Welcome!

Welcome to Premier Pediatrics of Houston! We are very excited that you have chosen us, and we are confident that you will be very pleased with the service and care we provide to your family. Please take a moment to read this short letter in order to get to know us a little better

PROVIDER
Dr. Tamecka Knight is a highly qualified and well respected board certified pediatric nurse practitioner with ten years of experience in caring for children from birth to college.

APPOINTMENTS
We see patients Monday-Friday between 7:30am and 6:00pm and Saturday from 8:00am to 1:00pm. Appointments are available for same day sick visits. We encourage you to schedule appointments; however, we are aware that occasionally walk-in appointments may be warranted. In this case, we are happy to see you as time permits between scheduled patients.

We understand that your time is valuable. We make every effort to see all of our patients on time. In order to provide you with prompt service, we need you to arrive 15 minutes prior to your scheduled appointment time *for every appointment*. If you are more than 15 minutes late, you may be asked to wait or to reschedule your appointment. Your appointment time has been reserved exclusively for you; therefore, we require a minimum 4 hour notice for cancellations. A fee may be charged for late cancellations and No Shows.

MEDICAL ADVICE
During business hours, we are happy to answer general questions over the phone. For more complex questions, please make an appointment so that we may evaluate your child and provide you with the most accurate information and the best care. Urgent matters will be addressed before the day is over. For less urgent matters we will return your call within 24-48 hours.

For after-hours advice, we offer our patients a nurse line that can answer most of your questions. In the event Dr. Knight is needed, she is always on-call and available to consult with the nurse about urgent needs. If your child needs to be seen after hours, we will refer you to a local urgent care office or the emergency department at the nearest hospital.

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What You Can Expect at an Appointment

We want you and your child to be as comfortable as possible at each visit. One way we can do this is by minimizing surprises. Here is a brief description of a typical appointment so you can prepare yourself and your child for the visit.

We require that all of our patients be accompanied by a parent or legal guardian to every appointment. In the event a parent or legal guardian is not able to accompany the child, we will accept a written note with your signature allowing a friend or family member to authorize care for your child. Patients between the ages of 16-18 years may be seen unaccompanied by an adult with the parent's written permission. We must receive written permission prior to seeing the child. **All patients under the age of 16 years must be accompanied by an adult in order to be seen.**

Arrival. Upon your arrival we will ask for your insurance card to verify your coverage and be given the opportunity to update your contact information.

Getting Started. After you and your child are called back to our Triage, your child's vital signs (weight, height, temperature, blood pressure, etc.) and history will be taken.

Physicals/Well Visits. Depending on the age of your child, in addition to vital signs, we will evaluate hearing and vision and/or draw lab work. During the appointment your child will need to remove clothing down to underwear so that we may perform a thorough exam. If your child is particularly self-conscious, we are happy to provide a gown for him/her. For older children and teenagers, a gown will be automatically provided. For patients 14 years and older, Dr. Knight will need to be alone with your child in order to give them an opportunity to discuss any issues in confidence.

Shots. The most common question we get is whether there will be any shots at a particular check-up. Shots are usually due at almost every well visit prior to age 2 and again at age 4. Further, ill children will occasionally need antibiotic and other injections and/or lab work. Therefore, we suggest that you prepare your child for the possibility of shots for every visit.

Sick and follow-up visits. Depending on the problem, your child may be asked to put on a gown. We understand that putting on a gown can be stressful for many kids but sometimes it is required to fully examine your child.

Questions. You will be given sufficient time to ask any questions you may have. Take a few moments before your appointment to gather your thoughts and to write down your questions so you don't forget them.

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IMMUNIZATION POLICY

Childhood immunizations were one of the greatest advances in public health in the 20th century. It has saved millions of children and adults throughout the world from developing meningitis, encephalitis, brain damage, severe respiratory problems, poliomyelitis, paralysis, and other severe illnesses, which can require hospitalization or cause death. And to this day, childhood immunization remains a cornerstone of pediatric care and public health.

- We firmly believe in the effectiveness of vaccines to prevent serious illnesses and save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that thimerosal, a preservative that has been in vaccines for decades does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults is the single most important intervention we perform as health care providers.

At Premier Pediatrics of Houston, we feel strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. We are committed to quality healthcare and we believe strongly in the safety, effectiveness, and the importance of these vaccines. **Therefore, our policy requires that every patient in our practice receive the vaccinations listed below or as recommended by the CDC and/or AAP:**

Immunization Schedule

2 month visit	Pediarix (DTAP/Polio/Hepatitis B), Prevnar, HiB, Rotateq (oral)
4 month visit	Pediarix, Prevnar, HiB, Rotateq (oral)
6 month visit	Pediarix, Prevnar, Rotateq (oral)
12 month visit	Prevnar, MMR, Varicella, Hepatitis A
15 month visit	DTAP, HiB
18 month visit	Hepatitis A
4 year visit	Proquad (MMR/Varicella), Kinrix (DTAP/Polio)
11 year visit	TDAP, Meningitis, HPV
16 year visit	Meningococcal

Influenza vaccine to begin yearly at 6 months of age

No Show Policy

A No Show occurs if a patient does not show for a scheduled appointment within 30 minutes ***OR*** a parent/guardian has not called to cancel a scheduled appointment at least 4 hours prior to the scheduled appointment. All insured and non-insured patients will be charged a $25.00 No Show fee for the second and third missed appointments and dismissal from the practice may result after any subsequent No Shows within a 1 year time frame. The purpose of this policy is not to punish, but rather to improve scheduling opportunities to allow for adequate use of available patient appointment slots and enhanced use of patient, staff and provider time.

