

Pediatric Associates of Austin, PA

New Patient Information/Acknowledgement of Privacy Practices

Today's Date: _____ MEDICAL CHART #: _____

Child's Name: (L) _____ (F) _____ (MI) _____

Date of Birth: _____ Place of Birth: _____ Sex: ☐ Female ☐ Male

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Preferred E-mail Address: _____

Parent 1 Name: _____ DOB: _____ SSN#: _____ Sex: ☐ Female ☐ Male

Occupation: _____ Mobile Phone: _____ Email: _____

Parent 2 Name: _____ DOB: _____ SSN#: _____ Sex: ☐ Female ☐ Male

Occupation: _____ Mobile Phone: _____ Email: _____

Preferred Pharmacy: _____ **Location** _____

I give consent for PAA to obtain Medication History and ERX benefit information from insurance carrier ☐ Yes ☐ No

Preferred Form of Communication: (Must complete Consent for Electronic Communication, Voicemail of Medical Info & ERX)

☐ Email Address ☐ Text Message (Parent 1 or 2) ☐ Voicemail to Home Phone ☐ Voicemail to Mobile Phone

How did you hear about Pediatric Associates: ☐ Friend/Relative ☐ Web-site ☐ Insurance Plan

☐ Doctor _____ ☐ Other _____

Siblings: Child's Name (Last, First, Middle) _____ Date of Birth _____ Sex _____ Chart # _____

_____ ☐ Female ☐ Male _____

_____ ☐ Female ☐ Male _____

_____ ☐ Female ☐ Male _____

_____ ☐ Female ☐ Male _____

Primary Ins. Co. Name: _____ ID#: _____ Group #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Policyholder Name: _____ DOB: _____ SSN#: _____

Home Address: _____ Phone #: _____

Employer: _____ Work #: _____

Employers Address _____

Secondary Insurance: If you have a secondary insurance, please notify the front desk.

I UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS:

1. This office expects payment at the time of service, unless specific arrangements are made in advance with the financial counselor.
2. Insurance claims will be filed only for those insurance plans we have contracted with as a participating provider.
3. Copay's, deductibles and Non-covered services are to be paid at the time of service.
4. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to PEDIATRIC ASSOCIATES OF AUSTIN, P.A.

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH THIS OFFICE'S 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.

DATE: _____
Parent/Insured's Signature _____

Pediatric Associates of Austin, P.A.

Financial Policy

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed-care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual benefits of the plans. Each one has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated or which policy you have chosen to enroll in. Please keep in mind, while we do have contracts with most of the major carriers; we are NOT providers for many of the Affordable HealthCare Act Policies they offer.

Please read the following information carefully. If you have any questions regarding our Financial policy, you may contact our billing department.

- Before enrolling or purchasing new healthcare coverage we strongly advise that you verify, with your **INSURANCE COMPANY**, that your healthcare providers are "in- network". We only file claims for insurance policies we have contracts with. If we are "out-of-network", we still welcome you as a patient; however, you will be responsible for all charges incurred.
- We verify eligibility at every appointment; however, the information we receive is very basic. For detailed information regarding your insurance benefits, please contact your insurance company directly. **ANY SERVICE RENDERED WILL BE THE RESPONSIBILITY OF THE PATIENT IF THE INSURANCE DOES NOT COVER THE SERVICE.**
- **In order for your baby to have coverage, you MUST NOTIFY YOUR INSURANCE WITHIN 30 days after the birth of the baby.** If you miss this deadline, the baby will not be covered until open enrollment with your employer. If this happens and you do not purchase an individual policy in which we are a contracted provider, you will be responsible for payment at the time of service. Some companies will automatically cover the baby for the first 30 days, even if you do not add the baby to the plan. Please contact your insurance company or Human Resources Dept. for a more detailed explanation about newborn (first 30 days) benefits. If parents are both covered by insurance, it is possible that your baby will be double covered for the first 30 days, and you will need to coordinate benefits with both companies.
- All payments are due at the time of service; this includes any co-pay, co-ins, deductibles or private pay charges incurred. We do understand that there may be a time when paying for these services is not possible. In order to set up a payment arrangement, you will need to speak with our billing department BEFORE your appointment.
- **After-Hours Telephone Calls:** For your convenience, a nurse is available to answer after hours telephone calls. Unfortunately, most insurance companies will not pay for this service. The charge is **\$25.00** and will be billed directly to you, not to your insurance company. We will provide you with a receipt, if you would like to pursue reimbursement with your insurance plan.
- **Week-end Hours:** Our office is open on Saturday and Sunday for urgent care to help our families avoid an emergency room visit. An additional charge applies for these after-hours services, which we will file with your insurance plan; however, depending on your policy coverage, the charge may be "non-covered", meaning you will be responsible for payment.
- **Health/Camp Forms:** These requests are best managed at the time of your child's well check. Our staff may complete forms at other times as long as your child has had a well-child exam within the previous year. There is no charge for this service at the time of the well check

