AUSTIN
1301 Barbara Jordan Blvd.,Suite 302
Austin, TX 78723

PHONE 512-472-6134
FAX 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

CEDAR PARK
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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. **Test results will not be discussed over the phone.**
2. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
3. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
4. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Pediatrix Urology of Central Texas at 512-472-6134.
6. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services and that Pediatrix Urology of Central Texas HIPAA notice of privacy practices is available on www.childrensurology.com.
7. I understand I have received information to file a complaint or that I can access it on www.childrensurology.com.
8. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. **Insurance:**
      i. I understand that health plan payment policies for telemedicine visits vary. I am responsible for any co-payments and/or deductibles.
      ii. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. **Self-Pay:**
      i. I understand that New Patients may be billed a fee of $175 and Established Patients may be billed a fee of $150 if insurance does not cover my telemedicine visit.
9. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

______________________	______________________
*Patient Name	*Date of Birth (DOB)
*Parent/Guardian Printed Name	*Parent/Guardian Signature
*Relationship to Patient	*Date

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Patient's Name: *________________________________ DOB: *____________

CHECK any symptoms

Must be completed on the day of your Telemedicine Visit

CONSTITUTIONAL: Weight loss ___ Fever ___ Chills ___ Weakness ___ Tiredness ___ **No symptoms** ___

Head and Eyes: Visual loss ___ Blurred vision ___ Double vision ___ Yellow eyes ___ Headaches ___ Concussions ___ **No symptoms** ___

Ears, Nose, Throat: Hearing Loss ___ Ear Infections ___ Tonsillitis ___ Trouble breathing ___ Bloody Nose ___ Sneezing ___ Congestion ___ Runny Nose ___ Sore Throat ___ **No symptoms** ___

SKIN: Rash ___ Itching ___ Skin issues ___ **No symptoms** ___

CARDIOVASCULAR: Chest pain ___ Palpitations ___ Swelling ___ Cyanosis (child turns blue) ___ Heart murmurs ___ **No symptoms** ___

RESPIRATORY: Shortness of breath ___ Cough ___ Productive cough ___ Pneumonia ___ Bronchiolitis ___ Wheezing ___ Chronic cough ___ Recent RSV ___ Coughing up blood ___ TB ___ Asthma ___ **No symptoms** ___

GASTROINTESTINAL: Nausea ___ Vomiting ___ Diarrhea ___ Abdominal pain ___ Blood in stool ___ Change in stool color ___ Constipation ___ Jaundice (yellow color to skin) ___ Colic ___ Loss of appetite ___ **No symptoms** ___

NEUROLOGICAL: Headaches ___ Dizziness ___ Fainting ___ Paralysis ___ Numbness ___ Tingling in hands or feet ___ **No symptoms** ___

MUSCULOSKELETAL: Muscle pain ___ Back pain ___ Joint pain ___ Joint stiffness ___ Joint swelling ___ Scoliosis ___ Muscle weakness ___ Recent injuries ___ Changes in walking ___ **No symptoms** ___

HEMATOLOGIC: Anemia ___ Abnormal bleeding/bruising ___ Sickle cell disease/trait ___ G6PD disease ___ History of cancer ___ **No symptoms** ___

LYMPHATICS: Enlarged lymph nodes ___ **No symptoms** ___

PSYCHIATRIC: History of depression/anxiety ___ ADHD ___ Behavioral/emotional issues ___ Autism Spectrum Disorders (ASD) ___ **No symptoms** ___

ENDOCRINOLOGIC: Abnormal sweating ___ Cold or heat intolerance ___ Abnormal thirst ___ **No symptoms** ___

ALLERGIES: Seasonal allergies ___ Asthma ___ Hives ___ Eczema ___ Runny nose ___ Allergies to food ___ **No symptoms** ___

UROLOGIC REVIEW OF SYSTEMS

VOIDING: Burning when urinating ___ Urgency with urinating ___ Frequency with urinating ___ Holding urine for long periods of time ___ Daytime wetting accidents ___ Bed wetting ___ Dribbling of urine ___ UTIs ___ Blood in the urine ___ Difficulty toilet training ___ Weak urine stream ___ Deflected urinary stream ___ Difficulty initiating urine stream ___ Flank pain (pain in the side and back) ___

