Pathways
Developmental Pediatrics
Personalized care for individual minds

Phone Consultation Registration Form

I am honored to be involved in the care of your child, and look forward to speaking with you.

Even though I will not be meeting with your child, I will be providing medical advice and recommendations. Therefore, the following forms must be completed in order to schedule a phone consultation.

I look forward to speaking with you.

Warmly,
Evelyn Frazier, MD

Patient Registration

Contact Information

Today's Date: _____

Child's Full Name: _____

Nickname:_____ Gender:_____ Date of Birth_____

Parent 1: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Parent 2: _____ ☐ Mother ☐ Father ☐ Guardian
Full Name

_____
Street Address City, State Zip Phone Number

Best number where you can be reached?_____

Emergency Contact Information: _____

Name

_____

Relationship Phone

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Billing Information

Primary Insurance Co: _____ Policy ID#_____

Policy Holder's Name: _____ DOB: ___/___/___ SSN:____-____-____

Address: _____

Consents

Consent to Treatment of a Minor Child:

I request and authorize Pathways Developmental Pediatrics PLC, physician(s) and staff to perform necessary services for my child which are deemed advisable by the physician(s), whether or not I am present at the appointment.

_____ **(INITIAL)** I hereby authorize the following individuals to bring my child, listed above, in for treatment. These named individuals may also receive test results, and information pertinent to the treatment and care of my child.

1. _____

Name Relationship to Patient Phone

2. _____

Name Relationship to Patient Phone

3. _____

Name Relationship to Patient Phone

4. _____

Name Relationship to Patient Phone

Consent to Receive Emails and Text Messages about Appointment Reminders:

_____ **(INITIAL)** I consent to receive emails and text messages from Pathways Developmental Pediatrics, PLC at my cell phone number, and any number forwarded or transferred to/from that number to receive appointment reminders. I understand that this request to receive emails and text messages will apply to all future appointment reminders unless I request a change in writing.

The email that I authorize to receive messages for appointment reminders is:

_____

The cell phone number that I authorize to receive text messages for appointment reminders is:

_____

Note: Pathways Developmental Pediatrics, PLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

_____ **(INITIAL)** I permit Pathways Developmental Pediatrics, PLC and the physician(s) or other health professionals involved in care to release healthcare information for purposes of treatment, payment or healthcare operations.

The above is in effect until revoked in writing by me, and receipt acknowledged by Pathways Developmental Pediatrics PLC.

_____

Parent/Guardian Signature **Name** **Date**

Acknowledgement of Notice of Privacy Practices

I was provided a copy of Pathways Developmental Pediatrics, PLC Notice of Privacy Practices which outlines how this practice may use and disclose my protected health information. I have been able to review and ask questions about the content in this notice.

I am aware that there is an additional copy of the Notice of Privacy Practices on the website of Pathways Developmental Pediatrics, PLC as well as posted in their clinic.

I acknowledge that I have received the Notice of Privacy Practices.

_____

Parent/Guardian Signature **Name** **Date**

Financial and Cancellation Policy

Pathways Developmental Pediatrics is a private practice dedicated to providing personalized care for patients and families. Discussing and understanding financial and patient responsibilities is an important step in our partnership, and one that helps to ensure an aligned and sustainable medical relationship.

Please read this thoroughly and ask Dr. Frazier any questions that you may have

Patient Visits:

- I understand that Pathways Developmental Pediatrics participates in select insurance plans as listed on the website. Dr. Frazier is an out of network provider for all other insurance plans.
- I understand that I am responsible for determining if referrals are necessary for insurance reimbursement, and requesting these referrals.

For participating insurance plan holders:

- I understand that all services will be submitted to my insurance plan. Coinsurance and deductibles are my responsibility, and will be accepted at the time of service.
- I understand that some services may not be reimbursed by my insurance plan, and I agree to pay any balances not covered by my insurance plan as outlined in the Fee Schedule.
- I acknowledge that my insurance card must be available at the time of service, or I will be charged the fee-for-service rate.

