PEDIATRIC Urgent Care
A Whole New Way To Treat Your Child

Welcome to Little Spurs Pediatric Urgent Care!

PATIENT INFORMATION **Today's Date:** **Please Provide a Photo ID**

Patient's Last Name: First: Middle: Patient's Gender: □ M □ F

Pt SSN: / / If 16 or Older: Emancipated?: Y N Patient Date of Birth: / / (mm dd yyyy)

Pt Age: Patient's Address: Apt # City: State: Zip:

Home Ph #: ( ) Cell #: ( ) Preferred Language:

Race: □ Am Indian/Alaska Native □ Asian □ Black/African Am □ White Ethnicity: □ Decline □ Hispanic/Latino □ Not Hispanic/Latino

RESPONSIBLE PARTY INFORMATION **Circle: You Are The Child's: Mother Father Grandmother Grandfather Aunt Uncle Brother Sister**

Your Last Name: First: Middle: Birth/Maiden Name:

Your Gender: □ M □ F Your SSN: / / Your Marital Status: S M W Sep Div Your Date of Birth: / / (mm dd yyyy)

Your Address: Apt# City: State: Zip: Home Ph #: ( )

Cell #: ( ) Work #: ( ) Emergency Contact: Emergency Phone:( )

How Did You Hear About Us? □ MD Referral □ Internet □ Insurance □ Friend □ Print Ad □ Drive By □ School:

Have You Seen Us On The Internet? □ Yes □ No Parent E-mail Address:

INSURANCE POLICY HOLDER INFORMATION **Check Here for No Coverage ( )**

INSURANCE POLICY # 1: **Name of Primary Insurance:** **Policy #**

Policy Holder Name: Gender: □ M □ F Policyholder Relationship to Patient:

Marital Status: S M W Sep Div Date of Birth: / / (mm dd yyyy) Policyholder Address:

Apt: City: State: Zip: Home Ph #: ( ) Cell #: ( )

Employer: Employer Ph #: ( ) SSN: / /

INSURANCE POLICY # 2: **Name of Secondary Insurance:** **Policy #**

Policy Holder Name: Gender: □ M □ F Relationship to Patient:

Marital Status: S M W Sep Div Date of Birth: / / (mm dd yyyy) Address: Apt:

City: State: Zip: Home Ph #: ( ) Cell #: ( )

Employer: Employer Ph #: ( ) SSN: / /

ASSIGNMENT OF BENEFITS FINANCIAL AGREEMENT ACKNOWLEDGEMENTS: PLEASE READ CAREFULLY

I understand that charges are NOT final until the chart has been reviewed and the billing process is completed. In the event that the account final balance is a credit, the Practice has 30 days to provide a refund to the policyholder, guarantor or other responsible party.

I authorize my insurance company to pay benefits directly to Little Spurs Pediatric Urgent Care, PLLC. I have read, understand, and agree to the Little Spurs Pediatric Urgent Care (The Practice) Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. In the event of my default, or non-payment of my bill, I agree to pay all costs of collections, reasonable attorney's fees and court costs due that may be attached as collection costs, in addition to the amount due for services rendered.

I acknowledge that Little Spurs Pediatric Urgent Care, PLLC, its' providers, owners and personnel have no control over how a claim for services rendered is processed, considered or denied by an insurance company or third party contractor, including whether or not a claim is in-network or out-of-network.

I authorize Little Spurs Pediatric Urgent Care providers and representatives to leave messages for lab results and other possible medical information at the phone numbers provided.

I hereby give my consent and authorization to The Practice, its' subsidiaries and its' practitioners to provide my medical treatment. I understand that the physician, and/or nurse practitioner and/or physician assistant will explain my condition(s), foreseeable risks, and methods of treatment for my condition(s) before treatment is provided. I authorize The Practice, its' subsidiaries and practitioners to perform any additional or different treatment that is thought necessary, should, in an emergency situation, a condition be discovered which was not known previously, I can be reached at the telephone # listed above in case of emergency results or further care is deemed necessary.

I authorize Little Spurs Pediatric Urgent Care, PLLC, to send e-mails to my e-mail address indicated above for business purposes such as surveys, announcements, events, articles, links, general medical information and marketing material. I understand that I can opt out of the e-mail program at any time by following the instructions to 'opt out'.

I authorize the release of my medical records, or in case of a minor, my child's medical records, to my primary care physician. This and any other subsequent authorizations to release Protected Health Information comply with the Privacy Practices Notice and Federal HIPAA regulations. I have been provided, or offered and declined, a copy of the Notice of Privacy Practices and Patient Financial Policies. I hereby authorize Little Spurs Pediatric Urgent Care, PLLC, and their healthcare providers to release all information necessary to my insurance company both when requested, or to facilitate the payment of my claim(s). I further agree that a photocopy of this agreement shall be as valid as the original.

