



PETERSON

MEDICAL ASSOCIATES

Location 1: 575 Hill Country Drive, Suite 101
Location 2: 1331 Bandera Hwy. Suite 3
Kerrville, Texas 78028
Phone: (830) 258-7762 Fax: (830) 258-7198

Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please complete the forms in their entirety. The paperwork may be returned in person, by mail or fax to # (830) 258-7198.

On the day of your appointment, please bring with you:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- If you use a mail-in prescription service, bring your drug formulary list that shows which medicines they pay for.
- Any over-the-counter supplements.
- Please arrive 15 minutes early for check in process.

Thank you for choosing Peterson Medical Associates as your healthcare provider. We look forward to meeting you. If you have any questions, please let us know at 830-258-7762.

Sincerely,

Peterson Medical Associates Staff

Peterson Medical Associates

PEDIATRIC REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Date: _____

IF EITHER PARENT HAS A DIFFERENT LAST NAME THAN ABOVE, PLEASE INDICATE:

Patient's address: _____

Home telephone: _____ Parent Cell: _____ Parent(s) work phone: _____

Parent's email address: _____ Patient's Age: _____

Preferred pharmacy: _____ City: _____

Mother/Guardian: _____ Date of Birth: _____ SS#: _____

Father/Guardian: _____ Date of Birth: _____ SS#: _____

Father's Employer: _____ Work phone: _____

Mother's Employer: _____ Work phone: _____

Primary Insurance Co: _____ Address: _____

Policy #: _____ ID#: _____ Group #: _____ Effective Date: _____

Policy Holder: _____ Office visit co-pay amount: _____

Emergency contact: _____ Relationship to patient: _____

Phone #: _____ Responsible Party's Driver's License #: _____

How did you hear about our practice?

I understand that I am responsible for all professional services performed by the physician or his staff. I am responsible for all services not covered or denied by my insurance company. Copayments are due at time of visit.

X _____

Date _____

Peterson Medical Associates

PEDIATRIC INTAKE FORM

Patient's name: _____ Today's date: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Reason for today's visit: _____

Prenatal History

Mother's age at child's birth: _____ Mother's health during pregnancy (circle any that apply): bleeding, hypertension, diabetes, cigarettes, alcohol, drug use, thyroid problems, medications, illnesses, physical trauma

Birth History

Term: (circle) Full Premature Late Length of labor: _____ Birth Weight: _____

Did your child have any of the following problems shortly after birth? (circle any than apply): rashes, jaundice, colic, birth injuries, seizures, fever, cerebral palsy, blue baby, birth defect, other (specify) _____

Breast fed? Yes / No If yes, how long? _____ Formula type: milk soy other

Any food allergies noted so far? (specify) _____

Age began: sitting _____ crawling _____ walking _____ talking _____

Diet/Exercise

What is your child's main source of fluid intake? _____ Favorite food: _____

Does your child drink sodas of any kind? Yes / No If yes, how many per day? _____

Does your child eat fast food more than twice per week? Yes / No If yes, how many times per week? _____

Does your child participate in any regular sports activity? Yes / No Which sport(s)? _____

School Environment

What type of school does your child attend? Public Private Homeschool Other Grade: _____

Is your child currently experiencing any academic difficulties? Yes / No If yes, please describe briefly: _____

Medical History

Medication allergies: (list) _____ Environmental allergies: _____

Has your child had or have: (circle) chicken pox, pneumonia, rheumatic fever, frequent colds, tonsillitis (# of times _____), ear infections (# of times _____), strep throat (# of times _____), asthma, diabetes, head concussion

List any medications your child is currently taking: _____

Has your child had any of the following:(circle) hearing test, speech or language test, psychological evaluation, electroencephalogram(EEG), injuries requiring surgery or hospitalization? Please list: _____

Does your child wear glasses, contact lenses, braces, retainers, or any prosthesis? _____

Does your child use a seat belt or sit in a child safety seat EVERY time they ride in a car? Yes / No

Does your child wear a helmet when he/she rides a bike? Yes / No

Did you bring your child's immunization record with you today? Yes/ No

Peterson Medical Associates

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your scheduled appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged \$25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written warning notification if you miss 2 appointments.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

Medication Refills: For non-emergency, and routine medication refills, please allow 48 hours and ask your pharmacy to send us a refill request. For any narcotic medications (ex. Norco, ADD meds) please allow 5 days notice. Also, please let a nurse or physician know if you need a 90 day prescription. Narcotic medications will only be written for a 30 day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill requests.

AFTER CLINIC HOURS (4:45 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at **830-258-7762** and following the instructions as given.

Please remember that your appointment is to focus on your medical needs. *If your family member, who is also our patient, has any medical needs (including medication refills), we will be happy to schedule an appointment for them at the conclusion of your office visit.*

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

Signature

Date

PETERSON MEDICAL ASSOCIATES

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as a part of the provision of healthcare services, Peterson Medical Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis's, treatment, and any plans for future care or treatment.

The Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information is posted on the first floor at 575 Hill Country Drive in the foyer. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

PATIENT OR PERSONAL REPRESENTATIVE
OR GUARDIAN'S NAME PRINTED

DATE

PATIENT OR PERSONAL REPRESENTATIVE
OR GUARDIAN SIGNATURE

SOCIAL SECURITY NUMBER
(FOR IDENTIFICATION PURPOSES ONLY)

WITNESS

DATE

Peterson Medical Associates
575 Hill Country Drive, Ste 101 / 1331 Bandera Hwy, Ste 3
Kerrville, TX 78028
(830) 258-7762

PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Peterson Medical Associates to disclose my protected health information to:

_____ Family member(s) (List): _____ Ph #: _____

_____ Ph #: _____

_____ Non-family member(s) (List): _____ Ph #: _____

_____ Myself only

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

_____ Test results, reports, and general health updates

_____ Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

e-mail: _____

_____ Please send a detailed message to my email address.

_____ Please send a message that only includes a call-back number and name at the doctor's office.

Home: _____ **Cell:** _____

_____ Please leave a detailed message on my answering machine/voice mail.

_____ Please leave information with any of the individuals listed above.

_____ Please leave a message with only call-back information with either an individual or on my answering machine / voice mail. Call back information will include doctor's name and staff member's name.

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

Patient Signature

Date