- **Account Guarantor:** In divorce situations, the parent who brings the child in for the visit is responsible for payment of copays and deductibles collected at the time of service. The parent who signs the financial agreement is the parent responsible for balances remaining on the account after insurance has paid. **WE ARE UNABLE TO NEGOTIATE SETTLEMENT OF YOUR MEDICAL BILLS BETWEEN YOU AND YOUR EX-SPOUSE. IF PARENTS ARE UNABLE TO RESOLVE THESE ISSUES IN ORDER TO KEEP THEIR ACCOUNT CURRENT, YOU MAY BE DISMISSED FROM THE PRACTICE for non-payment. If you have any questions, you may contact our billing department.**
- **Patient Billing/Collections:** We appreciate prompt payment of your account. If your account is past due and if a valid payment arrangement is not made or kept, your account will be sent to an OUTSIDE COLLECTION AGENCY and a 30% fee will be added to the account. In most cases, once sent to collections, the family is dismissed from the practice. To keep this from happening, please pay your bills upon receipt, or call to set up payment arrangements. We understand financial hardships may prevent you from paying your bill from time to time, but we cannot work with you if we don't hear from you. It is your responsibility to contact us about balances on your account.

I understand the Financial Policy of this office. Please initial each line below:

- _____ 1. The office expects payment at the time of service unless specific arrangements are made in advance with the billing department.
- _____ 2. I understand that it is my responsibility to know my child's insurance benefits and preventive ("well") services schedule limitations. Specifically, the number of visits allowed at each age and whether the schedule is based on a calendar year or every 365 days. I understand that well checks/and services scheduled too early or in excess of patient benefits will be patient responsibility.
- _____ 3. I understand that if my child is diagnosed with an illness while being examined for a well check, there will be two visits billed. One visit for the illness and the other for the well check. I understand that in this rare instance, a copay or deductible will apply and will be collected for the sick visit.
- _____ 4. Copay, deductibles and non-covered services are to be paid at the time of service.
- _____ 5. I understand that payments collected at the time of the appointment are only ESTIMATES and that there is a possibility that I will receive a bill in the mail for additional charges or a credit to my account.
- _____ 6. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits to Pediatric Associates of Austin, P.A.
- _____ 7. By signing below, I agree that I am responsible for balances remaining on the account.
- _____ 8. Listed below are some of the common services we offer **that may not be covered by insurance**, or that may be applied to your deductible instead of just co-pay. We are able to provide you with our charges for our services. Simply contact our billing department.
- _____ 9. I agree to keep a credit card, debit card, or HSA card on file with our office OR place a deposit on my account for an estimated patient responsibility payment of services at each appointment.
- _____ 10. I understand that if the payment card is declined for any reason an additional fee of **\$35.00** will be applied to my account (same as a bad check fee).

