Dr. Nagaratina Salem, M.D, P.A.
Adriane Nelson, CPNP
6850 TPC Drive, Suite 100 McKinney, TX 75070
Phone (214) 383-4400 Fax (214) 383-4403
www.CraigRanchPediatrics.com

New Patient Enrollment

Welcome! We thank you for choosing us to serve your healthcare needs. The information requested on this form will enable us to serve you better. Thank You.

PLEASE FILL OUT FORM COMPLETELY AND KEEP IT CURRENT VIA PORTAL

Patient's Name ________________________________D.O.B.______________________ M / F
Home Address____
City________________________ State____________ Zip Code__________________________
Cell Phone#__________________________ Home Phone#______________________________
Email Address____
Pharmacy ____ Ph. __________________________
Emergency Contact Name: _______________________________Ph.______________________

SIBLING INFORMATION

Name__________________________________ D.O.B.__________________ M / F
Name__________________________________ D.O.B.__________________ M / F
Name__________________________________ D.O.B.__________________ M / F

PARENT INFORMATION

Mother's Name________________________ Father's Name_____________________________
Cell #________________________________ Cell #___________________________________
Occupation ___________________________ Occupation_______________________________
Employer_____________________________ Employer________________________________
Driver's Lic. State/#____________________ Driver's Lic. State/#_______________________
Social: _______________ DOB: _________ Social: ______________ DOB: _______________
Please Circle Parents Status: Married Single Widowed Separated Divorced
PRIMARY Insurance Holder Name: ____________________________________
How did you hear About Our Office? ___________________________________

Craig Ranch Pediatrics will not provide health care to minors without a parent/legal guardian*, parent's written consent or contact from the parent/legal guardian giving said consent. I give consent to the following people to seek medical treatment and receive information regarding my child in my absence:

Name _________________________________ Relation __________________Tel _______________
Name _________________________________ Relation __________________Tel _______________

Medical History

Family Medical History: Are any family members with the following diseases? (Please circle)
Asthma, Allergies, Cancer, Seizures, Birth Defects, Heart Disease, Liver Disease, Diabetes, High Blood Pressure.
Other? If so, who & which disease ____
____

1. Consent to Payment/financial policies

- Patient or Person responsible must present insurance card at the time of visit. It is your responsibility to ensure all patients including newborns are covered under the insurance plan.
- While we will put in our best effort to validate eligibility, it is your responsibility to ensure that the providers are contracted and in-network with your insurance plan prior to the visit.
- If you do not have any insurance or we are unable to validate eligibility, payment in full is expected at the time of service.
- Co-payments, deductibles and any outstanding balance are due upon check in.
- Based on the services provided, additional money may be due at check out.
- If office is not notified of insurance changes within 30 days of service, payment in full is expected.
- For claims denied by insurance due to non-covered services, patient or responsible party is accountable and is expected to pay the denied amount for the services already provided.
- Payments can be made in the form of cash, credit cards or personal checks. There will be a $ 25 charge for returned checks.
- Forms of payment (credit card, health savings card etc.) may be stored on file to charge for payments due.
- There is a 2% interest fee for all balances over 60 days.

Due to contract language between the physician and the insurance company, I understand that I am financially responsible for all charges deemed to be “non-covered benefits” by my insurance company even if the insurance’s Explanation of Benefits state the procedure is a “non-covered benefit” and “patient is not responsible”.

I have read and agreed to the above financial policies. I assign insurance benefits to be paid directly to Craig Ranch Pediatrics. I authorize release of all medical information to the insurance company for purposes of filing insurance claims.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this Sheet and have completed the answers to the best of my knowledge. I will notify you of any changes in my health status or the above information.

2. Late/Missed Appointment Policies

If you arrive for your appointment more than 10 minutes late, there is a chance that we will not be able to accommodate you. If you are running late, please call us ahead of time so that we will be able to determine if your child can still be seen despite a late arrival or if it necessary for us to reschedule your appointment. Please notify us of an appointment cancellation as soon as possible.

Our No Show policy is for all patients. Each appointment you miss, you will be charged $25 per child per visit. This charge is not covered by insurance and is patient responsibility.

To avoid these charges PLEASE call us to cancel your scheduled appointment no later than 24 hours in advance before the appointment. If your appointment is early in the morning, please call the previous day to avoid the NO Show charge. This will allow us time to fill the appointment time with other children who need to be seen.

