DR. AMY JATZLAU, M.D., P.A.
219-B E. Railroad
Giddings, TX 78942

NEW PATIENT - DEMOGRAPHICS

Today's Date: _____

DUE TO NEW HEALTHCARE RULES, ALL PATIENT INFORMATION NEEDS TO BE COMPLETELY FILLED OUT.
!!INSURANCE IS NOW REQUIRING PATIENT SOCIAL SECURITY NUMBER FOR CLAIMS OR THEY WILL NOT PAY!!

DRUG ALLERGIES: _____ REACTION: _____

PATIENT INFORMATION – FULL LEGAL NAME

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: (Jr., III, IV): _____ Date of Birth ____ / ____ / ____ Sex: _____ Social Security #: _____ - _____ - _____

Address: _____ City _____ State _____ Zip _____

** PREFERRED PHARMACY **

Name & Address: _____ Phone (___) _____-_____ Fax (___) _____-_____

GUARANTOR INFORMATION – RESPONISIBLE PARTY – FULL LEGAL NAME

Relationship of Guarantor to Patient: ____ Self ____Mother ____Father ____Other: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____ / ____ / ____ Sex: M _____ F _____ E-mail Address: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Social Security #: _____-_____-_____

Employer Name: _____ Occupation: _____ Work Phone (____) _____-_____

OTHER PARENT / GUARDIAN INFORMATION – FULL LEGAL NAME

First Name: _____ Middle Name: _____ Last Name: _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____ / ____ / ____ Social Security _____-_____-_____ Sex: M _____ F_____

Home Phone: (____) _____-_____ Cell: (____) _____-_____ E-mail Address: _____

!!! INSURANCE INFORMATION - ALL INFORMATION IS TO BE COMPLETED FOR BILLING !!!

PRIMARY COVERAGE - INSURANCE / MEDICAID / CHIP

Plan Name: _____ Name of Policy Holder: _____

Insured's Social Security: _____-_____-_____ Date of Birth: ____ / ____ / ____ Relationship to Patient: _____

Policy / ID #: _____ Group #: _____ Eff. Date: _____

SECONDARY COVERAGE - INSURANCE / MEDICAID

Plan Name: _____ Name of Policy Holder: _____

Insured's Social Security: _____-_____-_____ Date of Birth: ____ / ____ / ____ Relationship to Patient: _____

Policy / ID #: _____ Group #: _____ Eff. Date: _____

** EMERGENCY CONTACT INFORMATION **

NAME _____ Relationship _____ Phone (____) _____-_____

CONSENT TO TREATMENT

I give permission for the following people to bring and authorize treatment for my child if I am NOT able to.
I HEREBY CONSENT TO EVALUATION, TESTING, AND TREATMENT AS DIRECTED BY DR. AMY JATZLAU, M.D., P.A. & STAFF.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Parent /Guardian Signature: _____ Date: _____

PATIENT NAME: _____ DOB: _____

REASON FOR TODAY'S VISIT: _____

SIBLINGS

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

HAVE YOU EVER BEEN HOSPITALIZED FOR: SURGERIES, OPERATIONS, OR ILLNESS

Reason:	Date:
Reason:	Date:

CURRENT MEDICATIONS & DOSAGE

Name:	Dosage:	How Often?
Name:	Dosage:	How Often?

PAST MEDICAL HISTORY

PATIENT		FAMILY	
Recent Weight Loss		Frequent Headaches	
Frequent Headaches		Seizures	
Seizures		Eye Disease (Not glasses)	
Eye Disorders		Hearing Disorder	
Hearing Disorder/Ear Infections		Arrhythmia/Heart	
Recurrent Nose Bleeds		Constipation/Diarrhea	
Frequent Sinus/Throat Infections		Bed Wetting (after age 10)	
Heart Problems		Neurological Problems	
Frequent Urinary Tract Infection		Mental Retardation	
Neurological Problems		Immune Problems (HIV/AIDS)	
Nasal Allergies		Asthma	
Asthma/Bronchitis/Pneumonia		Anemia or bleeding problems	
Anemia/Bleeding Issues		Diabetes/Anxiety/Mental	
Diabetes		Rashes	
School Problems		Kidney Disease	
Depression/Anxiety		Allergies (nasal)	
Rashes		Tuberculosis	
Chicken Pox		High Cholesterol	
FEMALES ONLY: Have you begun your menstruation:		YES NO	
If so, Date of last period:	Are you on birth control?		Yes No

I consent to the use/disclosure of my child's protected health information for the purpose of diagnosing, providing treatment, obtaining payment, operations or referrals.

** NOTICE TO ALL MEDICAID RECIPIENTS **

This to advise that there are certain tests and procedures, which are NOT covered under the Medicaid program and the parent/guardian will be responsible for payment of services.

Parent/Guardian Signature: _____ Date: _____

DR. AMY JATZLAU, M.D., P.A.