Males:

Genitourinary: Scrotal pain ___ Testicular pain ___ Penile pain ___ Foreskin problems ___

Females:

MENSTRUAL HISTORY

Age at start of menses __________

Number of days in menstrual cycle ________

Date of start of last menstrual period _____________

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Parent/Guardian Name (Printed): *____

Parent/Guardian Signature: *____

Relationship to Patient: *__________________________________ **Date:** *_______________

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Telemedicine Patient Intake Form

**Patient Name: ***____ **DOB: ***__________________

**Primary Care Physician (PCP): ***____

Last visit with PCP: ***_____________ **Reason:* ______________________________________

**Estimated Height: ***_______ Ft. *________ In. **Estimated Weight: ***_______________ Lbs.

Current Medications: * ____

____

**Allergies: ***____

**Preferred Pharmacy: ***____

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**Parent/Guardian Name (Printed): ***____

**Parent/Guardian Signature: ***____

**Relationship to Patient: ***_____________________________________ **Date: ***_______________

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Past Medical History

Patient Name: *______________________________

Date of Birth: *______________________________

Medications

Current medications:*____

____

Allergies

List all known allergies (medications, foods, or environmental):* ______________________________________

____

Previous Hospitalization(s): *Symptom & Date*

*____

____

Previous Surgeries: *Procedure & Date*

*____

____

Has your child had any blood transfusions? **No** ____ **Yes** ____

Has your child been circumcised? **No** ____ **Yes** ____ When? ____________________

Medical Conditions/Problems

Please list any other known medical issues:

*____

____

Reason for today's visit: *____

Has your child had any lab test or x-rays for this problem? **No** ___ **Yes** ___

If YES which test, when and where were they performed? ____

____

What Pharmacy do you use? *____

Location of Pharmacy: *____

Questions for Prenatal Only

When is your Due Date? ____________________ Who will be the Baby's PCP? ____________________

Who is your Obstetrician? ____________________ Which Hospital will you deliver?____________________

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Past Medical History

Social History

Parent 1 occupation: * ________________________________

Parent 2 occupation: ________________________________

Please list names and ages of siblings:

____

____

____

Who lives in the Household? ____________________________

Child's daytime activities

Home	**No** ____	**Yes** ___
Daycare	**No** ____	**Yes** ___
Recreation/Sports	**No** ____	**Yes** ___

List sports: ____

Birth History

Illness during the pregnancy of this child:

No ___ **Yes** ___ Explain: ____________________________

Medications taken during pregnancy:

No ___ **Yes** ___ Explain: ____________________________

Delivery: **Full Term** ____

Pre-Term ____ # of weeks ________________

Late: _____

Problems during delivery:

No ___ **Yes** ___ Explain: ________________________

____

Family history

Please list any family members (parent, sibling, grandparent, or other relatives) who have had any of the following medical conditions:

Bleeding Disorder	No ____	Yes ____	If yes, relation: ________________________
Anesthesia Complication	No ____	Yes ____	If yes, relation: ________________________
Kidney Failure	No ____	Yes ____	If yes, relation: ________________________
Kidney Stones	No ____	Yes ____	If yes, relation: ________________________
UTI	No ____	Yes ____	If yes, relation: ________________________
Hydronephrosis "extra urine in kidney"	No ____	Yes ____	If yes, relation: ________________________
Hypospadias "urine opening too low"	No ____	Yes ____	If yes, relation: ________________________
Diabetes	No ____	Yes ____	If yes, relation: ________________________
Hypertension	No ____	Yes ____	If yes, relation: ________________________
Vesicoureteral Reflux	No ____	Yes ____	If yes, relation: ________________________
Other	No ____	Yes ____	If yes, relation: ________________________

