our privacy practices, or additional copies of the notice, please contact us using the information listed at the end of the notice.

Protected Health Information (PHI) includes, but is not limited to, medical records, Jab reports, referrals, radiology/imaging specialist consultations, immunization records, current demographics, insurance information, telephone conversations and/or messages.

Permissible Uses and Disclosures without Your Written Authorization
We will use and disclose health information about your family for treatment, payment and healthcare operations. For example:

Treatment: To maintain high quality healthcare, it will be necessary to share projected health information with all members of your treatment team. This can include employees in this office as well as other health care providers; we may also use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.

Payment: Necessary information will be shared with appropriate payor sources and their representatives for payment purposes including, but not limited to, eligibility, benefit determination, claim processing and utilization review. It will also be necessary for our billing personnel to have access to PHI information to carry out their billing and collection efforts.

Healthcare Operations: Necessary information will be shared for the continuing operations for this office. Some examples include, but are not limited to, peer review, accreditation, and compliance with all federal and state laws.

We may also disclose PHI to our business associates for the treatment, payment of healthcare operations, or to other healthcare providers when such PHI is required for them to treat you, receive payment for service they render to you, or conduct certain health care operations, such as quality assessment and improved activities.

Specific Authorization required for other uses and disclosures

Other uses and disclosures of your projected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form you provide. Any specific authorizations you request will remain in effect till you revoke the authorization in writing. Some examples include, but are not limited to; marketing activities, the use or disclosure of psychotherapy records in our possession, transferring of your child's medical records in our possession to other doctors and in some instances for research purposes

Other uses and disclosures may be made without your authorization

The following are situations where this office may use or disclose your PHI without your consent or authorization

- As required by law, court orders, a legal process, or government agencies
- For matters of public health for the purpose of controlling disease as dictated by law
- Disclosures may be made to public health authorities in situations of suspected abuse or neglect
- Disclosures to Institutional Review Boards of your de-identified information for the purpose of medical research

Patient Rights effective April 14, 2003

- In general, you will have the right to look at or receive a copy of your protected health information. Request for this information must be in writing and detail the information you are requesting. Some exceptions include but are not limited to: psychotherapy notes, information compiled for use in civil, criminal, or administrative proceedings. There will be an administrated charge for expenses such as copies and staff time. Please allow 5 business days for copies to be make available.

- You have the right to request a restriction of the disclosure of your protected health information for treatment, payment or operations. This office is not required to agree to the request, but will do so at our discretion based on medical and business needs. This request may not apply in some emergency situations.

- You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests. These requests must be submitted in writing.

- You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment, and healthcare operations. Only one request a year will be allowed. There will be a charge for the preparation of this information.

- You have the right to request we amend your protected health information in your medical records. If you desire to amend your records, please submit a written request with changes outlined to the Privacy Officer. We will comply with your request unless we believe that the information that would be amended is accurate and complete and or other special circumstances apply.

- You may submit a written complaint to the Director, Office of Civil Rights of the US Department of Health and Human Services if you (1) are concerned that we may have violated your privacy rights, (2) disagree with a decision we made about access to your health information, (3) disagree with a response we made to a request to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. We would ask that you first contact us regarding your problem and allow us the opportunity to resolve your issue. At no time will there be any retaliation against a family for filing a complaint.

Questions and Concerns?

If you need additional information regarding our privacy practices, or have questions or concerns please contact our Privacy Officer at 972-566-5656. If you need to contact us by mail please send your written correspondence to:

Pediatric Neurology of Dallas, 7777 Forest Lane, A-317, Dallas, Texas 75230.

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