For any unscheduled appointments (Walk Ins) there will be a $15 charge out of respect for our scheduled patients.

I have read, agree and provide consent to Craig Ranch Pediatrics’
(Initial here)__________________ Privacy Consent Policy
(Initial here)__________________ Consent to Treatment Policy
(Initial here)__________________ Payment/financial Policy
(Initial here)__________________ Missed/Late Appointment Policy
(Initial here)__________________ Advertising/Promotion of goods or products Policy
(Initial here)__________________ Release of Patient Medical Information

I have read and agree to the financial policies stated herein. I assign insurance benefits to be paid directly to Craig Ranch Pediatrics and/or Dr. Nagaratina Salem. I authorize release of all medical information to the insurance company for purposes of filing insurance claims.

Printed name of Parent/Guardian ____

Signature of Parent/Guardian ____ Date: ____________

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of the medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed below.

FROM: ____
(Physician or Facility Name)

____
Address City St Zip

____
Phone Number Fax Number

I hereby request that my child's complete records or specific information as listed below be released to:

TO: Craig Ranch Pediatrics
Nagaratina Salem, M.D, MBA
Adriane Nelson, RN, MSN, CPNP
6850 TPC Drive, Suite 100,
McKinney, TX 75070
Ph: 214-383-4400
Fax: 214-383-4403

____
Patient's Name Patient's Date of Birth

____
Parent's Signature Phone number Today's Date

Information Requested

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Craig Ranch Pediatrics

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Craig Ranch Pediatrics Policies

Below are the standard policies that every Parent/Guardian of the patients must be aware of and abide by. Before providing health care, a signed consent to Privacy, Treatment, Appointment, Payment policies, Patient Medical information/history and authorization for release of records are mandatorily required.

1. Privacy Consent

I understand that as part of my healthcare, **Craig Ranch Pediatrics** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The *HIPAA Privacy Rule at* **www.hhs.gov/ocr/privacy/** provides specific information and complete description of how personal health information may be used and disclosed. I understand that I have access to the *HIPAA Privacy Rule* and have reviewed the notice prior to signing this consent.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. Consent to Treatment

Craig Ranch Pediatrics will not provide health care to minors unless accompanied by a Parent/legal guardian, or have a parent's written consent or there is a way to contact the Parent/legal guardian and obtain consent.
Exceptions:

1. Child abuse.
2. Patient seeking counseling/family planning services.
3. Treatment for drug/alcohol abuse.
4. Treatment for STDs
5. Suicidal ideation.
6. All routine pediatric immunizations.

If parent cannot be contacted, the following may consent in this order: **Grandparents, adult, sibling, aunt, uncle**. For questions regarding this, contact Texas Department of Health, Adolescent Health Promo at 512-458-7111 Ext 2021.

As the Parent/legal guardian of the child designated as patient, I hereby authorize **Craig Ranch Pediatrics** to perform the required medical treatment considered advisable for the patient. I understand that no guarantees can be made as to the eventual outcome of medical treatment advised or performed. I also understand that written authorization is required before allowing anyone other than parent or legal guardian to bring child to the office to be examined.

You can provide consent to up to three people to bring my child to **Craig Ranch Pediatrics** for medical treatment in your absence. Please note that Legal guardians should bring all related documents to prove guardianship, before patient can be seen.

3. Consent to Payment/financial policies

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5. Advertising/Promotion of goods or products Policy

Based on the Provider’s prior experience with certain health related products, Patient’s feedback on the product’s effectiveness, direct observations of health improvements or Supplier’s Supplemental facts/information, we promote/sell certain health related products such as Dietary Supplements, Oils and Vitamins at the office and/or on our website as a normal course of business. While we do receive financial remuneration, the products are sold at a very low cost and are primarily for the convenience of our Patients. The same or equivalent products are available at the local stores/online. The Patient/Customer is under no obligation to purchase these products from us. Purchasing or not purchasing products from us will not change how we treat them.

I have read, understand and hereby agree with the Promotion/Sale of goods/products policy. I understand that purchasing products at the office or their website is completely optional. I also understand that I am not being forced nor required to purchase in order to receive any special treatment or provide favors to the Providers. If I do purchase, it is out of my own free will and decision.

6. Release of Patient Medical Information Policies

I authorize the release of any medical records or other information provided to Craig Ranch Pediatrics to be able to provide healthcare service and to process medical claims.