- **No Show #1:** The parent/guardian for the patient will be notified of the missed appointment and advised that subsequent missed appointment, without notifying the practice within the cancellation time frame, will result in a $25.00 fee.
- **No-Show #2:** The parent/guardian of the patient will be notified by phone and receive a letter informing them of the two No Show visits and the $25.00 charge that must be paid prior to being seen for another appointment.
- **No-Show #3:** The parent/guardian of the patient will receive a phone call and letter informing them that their account has been flagged for habitual No Shows and that another no-show may result in dismissal from the practice. They will again be charged a $25.00 fee that must be paid prior to being seen for another appointment.

- Patients who No Show as a Double/Triple/Quad Appointment (2, 3, or 4 patients being seen at the same time) will be charged a No Show fee for each child who misses the appointment and may be restricted from scheduling multiples appointments in the future.
- Patients who No Show as a Double/Triple/Quad Well Child Visit appointments will be charged a $25 No Show fee for each child who misses their appointment and NO future multiple Well Child Visit appointments will be scheduled in the future.

Financial Policy

We are committed to providing the best possible care to our patients and their families and feel that this goal is best achieved if everyone is aware of our financial policy. We are doing everything possible to help keep the cost of medical care from increasing. You can help a great deal by eliminating the need for us to bill you.

Payment Procedures:
Full payment is expected at the time of service, regardless of who brings the child to the office. This includes applicable deductibles and co-payments.
We accept cash and all major credit cards. Once your balance is settled, we can provide you with insurance claim forms if applicable. A receipt must be offered to you for all payment transactions. The accompanying parent or other adult is responsible for full payment at the time of service and for providing the proper insurance identification. If there should be a dispute about the financial responsibility, we will hold the accompanying parent/adult responsible for payment.

Insurance Coverage
We participate with several insurance plans. As insurance benefit plans vary by employer, it is the policyholder/parent's responsibility to know the specific benefits of their plan. We will bill the insurance companies we participate with. If your carrier requests other information from you such as evidence of other insurance, they will not reimburse us until you provide it. If you do not do so, you will be billed for any outstanding charges.

Non-covered Services
We will always provide your child with what we consider the best and most-up to date medical care. Some insurance plans limit procedures and services in order to control their costs. As a result, certain services we may provide for your child may not be reimbursed by your plan. Except as provided by your insurance contract or by state law, we will hold you responsible for all charges not covered by your policy. We do not bill co-payments.

Secondary Insurance
We are unable to process secondary claims for you. At your request, we will be happy to provide you with a complete claim form following our reimbursement by your primary carrier.

Newborn Enrollment
It is essential that you enroll your newborn on your policy within a few days of the date of birth. We can only bill newborn services under the mother's insurance for the first 30 days following the date of birth. If you have not enrolled your newborn within the 30 day period, you will be responsible for payment at the time of service.

Most of our participating insurance contracts cover these fees, but in the event they do not, you will be responsible for these fees.

Laboratory services: We will send your lab work to the appropriate laboratory based on the insurance information you have provided to our office. We are not liable for insurance billing and balances due from outside labs. There is a charge for specimen handling and transport.

Medical Records: Upon your written consent, we will provide you with a copy of your child's medical record. There is a charge of $.75 per page for this service.

WIC forms: There is a $5.00 fee for each WIC form completed or provided outside your child's physical/well exam. Please bring forms to your appointment for faster processing.

Immunization Records: There is a $5 fee for all vaccine records requested outside an appointment for which the patient is receiving vaccines (this includes well visits). There is a $5 fee for new vaccine cards or to consolidate multiple vaccine records on one vaccine card.

Camp/Daycare/Physical/Medical Forms: There is a $10.00 fee for each camp/daycare/physical form completed or provided outside your child's physical/well exam. Please bring form to your appointment for faster processing.

Missed/No Show Appointment Fee: There is a $25.00 fee charged for appointments that are not canceled. Please call ahead, preferably at least 4 hours in advance, if you are unable to keep an appointment.

Ear Piercing: There is a $30 charge for ear piercing. This service is not billable to insurance. Ear piercing is available to infants and children age 2 months and older.

Re-billing Fee: Payment is expected at the time of service. A $10.00 refile fee will be charged to your account for every thirty days that your account is outstanding.