Patient Past Medical History

Ear/Eye Problems	No ___	Yes ___
Seizures	No ___	Yes ___
Heart Problems/Murmurs	No ___	Yes ___
Pneumonia	No ___	Yes ___
Diarrhea/Constipation	No ___	Yes ___
Frequent Nosebleeds/Bruising	No ___	Yes ___
Anesthesia Problems	No ___	Yes ___
Diabetes	No ___	Yes ___
Developmental Problems	No ___	Yes ___
Psychiatric Problems	No ___	Yes ___
Nose/Sinus/Throat Problems	No ___	Yes ___
Headaches/Dizziness	No ___	Yes ___
Asthma/Bronchitis	No ___	Yes ___
Stomach Problems	No ___	Yes ___
Bleeding/Clotting Problems	No ___	Yes ___
Sickle Cell disease Trait G6PD	No ___	Yes ___
Cancers	No ___	Yes ___
Behavioral/Emotional Problems	No ___	Yes ___
School Problems	No ___	Yes ___
Muscle/Bone Problems	No ___	Yes ___

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Name of Patient: *____

Signature of Patient (or responsible party if a minor): *________________________________ Date:* ____________________

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Patient Information

Patient

Last Name:* ______________________ First Name:* ______________________ Nickname: ______________________

Date of Birth:* ______________________ Patient SSN: ______________________ Gender:* Male ____ Female ____ Non-binary ____

Race: American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or other Pacific Islander ___ White ___

Other: ______________________ Decline: ____

Ethnicity: Hispanic/Latin ___ Not Hispanic/Latin ___ Other: ______________________ Decline: ____

Who referred you? (Please CHECK one) FAMILY ___ FRIEND ___ PHYSICIAN REFERRAL ___ WEBSITE ___

Person referring you: ______________________ Primary Care Doctor: *______________________ Phone: *______________________

In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient.

NAME:*______________________ RELATIONSHIP: *______________________

NAME: ______________________ RELATIONSHIP: ______________________

Parent 1

Last Name:* ______________________ First Name:*______________________ DOB:* ______________________ Social Security #:*______________________

Street Address:* ______________________ City:* ______________________ State:* ______ Zip:*______________________

Cell Phone:* ______________________ Secondary Phone:* ______________________ Email:* ______________________

Marital Status:* Single ___ Married ___ Divorced ___ Widowed ___

Parent 2

Last Name: ______________________ First Name ______________________ DOB: ______________________ Social Security #: ______________________

Street Address: ______________________ City:______________________ State:_______ Zip: ______________________

Cell Phone: ______________________ Secondary Phone: ______________________ Email: ______________________

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Emergency Contact

Last Name: *______________________ First Name: *______________________ Relation: *______________________

Cell Phone:*______________________ Secondary Phone: *______________________

Primary Insurance

Policy Holder

Last Name:* ______________________ First Name:*______________________ Policy Holder's Birth Date:* ______________________

Insurance Provider: * ______________________ Insurance ID Number:* ______________________ Group Number:* ______________________

Provider Phone Number (from insurance card):* ______________________ Policy Holder's SSN:* ______________________ Relation to Patient:* ______________________

Secondary Insurance

Policy Holder

Last Name: ______________________ First Name: ______________________ Policy Holder's Birth Date: ______________________

Insurance Provider: ______________________ Insurance ID Number: ______________________ Group Number: ______________________

Provider Phone Number (from insurance card): ______________________ Policy Holder's SSN: ______________________ Relation to Patient: ______________________

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER(S) - (Check all that apply)

___ **HOME TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WORK TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **MOBILE TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WRITTEN COMMUNICATION**
- ___ OK to mail to home address

___ **PATIENT PORTAL**

Email:* ____

PLEASE INITIAL

*____ I acknowledge I have reviewed the HIPAA Notice of Privacy Practices policy at childrensurology.com. This can be found at: childrensurology.com/Patient Information/Forms & Information/HIPAA Notice of Privacy Practices.

I hereby give authorization for payment of insurance benefits to be made directly to Pediatrix Urology of Central Texas for services rendered.
I understand that I am financially responsible for all charges whether or not they are covered by insurance.

In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

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Name of Patient: *____________________________________

Signature of Patient (or responsible party if a minor): *____________________________ Date: *______________

PATIENT FINANCIAL POLICY

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PATIENT NAME: *____ **PATIENT DATE OF BIRTH:** *____________________

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE unless other arrangements have been made in advance by either you or your health insurance carrier. For your convenience we accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

INSURANCE (PLEASE INITIAL)

*____ Insurance plans subject to a deductible will be charged $150 at Check-In and the balance collected at Check-Out.