Hearing/Vision Screening
Developmental Screenings (M-CHAT, ASQ, PHQ)
Dental Fluoride Treatment
Cerumen (ear wax) removal
Breast Feeding Consultations
Rental or purchase of a nebulizer
Dermabond

Well-child exams that exceed Ins. Plan limitations
Vaccines (**Including refusal of vaccine resulting in waste**)
After Hours Phone calls to speak with a Nurse or Doctor
Wart Removal
Umbilical cord cauterization
Incision and drainage
Nursemaids elbow reduction

****Fees are subject to change without notice**

Signature

Printed Name

Relationship to Child(ren)

Date

Pediatric Associates of Austin

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

Pediatric Associates of Austin, P.A. (PAA) 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.**

Pediatric Associates 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 breach 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 PAA 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 your 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 your 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.

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Please acknowledge the receipt of this Notice of Privacy Practices by completing and signing the Pediatric Associates of Austin New Patient Information Form. This form is for your records.



pediatric associates of austin, p.a.

1600 W. 38TH STREET, SUITE 100, AUSTIN, TX 78731

www.pediatricassociates.net | 512.458.5323

AUTOMATIC PAYMENT AUTHORIZATION

I authorize Pediatric Associates of Austin to charge the debit card, credit card, or bank account I have provided for patient account balances of up to \$500 per account after insurance has processed and the patient's responsibility has been determined.

I understand that:

- This authorization applies to all patient accounts for which I am financially responsible.
- Multiple charges may occur if more than one patient account or service balance is owed.
- I am responsible for ensuring my payment information remains current.
- If a payment is declined, this authorization may be canceled and I remain responsible for any outstanding balance.
- I may cancel or update this authorization at any time by notifying Pediatric Associates of Austin. Requests must be received at least two business days before a scheduled payment.
- Canceling this authorization does not eliminate my responsibility to pay any amounts owed.

I certify that I am authorized to use the payment method provided and authorize these transactions.

Child(ren)'s Name: _____

Child(ren)'s Date of Birth: _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____



pediatric associates of austin, p.a.

1600 W. 38th Street, Suite 100, Austin, TX 78731

www.pediatricassociates.net | 512.458.5323

Value-Added Program

At Pediatric Associates of Austin, we are committed to providing the best possible care to our patients and families. We have been practicing in Austin for almost 50 years and we love watching our families grow and thrive. We cherish our relationship with you and hope that you find expertise and consistent quality in the services we provide.

With the new year beginning, we wanted to share some information that may be helpful to you in understanding why we charge an annual Value-Added Service fee.

It was a hard decision to begin this program. We were faced with the dilemma of declining revenue and the ability to continue the high quality of care that the doctors and patients of PAA demand.

Employing a top-notch staff and having adequate time with each patient are vital in maintaining the highest level of pediatric medical care. Stacking patient schedules and eliminating RNs and laboratory services can reduce cost. The impact this would have, however, is not conducive to providing the best patient care experience that PAA strives to maintain.

Reimbursement from insurance companies has declined since the late 1990's. Without the ability to negotiate adequate reimbursement from the insurance companies, we began our Value-Added Service Fee Membership Program in 2005 after one of the largest payers in Austin cut our reimbursement by 28%.

Pediatric Associates of Austin has many contracts with insurance companies that allow us to be in-network providers for our patient families. What you may not know is that medical practices that are in-network providers with insurance plans are unable to raise their fees. The reimbursement from the insurance companies to provide this care is dictated by the insurance company. Small practices like ours have no negotiating power. Given that there are only a few insurance companies that have the greatest market share, we have no choice but to accept what is offered. In addition, as the healthcare industry continues to evolve, we are seeing many insurance plans with no out-of-network coverage and/or they belong to narrow networks which limit the number of providers you have to choose from. We want you to know that despite the difficult financial relationships we have with insurance companies, we are working hard to keep those relationships so our patient families can continue to see us "in network".

