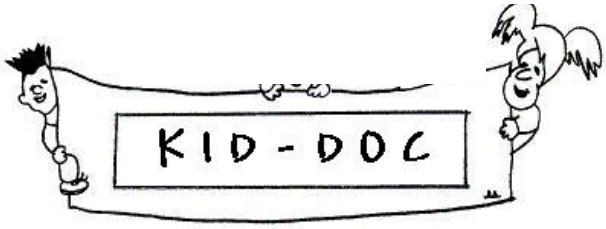


PEDIATRICS

Dr. Shahzad A. Sheikh, M.D., F.A..A..P
Pediatric and Adolescent Med

Name: _____ Date of Birth: _____ Male or Female

Please circle all answers

1. - Are you allergic to any medication? Yes / No
   If so, please list _____

2. - Are you currently taking any medication? Yes /No
   If so, please list _____

3. - Have you had any injuries/surgeries? Yes/No
   If so, please list description, dates and place: _____
   _____
   _____

4. - Smokers inside of the house? Yes/No Outside of the house? Yes/ No
   Alcohol Yes/No How often? _____

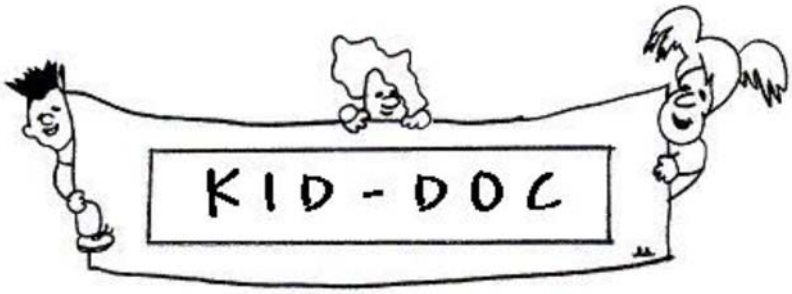
5. - Patient lives with: Mom Dad Stepparent Grandparents Other

6. - Does patient have problems with the following:
   -Behavior/ interaction with peers? Yes/No - School Performance? Yes/No

Parent's signature: _____ Today's date: _____

Cadillac Plaza ● 14351 Blanco Rd San Antonio, TX 78216 ● Office: (210) 492-0900 ● Fax: (210) 492-0977

Rev 09/2016



PEDIATRICS

Patients Name: _____

Date of Birth: _____

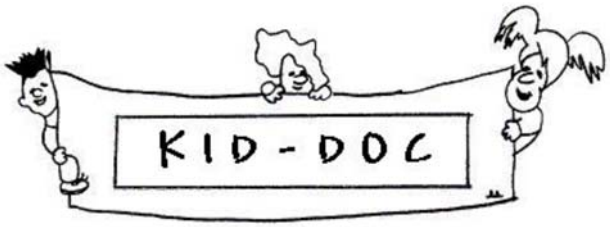
Release, Assignment, and Financial Responsibilities

1. I understand that I may be charged $25 for appointments not cancelled within 24 hours. Additionally there will be a charge for any forms filled out by the doctor or staff they are as follows: WIC/Daycare/School/ Sports/ Camp Physical $10, FMLA forms $20, Immunization records $5, Medical Records $25 for the first 20 pages then $0.10 cents each additional page.
2. I accept financial responsibility for any test or treatment I agree to or request, regardless of my insurance carrier's responsibility or reimbursement. I acknowledge financial responsibility for services rendered during periods when ineligible for or not covered by my insurance. I acknowledge being informed that my insurance may not cover all services requested. When a denial of a payment is received from my insurance carrier the charge will become my responsibility. My financial responsibility explicitly includes "non-covered" services including but not limited to: all immunizations (including influenza & vaccines for travel), immunization administration charge; after hours, weekend or holiday visit charges; vision screening, hearing screening; treatment for mental health, ADHD, school/behavioral problem (or similar issues), and physical exams or well child visits requested beyond allowance of insurance carrier.
3. I authorized the release of any medical or other information necessary to process a claim with my insurance carrier. I authorize payment of medical benefits to the practice of Dr. Shahzad Sheikh for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/ Guardian: _____ Date: _____

I have read and agree to the Notice of Privacy Practices and am aware that I may request a copy of these policies at any time.

Signature of Parent/ Guardian: _____ Date:_____



PEDIATRICS

Patient Name: _____ Date of Birth: _____

At Kid-Doc Pediatrics we are dedicated to providing the very best quality medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

At Kid-Doc Pediatrics we strive to provide the highest quality of care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Kid-Doc Pediatrics feels that this decision not only puts your child at risk of serious preventable diseases, but also contributes to the health risks of others. Therefore, please be advised that if you desire and "alternate" vaccine schedule or intend to refuse vaccines, you will do so against the advice of Kid-Doc Pediatrics, the AAP, the AAFP, and the ACIP. Because we believe that this decision puts your child at risk for vaccine preventable diseases, we therefore do not think we can provide the best care possible for your child, and Kid-Doc Pediatrics respectfully declines to be the pediatrician for your child or children. Should you at some time choose to resume nationally recommended immunization schedules, we will be happy to welcome you back to Kid-Doc Pediatrics. Thank You.