GOVERNMENT REGULATIONS

In an effort for us to remain compliant, we ask that you complete the following questions for the patient being seen.

!INSURANCE IS NOW REQUIRING PATIENT SOCIAL SECURITY NUMBER FOR CLAIMS OR THEY WILL NOT PAY!

Patient Full Name: _____ **Suffix:** _____ **DOB:** _____

Social Security Number: _____ - _____ - _____

PREFERRED LANGUAGE:

___ English ___ Spanish ___ Sign ___ German ___ Refused by Parent/Guardian

RACE:

___ White ___ Black ___ Hispanic ___ Asian ___ American Indian ___ Unknown ___ Refused

ETHNICITY: ___ Hispanic ___ Not Hispanic Origin ___ Refused By Parent/Guardian

Mother's Maiden Name: _____

Mothers Date of Birth: _____ **Living:** ____ **Deceased:** ____

Fathers Date of Birth: _____ **Living:** ____ **Deceased:** ____

Does the patient smoke? ____ Yes ____ No

1. Never smoked: _____
2. Current everyday smoker: _____
3. Current some days smoker: _____
4. Months Unknown if ever smoker: _____
5. Former smoker ____ Quit ____ Years _____
6. **Refused By Patient:** _____

DR. AMY JATZLAU, M.D., P.A.

ACKNOLWDGEMENT OF POLICY & PROCEDURES

I HAVE READ AND FULLY UNDERSTOOD THE POLICIES AND PROCEDURES THAT THE CLINIC HAS GIVEN ME. IF I HAVE ANY QUESTIONS I WILL ASK THE FRONT DESK FOR HELP.

'atient Full Name: _____

'arent / Guardian Signature: _____ Date: _____

*****PLEASE SIGN & RETURN TO FRONT DESK*****

Medical Records Request
Dr. Amy Jatzlau, M.D., P.A.

Authorization for Release of Healthcare Information

Patient Name:_____ DOB: _____

I hereby authorize the transfer/receipt of the following healthcare information:

From:	To: Dr. Amy Jatzlau, M.D.,P.A.
Address:	Address: 219-B E. Railroad Giddings, TX 78942
Phone:	Phone: (979) 542-0710
Fax:	Fax: (979) 542-0748

Please select all the specific documents that apply to your request:
I do hereby consent and authorize for release copies of my medical records.

	Clinic Notes		Radiology Reports		Nurses Notes		Emergency Room
	Progress Notes		Lab Reports		Operative Reports		Urgent Care
	History & Physical		Pathology Reports		EKG, EEG, EMG		Doctor Consults
	Discharge Summary		Physician Orders		Other:		

Purpose of your request: ____ Continuing Patient Care Other:_____

I understand that specific information to be released may include, but is not limited to history, diagnosis and drug or alcohol abuse, mental/physical related illnesses or communicable disease, including HIV and AIDS. I understand this consent can be revoked at any time except to the extent that disclosure made in good with occurred in reliance of this consent. The revocation must be in writing and delivered to Dr. Amy Jatzlau. It is further understood that the information released is for that specific purpose stated above and may not be in whole or part to any other agency, organization, or person. Information used or disclosed pursuant to this may be subject to re-disclosure by the recipient and is no longer protected. Pediatric Associates, its employees, partners and providers are release from legal responsibility for the release of the above information to the extent indicated and authorized herein.

THIS CONSENT WILL EXPIRE IN 180 DAYS, AFTER THE DATE OF SIGNATURE

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Relationship to Patient Witness Date

DR. AMY JATZLAU, M.D., P.A.
OFFICE FINANCIAL POLICIES & PROCEDURES

Welcome to the office of Dr. Amy Jatzlau, M.D., P.A. My staff & I are committed to giving you the quality medical care you deserve. We strive to make your visits to our office as comfortable as possible. Please read these policies so that you will have a clear understanding of how our office operates.

OFFICE HOURS

CLOSED FOR LUNCH DAILY: 12:00P.M. - 1:00P.M.

Monday & Tuesday – 8:00am – 4:30pm

Wednesday 8:00a.m. - 4:00p.m. Thursday 8:00a.m. - 12:00p.m. Friday – 8:00am – 4:00pm

APPOINTMENTS

****New Patients if possible, request a new patient packet prior to your appointment. New patients will be asked to arrive 30 minutes early to complete paperwork and insurance information.** New Patient Appointments will NOT be reschedule if you miss your appointment without 24 hour notification, considered a NO CALL NO SHOW.
****All established patients MUST check in 15 minutes early to show insurance card and collect copay,** as well as to fill out well child check up forms and update patient information if needed. To reschedule or cancel an appointment contact our office at least 24 hours prior to your appointment time.. You may leave a message at anytime, day or night, regarding rescheduling an appointment and we will contact you to reschedule. In any urgent situation, please call our office and we will make every effort to provide you with with an appointment as soon as possible. All patients require an appointment to be seen we are not a walk-in-clinic.

