Sugar Land NeoPeds Care
-Dr. Sonia Chauhan M.D.-
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Child

Name:_____Date of birth:__/___/___Sex:_____
(last) (First) (MI)

Contact Information

Mother's Name:_____Father's Name:_____

Home Address:_____

Phone | E-mail:

Home(____)_____-_____ Mother's Cell:(____)_____-_____Father's Cell(____)_____-_____

E-mail:_____@_____._____

Primary Insurance | Primary Subscriber

Primary Insurance Holder Name: _____
Type of Insurance: HMO/ PPO / POS / EPO

Date Of Birth:_____ Member ID:_____

SSN: _____-_____-_____ Group #:_____

Secondary Insurance (If applicable)

Primary Insurance Holder Name: _____
Type of Insurance: HMO/ PPO / POS / EPO

Date Of Birth:_____ Member ID:_____

SSN: _____-_____-_____ Group #:_____

Pharmacy of Choice

Name of Pharmacy:_____Phone:_____

Address:_____Fax:_____

Emergency Contact (other than parents)

Name:_____

Phone Number:(_____)_____-_____ Relationship:_____

- Office Policies/Fees -

Seen by appointment only, we do not have a set of time for walk-ins (see below)
$35.00 WALK-IN FEE (for ALL appointments)/ $35.00 for arriving 15 mins or later to all appts
$35.00 No Show Fee(Wellness Examinations Only)
$25.00 for the first 25 pages of medical records, every page after 25 pages will be 50 cents/page
Co-Payment due at time of service unless payment arrangements made prior to visit.
E-Prescribing: Physician's will send prescription written at office before lunch or end of work day.
Signature Acknowledges
-You have read and understand the above policies/Fees-
-All Information provided is correct and current.-

Signature:_____ Date:_____

Name (print):_____Relationship to patient:_____

HIPAA: Signature acknowledges you read and understand the
Health Insurance Portability And Accountability Act (HIPAA) provided by the office.

Patient Information: Credit Card on File Policy

To Our Patients:

We have implemented a policy requiring a credit card held on file. As you may be aware, the current healthcare market has resulted insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit.

Your credit card information will be held securely until your insurances had paid their portion and notified us of the amount of your share, you will receive a phone call from our office. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. This is an advantage since it makes the process easier, faster and more efficient. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask. Thank you for your understanding.

Name on Card:_____

Credit Card #_____ Exp. Date_____

Zip Code:_____

Check here if
____: I decline to give my credit card information. Please contact me for any remaining balances.

Financial Policy

Please Initial Next to each of the blanks to agree with each of the policies.

We are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.
To assist our office in establishing your financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company with any additional information requested to complete the processing of claims filed on your behalf.

REGARDING DIVORCE: Sugar Land NeoPeds Care does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse. **Initial**_____

REGARDING INSURANCE Indemnity/Fee For Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require detailed descriptions of services, please have them request in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, per-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account. **Initial**_____

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO) Each time you make an appointment with us it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current insurance and ID card at each visit. If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call us in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving our office a minimum of 72 hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the specialist. **Initial**_____

SELF PAY: Self pay rate are at discounted rate. Full balances are due at the time of service. **Initial**_____

I have read and understand that I am personally responsible for payments on this account. In this event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment. I agree to the release of any and all medical information and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release.

Guarantor Signature:_____
Date:_____

Print Name:_____ Relationship to Patient:_____

Patient(s) Name:_____
Patient's DOB:_____

Medical History

Allergies: (Include name of medication or food, reaction, and age of onset)

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight:_____ Name of Hosiptal:_____
Birth Head Circumference:_____Discharge Weight: _____
Gestational Age at Birth (weeks):_____Delivery Method: Vaginal C-section
If C-section, why? _____
APGAR scores: 1 min ____ 5 min _____ 10 min _____ Infant Feeding: Breast/ Bottle/ Both
Formula name: _____
Hearing Screening: Pass / Fail / Re-testing Heart disease screening: Pass / Fail

Medical History: (Check any that have been diagnosed and comment below)
____Hospitalizations? ____Asthma ____Allergic Rhinitis ____Eczema ____Wheezing ____Food Allergies ____Murmur ____Congenital Heart Disease
____Prematurity ____GE Reflux ____Constipation ____Anemia ____Recurrent Ear infections
____Recurrent Strep ____Urinary Tract Infection (UTI) ____Vesicoureteral Reflux (VUR)
____Diabetes ____Vision problems ____Developmental Delay ____Seizures ____ADD/ADHD
____Mental Illness ____Substance Abuse
Other Medical History:

_____

_____

Surgical History: _____No Surgeries (Check any past surgeries and complete age/date and surgeon if known)

Procedure	Date or Age	Surgeon
Adenoidectomy/tonsillectomy		
Appendectomy		
Ear Tubes		

Other Surgical History:

_____

_____

Family History		**Name**	**Living?**	**List any medical conditions**
Parents	Mother			
	Father			
Siblings	Bro or Sis			
	Bro or Sis			
	Bro or Sis			
	Bro or Sis			

	Bro or Sis			
	Bro or Sis			
Grandparents	MGM			
	MGF			
	PGM			
	PGF			

Comments (including Other responses):

_____

_____

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather For example: MGM = Maternal Grandmother

Home Environment:

Number of People at Home: _____

Lives with biological parents: Yes No Foster Care: Yes No

Primary Care Givers (circle): Parents Daycare Relatives Others:_____

Daycare (hours/day): _____ Time at Relatives (hours/day): _____ Pets: Yes No

Parent's Status: Married Divorced Single Other_____

Mother's Occupation: _____ Father's Occupation: _____