As the person bringing the patient in, (the parent, the guardian and/or the custodian of the patient, or a person as allowed by Texas Law), I agree to be responsible for all services rendered to minor patients. I hold The Practice harmless for attempts to collect regardless of parental, guardian or custodial financial responsibility. I agree to be responsible for payment regardless of any divorce, separation or other outside agreements that may or may not be in effect at the time of service.

I have read The Practice Policies above regarding: Authorizations, Consents, Medical Records, Billing, Refunds, Guardian, Assignment of Benefits, Message, and email Marketing. I have read, understand and have been offered a copy of the posted practice policies: 'Patient Financial Policy', 'Notice of Privacy Practices' and the 'Notice to Patients Regarding Credit Balance and Refunds' policies. I certify the information provided is true, correct and accurate.

X

Authorized Signature of Parent, Guardian, Custodian, Patient (if 18 or over) or Person With Patient Today **Relationship to Patient** **Date**

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Today's Date: _____ Account #:_____

Patient Name _____ Date of Birth _____ Age___ Sex: M F
Nombre del Paciente Fecha de Nacimiento mm/dd/yyyy Edad Sexo

Your Name (Person Bringing Child)_____ Phone # _____Your relationship to child? _____
Su Nombre Su relación al niño /a?

Primary Doctor Name & Phone Number_____ Pharmacy_____/Cross Street_____
Médico de atención primaria y telefono Farmacia Calle Cerca

Reason for today's visit: _____
Motivo de la visita de hoy

Please circle all that apply to today's visit
Favor de marcar con un círculo todas las que correspondan a la visita de hoy:

Car Accident (Accidente automovil) **Work related accident (Accidente en el trabajo)**

General: Fever Chills Fatigue Body Aches Malaise
General: Fiebre Escalofríos Fatiga Dolores en el cuerpo Malestar

Eyes: Drainage Pain Redness Blurred Vision Injury
Ojos: Drenaje Dolor Rojez Visión borrosa Lesión/Herida

ENT: Nasal congestion Runny nose Sore throat Sores in mouth Ear pain
ENT: Congestión Secreción nasal Dolor de garganta Llagas en la boca Dolor de oído

Heart: Chest pain Palpitations Fast heartbeat
Corazón: Dolor de pecho Palpitaciónes Latidos rápidos del corazón

Lungs: Cough Chest congestion Wheezing Shortness of breath
Pulmones: Tos Congestión del pecho Sibilancias Falta de aliento

GI: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool
GI: Dolor Abdominal Náusea Vómitos Diarrea Estreñimiento Sangre en las Heces

Kidneys: Painful urination Frequent urination Blood in urine Flank pain
Riñones: Dolor al orinar Orina frecuente Sangre en la Orina Dolor en el Lado

Skin: Rash Itching Growth
Piel: Erupción Picazón/Comezón Crecimiento/Bulto

Muscles/Bones: Joint pain Joint swelling Limping Injury
Músculos/Huesos: Dolor en las articulaciones Hinchazón en las articulaciones Cojeando Herida

Neurological: Headache Dizziness Seizure Fainting Muscle Weakness
Neurológico: Dolor de Cabeza Mareo Convulsiones Desmayo Debilidad muscular

Medical Conditions (Physical/Psychiatric/Developmental) List: _____
Condiciones Médicas (Físico/Psiquiátrico/del desarrollo)

Hospitalizations/Surgeries (reason and date) _____
Hospitalizaciones/Cirugías (razón y fecha)

Current Medications (prescription and over the counter) _____
Medicamentos (receta y en el mostrador)

Medication Allergies (name and reaction) _____ **Shots up to date?** Yes No
Alergia a Medicamentos (nombre y reacción) **¿Vacunas al día?** Si No

Below for Office Use Only

* **Practitioner's Name *** _____ **Room #** _____

Wt: _____**kgs** **Ht**: _____ **cm** **Strep:** + / - **Mono:** + / - **Flu A:** + / - **Flu B:** + / - **HCG:** + / -

Time _____ **Temp** _____ RR _____ BP _____/_____ HR _____ O2 Sat _____

Time _____ **Temp** _____ RR _____ BP _____/_____ HR _____ O2 Sat _____

Orders:_____

_____

_____

_____

School Note _____ **Work Note** _____ **PE/Activity Note** _____
Date/s From To Date/s From To Restriction/s Until