

2715 OSLER DRIVE – GRAND PRAIRIE, TX 75051
T 972-206-2940 F 972-602-7261
EMCATURAYMD.COM

PATIENT REGISTRATION DISCLOSURE FORM

PACGPA Policies

YOUR INSURANCE

All services are to be paid at the time services are rendered under the terms of your policy. This office extends 30 days to file your insurance as a courtesy for those contracts in which we participate. Balance for services rendered is due 45 days from the date of services. We are sorry we do not file secondary insurances

We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active that claims are paid.

You may receive a separate bill from an off-site laboratory (Quest or Labcorp, etc.) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

If I am covered by an HMO, I understand that I will be responsible for 100% of charges incurred if I have not selected one of PACGPA's physician as my Primary Care Physician.

APPOINTMENT POLICY

1. WELL CHILD: Patients arriving **15 minutes or more** after their scheduled **WELL CHILD** visit appointment will be asked to reschedule.
2. MISSED APPOINTMENTS: Patients with 3 MISSED appointments will automatically be removed from PACGPA's panel.
3. Missed appointments may incur a \$25 charge.

We acknowledge that your time is valuable and have adopted this policy in an effort to better service our other well and sick children in a timely manner.

CONSENT TO TREAT

I give permission and do hereby authorize the medical staff of Pediatric and Adolescent Center of Grand Prairie & Arlington (Dr. Epifania Caturay, et al) as agents for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or specific supervisions of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care begin required but is to give authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which aforementioned physicians in the exercise of his/her best judgment may deem medically advisable. These authorizations shall remain effective unless revoked in writing and delivered to said agent(s) or until minor reaches 18 years of age.

MEDICAL RECORDS

One copy of on site medical records will be available at no charge. Additional copies will be available for a processing fee of \$25.00. Off site medical records are available at a cost of \$25.00 and off site shot records are available at a cost of \$10.00.

INSURANCE/MEDICAID PATIENT ACKNOWLEDGEMENT STATEMENT

You understand that, in the opinion of Pediatric and Adolescent Center of Grand Prairie and Arlington (Dr. Epifania Caturay, et al), and the services or items that you have requested to be provided to your child(ren) by Pediatric and Adolescent Center of Grand Prairie & Arlington may not be covered under the Texas Medical Assistance Program (Medicaid, Star Plans, etc) or your primary insurance carrier as being

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reasonable and medically necessary for my care. You understand that the parent/guardian, the Texas Department of Health or its health insuring agent determines the medical necessity of the services or times that the request and receive. It is also understood that the parent/guardian is responsible for any and all payments of the services or items requested and received and medically necessary for their child's care.

Email Policy

To better serve our patients, Pediatric and Adolescent Center of Grand Prairie & Arlington has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at pacgpa@emcaturaymd.com. Please remember, however, that this form of communication is **not appropriate for use in an emergency**. The turnaround time for routine patient communication is **within one business day**. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Types of communication that are appropriate for e-mail include:

- Scheduling inquiries
- Non-urgent medical advice
- Billing or insurance questions
- Test and lab results
- Home health monitoring reports
- Prescription refill requests (per practice policy)
- Education materials

So we can process your e-mail more efficiently, please put the subject of your message in the subject line. Some forms of communication (e.g. HIV, mental health, emergency situations) are not appropriate for e-mail. Also, be sure to put **your child's name, date of birth, return phone number, and your name** in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the autoreply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that Pediatric and Adolescent Center of Grand Prairie & Arlington (PACGPA) will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond PACGPA's control.

PATIENT NAME: _____ **DOB:** _____

EMAIL ADDRESS: (PLEASE PRINT) _____

PARENT/GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

YOU MAY FAX (972-602-7261) OR E-MAIL THIS FORM BACK TO OUR OFFICE
PACGPA@EMCATURAYMD.COM.