*____ I acknowledge that I have disclosed all insurance coverages. My primary insurance will not pay the claim(s) if they suspect other insurance coverage.

*____ We have contracted with many insurers and health plans to accept assignment of benefits. This means we will bill those plans and will only require you to pay the authorized co-payment, deductible and/or co-insurance at the time of service. It is the responsibility of the guarantor to know the benefits associated with their insurance plan or coverage and to obtain all referrals and authorizations from the primary care physician, when applicable. **IF YOU DO NOT HAVE A CURRENT REFERRAL OR AUTHORIZATION ON FILE, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.**

*____ In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

*____ Surgery deposits are due 10 business days prior to surgery. If for any reason surgery needs to be canceled it must be done 10 business days prior to the surgery date or a **$150 cancellation fee** may be charged to the parents.

SELF-PAY PATIENTS

*____ If you do not have insurance you will be considered a self-pay patient. Before seeing the doctor you need to make a deposit of **$150.** If the ENTIRE account is paid in FULL we will apply a 30% discount to your account. If you are unable to pay the entire account in full you will not receive the 30% discount. You will also need to make payment arrangements at CHECK-OUT with a credit card to pay the balance in full within **3 months.**

*____ We use a billing service. For any billing questions call 512-600-0125 for assistance.

*____ Telemedicine fees are $175 for new patients and $150 for established patients.

We accept VISA, MasterCard, Discover, American Express, Care Credit, cash, and checks.

ESTIMATES

*____ Upon request, our staff provides an estimate of costs for services. However, the actual cost of services is established according to the level of care needed as determined by your provider.

FEES

*____ I understand that in the opinion of our Providers, the services or items that I have requested to be provided to me at Pediatrix Urology of Central Texas may not be covered under my insurance as being reasonable and medically necessary for my care. I understand my health insurance plan determines the medical necessity of the services or items I request and receive. If my plan determines these services and/or items are not reasonable and medically necessary for my care, I am responsible for payment for the services or items I received.

*____ I understand lab work is sent to a reference lab. Pediatrix Urology of Central Texas will provide the reference lab your insurance information necessary to submit a claim. Any charges incurred are my responsibility to pay.

*____ **FEES FOR FORM COMPLETION:**
I understand I will be responsible for paying **$25** for forms completed by my physician or staff (Example: Disability forms, FMLA forms, etc.). There is a **$50** fee for Immigration forms/ letters.

*____ **FEES FOR "NO SHOW":**
I understand that a **$60** "no show" fee may be assessed for appointments that I do not keep.

I understand that a **$150** "no show" fee may be assessed for in-office procedure appointments and surgical center procedures that I do not keep.

Medicaid Members: No shows will be reported to your health plan.

*____ **FEE FOR MEDICAL RECORDS: $25**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice mayamend such terms fromtimetotime.

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NAME OF PATIENT *____

SIGNATURE OF PATIENT
OR RESPONSIBLE PARTY IF A MINOR *____ DATE* ____________________

Pediatric Urology of Central Texas, PA DBA Children's Urology. ©2022 Children's Urology.

* Required Field

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Policy for Divorced or Separated Parents

Pediatrix Urology of Central Texas providers and staff are dedicated to our patients and to providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, and psychological health. We are not party to or involved in any legal issues involving divorce, separation or custody agreements. Please read and sign the following so that we may provide care to your child(ren).

1. The physicians, nurses, medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments and office procedures **PRIOR** to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Pediatrix Urology of Central Texas must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treatment" form that authorizes any named individuals (grandparents, nannies etc.) to bring your child to our practice, be present during the visit, and consent to treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. We reserve the right to charge an administrative fee for copying records should the requests become excessive.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless required by law, or tolerate appointment scheduling/canceling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collections process will be due at the next time of service.
8. Should the issues that come between parents become disruptive to our clinic or there is non-compliance with this policy, we may immediately terminate the patient/provider relationship. Your PCP will be notified.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

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Please List Children - Name and Date of Birth (DOB):

Child's Name	DOB	Child's Name	DOB
Child's Name	DOB	Child's Name	DOB

Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date
Print - Parent/Legal Guardian	Sign - Parent/Legal Guardian	Date