Other private pediatric practices in Austin have faced increasing financial and administrative uncertainty as well. Many have decided to join large corporate hospital groups based outside of Austin. Pediatric Associates of Austin wants to remain a private, independent pediatric practice. We value our close relationships we have maintained with our patients over the years and we value the "family atmosphere" that allows us to keep that special relationship with our patients. We want to maintain our autonomy that allows us to continue to offer quality care and convenience to our wonderful patient families.

This fee is not voluntary and for legal reasons we cannot structure payment around services that you use or do not use or by the number of visits you have each year. We understand that paying this fee is a very personal decision for your family to make. We understand if this is something that is not best for your family. If you decide to leave the practice to seek care elsewhere and decide later you would like to return we will gladly welcome you back. If you have a financial hardship, please let us know so we can work with you so you may remain in the practice.

Thank you for entrusting your child's health care to us. We look forward to taking care of your children for years to come.

If you have any questions or concerns, please email patientcare@pediatricassociates.net

Pediatric Associates of Austin, P.A.

Benefits of Joining our Practice

March 1, 2026 – February 28, 2027

Open Saturday and Sunday

mornings for urgent care appointments.

E-Prescribing to your pharmacy both new and refilled prescriptions when appropriate so medication may be ready when you arrive there.

Ability to access our **patient portal** to communicate securely with our staff.

No charge for completion of forms for childcare centers, schools, sports, and camps. (There will be a charge for same-day form completion).

Our own **full-service website** with American Academy of Pediatrics approved medical Information.

An **in-house lab** is available at your convenience with “while you wait” results. We are a moderate complexity lab which gives us the ability to run tests that other clinics may not be able to. Every time your doctor makes the correct diagnosis the first time because the lab is right here, you pay only one co-pay.

Finger-stick technology used whenever possible—outside labs such as Clinical Pathology labs do not use finger-stick technology but rather collect blood by venipuncture (out of the arm).

Ability to **e-mail our office staff** for appointment requests, for questions about insurance and billing, to send in school and camp forms and have us send them back to you.

Pediatric nurses are available seven days a week including all holidays. Advice given during regular business hours for free and available after hours for a \$25.00 fee. As always, the on-call physician supports them.

Our On-call team will minimize unnecessary visits to the emergency room or urgent care center where they do not know your children or their medical information. This can save you hundreds of dollars on unnecessary high copayments and facility fees.

Documenting with an electronic health record system that is designed specifically for the practice of pediatrics

Our goal is to provide comprehensive, high quality medical care to your family.

We are honored to be your family's medical home!

I want to maintain a relationship with my pediatrician's office and understand that to prevent services from being reduced or eliminated, an annual value-added service fee will be charged. I agree and accept the annual fee for these value-added services. These services are not covered or required under my managed care plan. If you are experiencing a financial hardship, we will work with you so you can remain in our practice.

The annual fee is:

	<u>Fee</u>	<u>Discounted if paid by 4-1-26</u> – in addition, the family will receive one waived convenience fee at our After Hours Kids Clinic
1 Child	\$130.00	\$117.00
2 Children	\$235.00	\$211.50
3 or More Children	\$265.00	\$238.50

Parent Name: _____

Email: _____

Signature: _____

Enclosed is my payment of \$ _____

Please list your child/children below. (use back if needed)

Child's Name: _____

Date of Birth: _____

Child's Name: _____

Date of Birth: _____

Child's Name: _____

Date of Birth: _____

Child's Name: _____

Date of Birth: _____

Who is your preferred provider? Please circle:

☐ Dr. Mirrop ☐ Dr. Hargrave ☐ Dr. Gonzalez ☐ Dr. Sanford ☐ Dr. Kasbarian ☐ Dr. Gnagi ☐ Dr. Martino ☐ Lauren Karnesky, CPNP

Pediatric Associates of Austin, After Hours Kids & SportsSafe

Consent for Electronic Communication and Voicemail Delivery of Medical Information