I have been provided a copy of the appropriate Centers for Disease Control (CDC) and Vaccine Information Sheet (VIS) to have and read, or have had explain to me, information about disease preventable vaccines that will be administered by Kid-Doc Pediatrics. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines that will be administered by Kid-Doc Pediatrics and allow consent for the vaccines to be administered.

Signature of Parent/Guardian: _____ Date: _____

Cadillac Plaza ● 14351 Blanco Rd San Antonio, TX 78216 ● Office: (210) 492-0900 ● Fax: (210) 492-0977

OFFICE FINANCIAL POLICY
FORM FEES/LATE FEES

SCHOOL FORMS – IMMUNIZATION RECORDS – RECORDS – FAXES

We receive many requests for records and forms to be filled out, mailed out, faxed out or picked up. We are here to help with these needs. We DON'T like Fees either! BUT as any other business, there is overhead involved with providing quality care.

DODGE those fees! We are thinking ahead…FREE!
- **Triplicate Rx refill/admin – ALL ADD/ ADHD MEDS – This gets sent electronically to your Pharmacy Now!**
- **NO CHARGE on Forms and Immunization Records at Time of Service! (1-2 page limit)**

If, however, a request is made for a child other than the one with the appointment or if your are mailing/calling/faxing us for records and/or a form completion, then we ask that you please call us at least one business day in advance. Please note that there is a nominal charge for this service, as it requires the staff to pull the patient's chart, review the request, prepare the form and transmit the information. Your insurance company does not pay for these services, they are your responsibility.

Fee schedule per child:

1. School / Camp /Sports Physical Forms	**$10.00**
2. Immunization Record/Fax	**5.00**
3. Daycare Medication forms	**5.00**
4. Billing forms	**5.00**
5. Computer chart summary*	**25.00**
6. Medical Records/chart copy*	**25.00 for first 20 pages, for subsequent pages $0.10 cents each.**
7. "Drop what you are doing. I need this NOW! *	**30.00**
8. FMLA/ HR forms	**20.00**

Billing – Late / Collection fees:

1. Returned checks	**$25.00**
2. 30 Day late fee	**10.00**
3. 60 Day late fee	**10.00**
4. 90 Day late fee	**10.00**

These fees cover our expenses for delivering the service. **Remember that all of these services are included with an office visit, if requested during the office visit for that child, except the ones that have a (*) by them**. The chart has already been pulled, the record reviewed and the situation discussed. Physical forms fee will be waived only for the first 30 days after the physical. Please make sure you bring forms and requests to your children's appointment. This helps us stay on time and saves you money.

Thank you.

Staff at KID-DOC Pediatrics

KID-DOC

PEDIATRICS

Patient Registration

PATIENT(S) DEMOGRAPHIC(S)

Patient Name_____ SSN_____ DOB _____ Age_____ Sex: M ☐ F ☐

Patient Name_____ SSN_____ DOB _____ Age_____ Sex: M ☐ F ☐

Patient Name_____ SSN_____ DOB _____ Age_____ Sex: M ☐ F ☐

Contact Name: _____ Text/Email:_____

Street Address: _____ Phone: _____

City/State/Zip: _____ Apt: _____

How did you hear about us? Google Search ☐ Google Ad Yelp ☐ ZocDoc ☐ Yellow Pages ☐

Referred By: OB-Gyn_____ Other_____

MOTHER'S EMPLOYER INFORMATION

Marital Status: ☐S ☐M ☐W ☐SEP ☐D

Mother's Name _____DOB_____ SSN_____Driver's Lic_____

Employer Name _____Occupation_____Cell_____ Work_____

Employer Address_____City/State/Zip_____

FATHER'S EMPLOYER INFORMATION

Marital Status: ☐S ☐M ☐W ☐SEP ☐D

Father'sName _____DOB:_____ SSN_____Driver's Lic_____

Employer Name _____Occupation_____Cell_____ Work_____

Employer Address_____City/State/Zip_____

PERSON TO CONTACT IN CASE OF EMERGENCY (Other than parent)

Name _____Relationship _____Phone _____

INSURANCE - Please, provide insurance to be copied.

*** A copy of my insurance serves as valid proof of current insurance. I agree to notify and provide a copy of my insurance to KID-DOC Pediatrics upon any insurance changes that occur.**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Shahzad A. Sheikh, M.D., P.A. dba KID-DOC Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to any parties necessary to secure payment and or to facilitate quality assurance. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I certify that the information I have provided with regard to my insurance coverage is correct. I have read and understand the HIPAA and Financial Policy in its entirety and agree to abide by ALL policies and procedures and be responsible for ALL charges and fees applicable to the services rendered at KID-DOC Pediatrics. I authorize being contacted by email/text for appointment reminders, balances, and or any notifications.

Signature:_____Date:_____

Rev 04/2017 **(Patient, Parent, Guardian)** ***Attach copies: Insurance Card/Driver's License***