

Medical Records Release Form

In accordance with state law and regulatory agency requirements, the health record is the property of **PEDI PLACE @ WESTOVER HILLS**. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

I hereby authorize the release of information

FROM:

TO:

Physician Name: _____

Yvonne Miranda, MD

Office Name: _____

Pedi Place @ Westover Hills

Address: _____

3903 Wiseman Blvd, #302

City/State/Zip: _____

San Antonio, Texas 78251

Phone #: _____

210.680.7334

Fax #: _____

210.680.7337

Patient Information

Patient Name: _____

Date of Birth: _____

Address/City/State/Zip: _____

Phone #: _____

Information to be released

_____ Complete medical record

_____ Items as indicated below

_____ Progress Notes

_____ Problem List

_____ Consultations

_____ Lab Reports

_____ X-ray Reports

_____ Immunizations

_____ Medication List

_____ H&P

_____ Mental Health Records

_____ Other (specify: _____)

Parent, guardian or legal representative

Date

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.



FINANCIAL POLICY

We would like to thank you for choosing Pedi Place @ Westover Hills as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Credit Card Policy: Master Card, Visa and Flexible Spending Account Cards are accepted for services rendered. Your credit card / bank account will be charged at the time services are rendered.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our office.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice (exceptions will be determined on a case by case basis), as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, contact our office prior to your appointment.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Return Checks: A \$25.00 charge will be added to your account for any check returned by your bank for any reason.

Forms: There will be a charge of \$25.00 for the completion of medical forms. Payment is due at the time that you pick-up the forms. Please allow 7-10 business days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 3-5 business days for us to copy your records. There will be a \$25.00 charge for copying of your child's chart. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record.

After Hour Services: All after hours calls will be answered in a timely manner by the physician on call. There will now be a \$25.00 physician call charge for any call after 12:00 A.M.

Medication Refills: Please allow 48 hours for medication refills to be processed.

Appointment No Show Policy: Failure to cancel your appointment within 24 hours notice will result in a \$25.00 charge. This will be enforced on the 3rd no show, no call. This charge must be paid prior to your next appointment.

Late Appointment Policy: If you are 15 minutes late for your appointment, you may be asked to reschedule for a later date. If your child is sick, you may wait in the office and be worked in between patients. Please note there will be an extended wait time if you are late for your appointment.

Thank you for allowing us to be part of your children's lives.

Pedi Place @ Westover Hills

Signature _____