Collections Agency: Any charges remaining unpaid for more than 90 days from the date of service are considered delinquent and may be sent to a collection agency. In this situation, the responsible party will have to correspond with the collection agency regarding any financial arrangements and will be responsible for the original amount due in addition to any fees charged for the cost of collection.

Should you experience financial hardship, please contact our Billing Department for assistance with a payment plan. We are available Monday through Friday between 10:00am and 5:00pm.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: basis for planning your care and treatment means of communication among the many health professionals who contribute to your care legal document describing the care you received means by which you or a third party payer can verify that services billed were actually provided

- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Director of Health Information Management at Premier Pediatrics at 281-979-2112. If you believe your privacy rights have been violated, you can file a complaint with Director of Health Information Management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this hospital.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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PATIENT HISTORY FORM

Patient's Name: _____ **DOB:** _____

Birth History

Was this child O Full Term O Preterm O Adopted (at what age?) _____
How many weeks at delivery? _____
Birth Weight: _____ Length: _____
Type of delivery: O Vaginal O C-section Reason for C-section _____ NICU stay: O Yes O No
Did he/she have any problems in the newborn period? _____

Past Medical History

Please check any illnesses your child has had

O Anemia	O Heart Murmur	O Seizures	O Allergies
O Asthma	O Pneumonia _____ (date)	O Eczema	O Reflux (GERD)
O Chicken Pox _____ (date)	O RSV/Bronchiolitis/Bronchitis	O Urinary infection	O ADD/ADHD
O Recurrent ear infections	O Recurrent throat infections	O Other: _____	

List any surgeries/hospitalizations & dates: _____
List any known allergies: _____
List all medications taken on a regular basis: _____

Family History

Please indicate what family member has the following: Mother(M), Father(F), Brother(B), Sister(S), maternal grandmother(MGM), maternal grandfather(MGF), maternal aunt(MA), maternal uncle(MU), paternal grandmother

(PGM), paternal grandfather(PGF), paternal aunt(PA), paternal uncle(PU)

Anemia	Allergies	Asthma	Bleeding disorder
Bipolar	Cancer	Crohn's disease	Diabetes
Eczema	Emotional problems	Epilepsy	Heart Attack
High blood pressure	High cholesterol	Kidney Disease	Lazy Eye
Lupus	Migraines	Pneumonia	Renal disease
Sickle Cell Trait/Diease	Stroke	Thyroid disease	Tuberculosis
Ulcerative Colitis	Unexplained/Sudden Death	HIV/AIDS	Urinary Reflux

Other conditions not listed _____

Is there anything more you would like us to know about your child? _____
_____

I voluntarily authorize and consent to the child listed below to receive medical care, treatment, vaccines, and diagnostic tests that is deemed necessary by the clinicians and healthcare personnel at Premier Pediatrics of Houston, PLLC while he/she is a patient in this office or until I withdraw my consent. By signing below, I verify that I have the legal right to consent for the patient listed below and that I have read (or they were read to me in a language that I understand) and I agree to follow the policies set forth in the No Show Policy, Immunization Policy, Financial Policy, and Privacy Practices.

Patient Name: _____ Patient's DOB: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

PATIENT INFORMATION FORM

Today's date: _____
Who referred you to our practice? _____

Child's Information

Child's Legal Name: _____ **D.O.B.:** _____
Goes by/Nickname: _____ M / F:
Address: _____ Race: _____
_____ Grade: _____

Home phone #: _____ Cell phone #: _____
Insurance Company Name: #1 _____ Primary or Secondary
Policy number: _____ Group #: _____
Insurance Company Name: #2 _____ Primary or Secondary
Policy number: _____ Group #: _____

Mother's Information

Mother's Name: _____ D.O.B.: _____
Address: _____ SS#: ____ / ____ / _____
o Same as Patient _____

Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____

Father's Information

Father's Name: _____ D.O.B.: _____
Address: _____ SS#: ____ / ____ / _____
o Same as Patient _____

Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____

Siblings' Information

Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____

Emergency Contact: _____ **Relation to Patient:** _____ **Phone #:** _____

Release of Medical Records

Patient Name_____ Date of Birth_____

Address_____

_____

Phone Number_____

Please release the following health information:

☐ All Medical Records ☐ Immunization Record only

☐ Lab and XRAY ☐ ER visit

☐ Other (describe)

_____

The reason(s) for this release of information:

☐ Moving Out of Area ☐ Transferring Care ☐ Other (describe)_____

_____

☐ **Obtain records FROM** ☐ **Release records TO**

Facility:_____

Address: _____

City: _____**State:**_____

Zip:_____

FAX: _____ **Phone:** _____

Please complete info in its entirety. A facility name and number or fax number is required to process this request. Incomplete information will delay this request.

This authorization shall be in force and effective 1 year from date of signature unless otherwise stated.

Disclosures

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the office. I understand that a revocation is not effective to the extent that the Organization has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient /Parent/Guardian/Authorized Representative

Printed Name of Patient/Parent/Guardian/ Authorized Representative

_____ _____

Date

Relationship to Patient