Pediatric Associates of Austin (PAA), After Hours Kids (AHK) and SportsSafe (SS) offer Electronic Communication and Voicemail Delivery of Medical Information, in an effort to provide efficient, quality, patient-friendly medical care. In order to be HIPAA compliant, we ask that you authorize these forms of communication. **(HIPAA (Health Insurance Portability & Accountability Act of 1996) provides specific guidelines to protect patient's privacy specifically restricting Protected Health Information (PHI). Detailed information regarding HIPAA, PHI and patient privacy can be found in the Notice of Privacy Practices, which you received on your first visit to our office, following the enactment of HIPAA. Additional copies of the Notice of Privacy Practices are available at our front desk.)**

- Electronic communication means talking through texts and emails.
- Voicemail Delivery of Medical Information is available in an effort to avoid "phone tag" issues often associated with informing patients of their test results.

Electronic Communication is a great way for us to communicate with each other.

We use texts and emails:

- To remind you of appointments;
- To notify you of health services that may need to be scheduled, such as well checks, labs and/ or immunizations;
- To notify you of new services available at PAA;
- To notify you of Holiday Closures and/or Bad Weather Delays.

You can use email to:

- Send in school and camp forms to be completed; (Please allow 72 hours to complete.)
- Send non-urgent messages to our nurses/doctor;
- Request a refill for your child(ren)'s prescriptions;
- Request a Specialists name and contact information.

There are risks of using electronic communication, including:

- Someone who does not have permission to see your email may see it. Protect your cell phone, computer, user name, and password. Even if you protect your user name and password, someone might be able to guess it.
- Someone who does not have permission to see your email may break the law and hack into your account.

There may be other risks of using electronic communication not listed here. PAA, AHK and SS are NOT responsible for messages sent by mistake.

We DO NOT give emergency care by electronic communication. If you have an emergency, call 911. Additionally, we DO NOT use electronic communication to give you advice about your health, prescribe you a new medicine, or sell any information.

Patient Acknowledgement and Agreement to Electronic Communication and Voicemail Delivery of Medical Information

Please indicate which consents you wish to accept or decline, by check marking the appropriate boxes below:

☐ I have read this form. I fully understand the consent to communicate electronically. I understand the risks and agree to the terms. I agree to follow the rules of the electronic communication services, and understand that PAA, AHK and/or SS may stop communicating with me electronically if I do not follow these rules. I understand that PAA, AHK and/or SS may stop this service at any time and for any reason. Further, I understand that it is my choice to use these services. I can opt-out of, or stop using these services at any time by e-mailing PAA at patientcare@pediatricassociates.net.

☐ **I AGREE** ☐ **I DO NOT AGREE** to use these electronic services.

I prefer the following forms of communication: ☐ Email -- Preferred Email Address: _____

☐ Text messages – Preferred Cell Phone: _____

☐ **I DO** ☐ **I DO NOT** authorize PAA, AHK and/or SS, its physicians and employees to leave detailed messages specific to my child(ren)'s medical care, including test results on my voicemail. I understand that once a voicemail message exists, it is no longer covered under HIPAA, and therefore is not protected from unauthorized access. I understand that this authorization can be revoked at any time, by submitting a written request to the practice.

Name of Each Child in Practice: _____

Signature: _____ Printed Name: _____

Relationship to Children: _____ Date: _____

Patient Care Team Acknowledgment

At our practice, we are committed to providing high-quality, accessible care for your child. To best meet the needs of all of our patients, we use a **team-based care model** that includes both Physicians (MDs) and Advanced Practice Providers (APPs), such as Pediatric Nurse Practitioners.

What to expect:

- **Sick visits and same-day care** are often scheduled with one of our **APPs**, who are highly trained and experienced in pediatric care.
- **Well visits and preventive care** are typically scheduled with one of our **Physicians (MDs)**, who oversee your child's long-term health and development.

Our commitment to you:

- Our APPs and MDs **work closely together every day** to ensure coordinated, consistent care.
- All providers have access to your child's medical history and collaborate on treatment decisions when needed.
- If a situation requires physician involvement, an MD is **always** available for consultation.