For all other health insurance policy holders:

- I agree to pay for each visit at the time of service in accordance with the published fee schedule.
- I understand that payment is due at the time of service.

Parent's Initials: _____.

Payment Policy:

- Pathways Developmental Pediatrics uses a secure, third party appointment booking program. This company stores your credit card payment information, and only the last four digits of your credit card number can be seen.
- I understand that co-pays and other out of pocket expenses will be charged at the completion of my appointment to the credit card I have put on file.
- I understand that out of pocket expenses incurred between visits will be charged to this credit card on file immediately. These expenses include, but are not limited to, no-show/late cancellation fee, telephone encounters, refills, and forms fees.
- If my participating insurance policy is subject to deductibles and/or co-insurances that cannot be collected at the time of service, I understand that Pathways Developmental Pediatrics will charge my credit card on file any outstanding balances as outlined on my Explanation of Benefits (EOB).
- It is my responsibility to understand my insurance policy and if referrals or prior authorizations are required.
- I agree to update my credit card on file when needed. I will receive a paper statement, which must be paid within 30 days, in the event my credit card on file cannot be charged.
- Payment of all statements is due upon receipt in order to remain in good standing with the practice. If charges remain unpaid, despite reasonable efforts on the part of Pathways Developmental Pediatrics to secure and notify me of necessary payments, I understand that my statements will be sent to a collection agency, and that treatment at Pathways Developmental Pediatrics cannot ethically be continued.

Parent's Initials: _____.

Cancellation Policy:

- I understand that I will be charged 50% of the visit fee if I cancel less than 48 hours prior to my appointment time, or after 11am on Fridays for Monday appointments.
- I understand that I will be charged the full visit fee if I cancel 24 hours prior to my appointment time, or no-show for my appointment without cancellation.

Parent's Initials: _____.

Late Arrival Policy:

- Dr. Frazier wants all patients to have the opportunity to be seen for his/her entire scheduled visit time. Thus, she operates under a "therapist" model; meaning, each appointment has a dedicated length of time.

- I understand that arriving late for my appointment may result in my visit being truncated to allow for others to be seen on time.
- I also understand that a shortened visit may result in an incomplete assessment, and I may need to return for further assessment.
- I also understand that if I arrive late for the visit, I may not be seen, and will still be required to pay for the appointment.

Parent's Initials: _____.

Telephone Policy:

- I understand that often, I will be asked to schedule an appointment if issues or questions arise between scheduled appointment times.
- I understand that the best way to discuss my child's care is in a scheduled office visit. I agree to pay an out of pocket encounter fee of $50 per 15 minute increment if I require non-emergent telephone communication between office visits regarding my child's care.

Parent's Initials: _____.

Refill Policy:

- I agree to request all refills at the time of my visit.
- I understand that if I cancel or reschedule an appointment, I may run out of my child's required medication.
- I agree to pay $50 for any refill required between appointment times.

Parent's Initials: _____.

Forms/Paperwork Policy:

- I understand that requesting paperwork and form completion is best done during my child's appointment.
- I agree to pay the out of pocket fee of $50 for any letters, forms, or other paperwork that require completion by Dr. Frazier, outside of schedule appointment times. I understand that I can avoid this charge by scheduling an appointment, and bringing these forms with em to this office visit.
- Records are provided at appointment times upon request. There is a $35 fee for records requested outside of appointment times.

Parent's Initials: _____.

Attorneys and Courts:

- In the event Dr. Frazier is required to work with your attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.
- Additionally, you are responsible for fees issued from the Practice Attorney of Pathways Developmental Pediatrics.

Parent's Initials: _____.

Financial and Cancellation Policy Agreement

I have read and agree to the above financial and billing policies.

_____

Parent Signature **Written Name** **Date**