*** NO CALL – NO SHOW POLICY ***

1st NO-CALL NO-SHOW - You will receive a warning letter stating that you missed your appointment.
2nd NO-CALL NO-SHOW – You will be charged $25 non-refundable fee prior to schedule next appointment.
3rd NO-CALL NO-SHOW – We will no longer schedule appointments for your child and a new pediatric clinic will need to be selected. With your authorization, we will release records to your new provider when requested.

We are trying to make sure that your child as well as others, receive the best possible care. If you have Medicaid, we report no calls no shows to them and they will contact you.

COVERAGE - PRIVATE INSURANCE, MEDICAID, & CHIP

****If Unable To Verify, You Will Be Given The Choice Of Rescheduling Or Be Considered Private Pay****

I hereby authorize direct payment of my insurance benefits to Dr. Amy Jatzlau, M.D., P.A., individually for services rendered to my dependent(s) by the physician or her staff under her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Dr. Jatzlau, M.D., P.A. is unable to collect from my insurance carrier for whatever reason. Verification of your plan benefits and Coverage is required. Payments, co-pay's, deductibles, or fees for non-covered services must be made prior to visit. MEDICAID requires you to show your card EVERY visit.

REFERRALS

Referrals may take anywhere from 24-72 hours to be approved by insurance once they are approved our office or the specialist should call parent and arrange appointment. In order to speed up process in regards to referrals made from our office to a Specialist, PT, OT, or DME Equipment & Supplies, we must have a current up to date insurance card on file to expedite process. If you insurance is an HMO (example: BCBS, Tricare, CHIP, Medicaid, etc). IT is YOUR responsibility to contact our office at least 7-14 days, to let us know about any necessary referrals BEFORE appointments are made. HMO plans will NOT pay for a visit to a specialist with out a referral from your PCP, making YOU responsible for payment in full.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify that I have received and read a copy of Dr. Jatzlau's Patient Information Privacy Policy. I hereby authorize Dr. Jatzlau & staff to individually release my dependent(s) medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

METHOD OF PAYMENT

We accept cash, checks, and Credit Cards including Visa, MasterCard, Discover, and American Express. Ther will be a $25.00 charge on any returned check and this must be paid in cash or cashiers check. Checks will n longer be accepted after a check has been returned. In that case only cash or Credit Cards will be accepted only.

FINANCIAL ARRANGEMENTS / GUARANTEE

In situations where either spouse has responsibility for providing health care coverage for a child this informatio must be made available to the billing department prior to the visit. Unless arrangements for payment are mad prior to visit, whoever brings children in will be responsible for the full amount charged.

MINORS

Parents/Guardians of minors are responsible for providing insurance information and copay's. Minors must have a signed authorization for medical treatment by parent/guardian on file. If accompanied by someone other than a parent/guardian, this will be needed before appointment. To assist us in updating your accounts please notify the front desk of any changes such as insurance, address, or contact info.

AFTER HOURS

In an emergency, go to the nearest Emergency Room/Urgent Care Center. If you are unsure if this is a tru emergency, call St. Mark's Medical Center at 979-242-2200. Non-urgent calls left on our voicemail, will b answered within 24 hours of next business day. Please speak loud and clearly when leaving voicemail, spell you name and leave a phone number so that we may return to your call.

DO NOT LEAVE URGENT OR EMERGENCY MESSAGES ON VOICEMAIL

RX REFILLS

If your child is on "maintenance medication" (Ritalin, Concerta, or other ADHD/ADD Medications) this medicatior needs to be requested from our office 7 days PRIOR to running out. You should make an appointment to see the doctor 2 weeks before any maintenance medications run out. Other refills may be filled by calling your pharmacy and have them send us a request via fax.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Dr. Jatzlau & her staff representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Amy Jatzlau, M.D., P.A. to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

MISCELLANEOUS

For the safety and comfort of all our patients, please do not bring children that DO NOT have appointments to the office visit. Also please limit the number of adults in patient rooms to only 2 adults.

NO FOOD/DRINKS - allowed in waiting room or patient rooms. (Sippy cups & bottles are welcomed).

NO CELL PHONE - use at check-in/out and once patient has been brought to their designated room.

** VERBAL ALTERCATIONS OF ANY KIND IN CLINIC OR ON THE TELEPHONE WILL NOT BE TOLERATED. NEGATIVES REMARKS TOWARD OUR STAFF OR PHYSICIAN MAY RESULT IN RESCHEDULING, CANCELING, OR PATIENT MAY BE FIRED FROM CLINIC.**

While we are doing our best to make your visit as pleasant as possible, please assist us in taking part and helping everyone else feel comfortable at all times, we welcome suggestions and comments. Our policies are established in an effort to provide quality care to all our patients and we thank you for your help in accomplishing them.

Sincerely,

Dr. Amy Jatzlau, M.D., P.A.