This team-based approach allows us to:

- Provide **timely access** to care when your child is sick
- Maintain **continuity and quality** in your child's overall health care
- Ensure you receive the **right level of care at the right time**

We understand that families may have preferences for a particular provider, including requesting to see an MD. We will always do our best to accommodate those requests whenever possible. However:

- Availability may vary based on scheduling and urgency of the visit.
- Same-day sick visits may be scheduled with the first appropriate available provider, which is often one of our APPs.
- In some cases, waiting for a specific physician may delay appointment availability.

We value your trust and are confident in the care provided by every member of our team.

Acknowledgment

I understand and acknowledge the care model described above and agree to receive care from both Physicians and Advanced Practice Providers as part of my child's healthcare team.

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____

Date: _____

PEDIATRIC ASSOCIATES OF AUSTIN

PERMISSION TO TREAT MINOR WITHOUT PARENT/GUARDIAN PRESENT

By law, if your child(ren) need(s) medical care, a parent must give permission, except in true emergency situations. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, trying to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

When you cannot be reached for permission, we will look to this document to determine who can consent to your child's general pediatric health care. Additionally, if your child is 16 years of age or older, and you wish for him/her to see the physician without your presence, we will also need your permission.

By providing the information below and signing, you are giving permission to the physicians and nursing staff of Pediatric Associates of Austin, P.A., to diagnose and treat your children, under the care of those appointed below, in the event you cannot be present. **Please remember that those appointed below will need to provide a photo I.D. at the time of the visit. This authorization is valid until rescinded by the parent or guardian.**

Name of Minor(s)	Date of Birth	Children 16 and older can be seen without an appointed adult listed below:	Children 16 and older can receive vaccines without an appointed adult listed below:
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

I/ We, being the parent(s) or legal guardian(s) of the above-named minors(s), do hereby allow the following person (s) to act on my/our behalf in authorizing medical treatment for the above-named minors(s) during the period of my/our absence. I authorize any treatment necessary as deemed by the physicians at Pediatric Associate of Austin. Please also authorize approval or denial of vaccine administration in the area below.

Name (Relative, Friend, Babysitter, etc.)	Relationship to Child	Phone #	I authorize vaccines to be administered while under the supervision of the following person (s):
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Parent/Legal Guardian (Print Name)

Relationship to Child

Signature of Parent / Guardian

Date

Signature of Witness

Date

Pediatric Associates of Austin e-Prescribing Consent (PBM)

The providers at Pediatric Associates of Austin use an electronic medical record system that allows ePrescribing of medications. ePrescribing is defined as a physician's ability to electronically send accurate, error free, and understandable prescriptions directly to a pharmacy from the point of care, through a secure connection (Surescripts), greatly reducing medication errors and enhancing patient's safety.

Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribing program. These include:

☐ **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan.

☐ **Medication history transaction-** Provides the physician with information about previous and current medications the patient is taking to minimize the number of adverse drug reactions.

☐ **Fill status notification-** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up or partially filled.

By signing this consent form, you are agreeing that Pediatric Associates of Austin, PA may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Pediatric Associates of Austin, PA to enroll me in the ePrescribe program. I have had an opportunity to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient

Pediatric Associates of Austin, PA

Vaccination Policy & ImmTrac 2 Consent

Pediatric Associates of Austin has updated our vaccination policy in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control.

Our first and most important priority is the safety and well-being of our patients. Vaccines are among the safest and most effective ways to protect your child from diseases that can lead to serious illness or death. Vaccinating all children helps minimize exposure to vaccine-preventable illnesses for our most vulnerable patients, including newborns, children with weakened immune systems, and pregnant women.

For our current families whose children are not up-to-date on vaccinations, we require you to discuss this with your physician to create a plan to complete the necessary vaccines. We will, of course, continue to provide care for patients who cannot receive vaccines due to medical reasons.

Please note that once you have verbally consented to administration of immunizations and our nurse has prepared the vaccine, you will be responsible for the cost of the vaccine if you subsequently refuse administration, resulting in vaccine waste.

