PEDIATRIC *Urgent Care*

Welcome to Little Spurs Pediatric Urgent Care!

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 One: 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: / /

Check here: O if address is the same as patient's (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 Other:

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 Relationship to Patient:

Marital Status: S M W Sep Div Date of Birth: / /

Check here: O if address is the same as patient's. (mm dd yyyy)

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

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

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: / /

Check here: O if address is the same as patient's. (mm dd yyyy)

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

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

ASSIGNMENT OF BENEFITS FINANCIAL AGREEMENT HIPAA INFORMATION

I understand that charges are NOT final until the chart has been reviewed and the billing process is completed. In the event that the final balance on the account or invoice is a credit, the Practice has 30 days to notify the policyholder, guarantor or other responsible party by US Mail that a credit balance is on the account. In the event of no response to the notification, I authorize the credit to remain on my account and applied to any future services.

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 collection costs, reasonable attorney's fees and court costs that may be added to the account 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 an insurance claim for services rendered is processed, considered, approved 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. If the patient is a minor, I, as custodian of the child, give my consent and authorization to The Practice, its' subsidiaries and its' practitioners to provide treatment for the minor patient. 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 the known condition(s) before treatment is provided. I authorize The Practice, its' subsidiaries and practitioners to perform any additional or different treatment(s) that is(are) necessary as deemed by the professional opinion of the Dr., NP or PA. Should a condition be discovered which was not known previously, I certify that I can be reached at the telephone # listed above in case of emergency, emergent test results, and/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 Notice of Privacy Practices, the 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**

PEDIATRIC Urgent Care

Today's Date: _____ Account #:_____

Patient Name _____ **IDENTIFY THE PATIENT** 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?

Address_____ City_____ State _____ Zip _____

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: **Car Accident** **Work Related Accident**
Favor de marcar con un círculo: **Accidente automovil** **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)

Any Allergies To: Meds? Y N _____ **Foods?** Y N _____ **Latex?** Y N
Alergias A: ¿Meds? Si No **¿Comidas?** Si No **¿Latex?** Si No

Shots up to date? Y N
¿Vacunas al día? Si No

First Day of last menstrual period (if applicable):_____
¿**El Primera Dia** de su ultimo periodo menstrual? (regla)

++**Below: For Office Use Only**++

IDENTIFY PATIENT: @TRIAGE: DOB__NAME__ @PROVIDER: DOB__NAME__ @Lab: DOB__NAME__ @ X-Ray:DOB__NAME__

******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