Thank you for your understanding. Your child's health is of utmost importance to us.

ImmTrac2 Consent: Consent for Registration of Child and Release of Immunization Records

I understand that, by granting this consent, I am authorizing the release of my child's immunization information to the Texas Department of State Health Services (DSHS), and the 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.
- A physician or other health-care provider legally authorized to administer vaccines, for treating the child
- 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 Texas Department of Insurance, for immunization records relating to the covered child.

I understand that I may withdraw this consent at any time by written communication to the Texas Department of State Health Services, ImmTrac Group - MC 1946, P.O. Box 149347 Austin, TX 78714.

By my signature below, I make the following choice regarding my child's participation in the Texas immunization registry (ImmTrac2):

- ☐ **YES – I GRANT** consent for registration. I wish to **INCLUDE** my child's information in ImmTrac 2.
- ☐ **NO – I DO NOT GRANT** consent. I **DO NOT** wish to include my child's information in ImmTrac 2.

ACKNOWLEDGEMENT OF VACCINATION POLICY

Child's Name: _____

Child's Date of Birth: _____

Signature of Parent/Guardian: _____

Printed Name: _____

Date: _____

Pediatric Associates of Austin, P.A.

Newsletter Signup

Pediatric Associates works very hard to communicate with our families through our Monthly Newsletters. Our Newsletters will provide valuable information relating to children's growth and development and overall health, vaccines, allergies, and seasonal topics.

We also use our Newsletter as a tool to notify you of Holiday Closings, Bad Weather Closures, Insurance plan updates, as well as dates of our seasonal Flu Clinics each year.

You may visit our website at www.pediatricassociates.net and choose "Newsletter Signup" located under "Parent Resources" on our Home Page, or complete the information below and provide to our staff at your upcoming appointment.

Thank you.

Pediatric Associates of Austin, P.A.

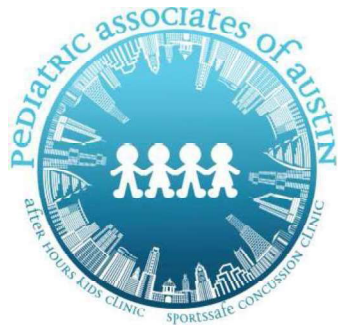
Pediatric Associates of Austin Newsletter Signup

Parent Name: _____

Preferred Email Address : _____

Preferred Phone: ☐ Home ☐ Cell: _____





1600 W. 38th Street, Suite 100

Austin TX, 78731

www.pediatricassociates.net | 512.458.5323

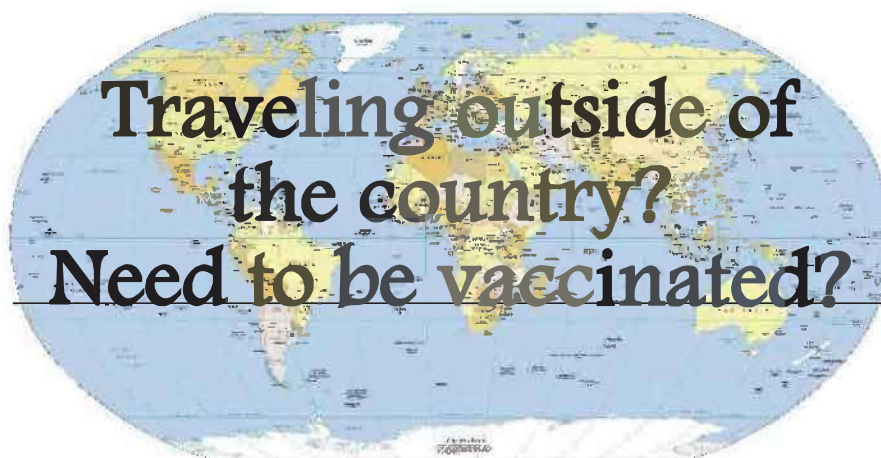
Well Check Age	Vaccination	Details
Newborn	Hep B	1 injection
1 Month	Hep B	1 injection (Must be at least 28 days after 1st Hep B)
2 Months	Pentacel (DTaP, IPV, Hib), PCV, Rotavirus (oral)	2 injections, 1 oral (Must be at least 6 weeks old)
4 Months	Pentacel (DTaP, IPV, Hib), PCV, Rotavirus (oral)	2 injections, 1 oral (Must be at least 1 month since last)
6 Months	Pentacel (DTaP, IPV, Hib), PCV, Rotavirus (oral)	2 injections, 1 oral (Must be at least 1 month since last)
9 Months	Hep B	1 injection
12 Months	Hep A, MMR, Varicella	3 injections (Must be at least 12 months old)
15 Months	PCV, DTaP, Hib	3 injections
18 Months	Hep A	1 injection (must be administered $\geq$ 6 months from dose)
2 Years	No Shots	(If up to date. Flu vaccine recommended seasonally)
3 Years	MMR, Varicella	2 injections
4 Years	DTaP, IPV	1 injection (Must be at least 4 years old)
11-12 Years	Tdap, MCV4, *HPV (Recommended and optional)	2/3* injections
12+ Years	*HPV (Recommended and optional)	(HPV is a series of 2 vaccines if started <15 years, or 3 vaccines if started $\geq$ 15 years)
16 years	MCV4	1 injection
17-18 years	MenB (Recommended and optional)	2 injections, spaced > 6 mo apart

Vaccine Abbreviation Key

Hep B = Hepatitis B
 Pentacel = Dtap + IPV + Hib
 DTaP = Diphtheria, tetanus & pertussis
 IPV = Poliovirus
 Hib = Haemophilus influenzae type b
 PCV = Pneumococcal conjugate vaccine

MMR = Measles, mumps, and rubella
 Varicella = Chicken pox vaccine
 Tdap = Tetanus, diphtheria, and pertussis
 MCV4 = Meningococcal strains ACYW
 HPV = Human Papilloma Virus/Gardasil
 MenB = Meningococcal strain B

Samuel Mirrop, MD | Lance Hargrave, MD | Ashley Gonzalez, MD | Katie Sanford, MD
 Christine Kasbarian, MD | Forrest Gnani, MD | Margot Martino, MD



If so, visit the CDC website (www.cdc.gov) and click on the traveler's health tab to choose your travel destination. You will then find information on what vaccines are recommended and other traveling tips.

At Pediatric Associates of Austin, we can provide all routine vaccines, but if you are needing travel vaccines such as typhoid or yellow fever, you will need to visit a travel clinic.

Remember that it is recommended that you receive vaccines at least 2 weeks before you travel, as it takes 2 weeks for vaccines to be effective. Some medications may need to be started prior to travel as well.

Traveling Vaccine Clinics

Passport Health Locations:

- 631 W. 38th Street, Suite 1
Austin, Texas 78705
512-459-0672
- 4501 Spicewood Springs Rd, Unit 1033
Austin, Texas 78759
512-459-0672
- 6600 South Mopac Expressway, Ste 2180
Austin, Texas 78749
512-459-0672
- 12801 Shops Parkway, Suite 400
Bee Caves, Texas 78738
512-459-0672
- 100 Heritage Center Circle
Round Rock, Texas 78664
512-459-0672
- 1335 E. Whitestone Blvd., Suite 100
Cedar Park, Texas 78612
512-459-0672

Martin's Wellness & Compounding Pharmacy

- 1509 S Lamar Blvd #550
Austin, Texas 78704
512-422-6777

Walgreens and CVS have vaccines such as typhoid or yellow fever as well. Call your local pharmacy to see if they have these vaccines available.

If you have any questions about your child's vaccines or any other travel related concerns, please leave a message for our nurses at 512-458-5323.

If you receive any travel vaccines, please let our practice know, so that we can update your child's vaccine record.