SHALOM PEDIATRICS

VICTOR& BOSEDE OGUNLANA MD FAAP

2116 W. Griffin Pkwy

Mission, Tx 78572

PH (956)519-2800 FX(956) 519-9424

PATIENT'S INFORMATION

Patient's Name:_______________________SS#__________________DOB:_______________

Address______________________________City:__________________Zip Code:____________

Phone#:____________________Age:_________Race:__________Ethnic Group:______________

PARENT'S INFORMATION

Father's Name:_________________________DOB:______________SSN#:_______________

Employer______________________Occupation__________________Work#:______________

Insurance Co.______________________ Policy#:__________________________

Mother's Name:_________________________DOB:______________SSN#:_______________

Employer______________________Occupation__________________Work#:______________

Insurance Co.______________________ Policy#:__________________________

INSURANCE INFORMATION

INDIVIDUAL RESPONSIBLE: FATHER,MOTHER,GUARDIAN INSURANCE,MEDICAID,OTHER

BILLING ADDRESS:________________________PHONE #:_____________________________

City:________________________State:________ Zip Code_____________________________

EMERGENCY CONTACT

Name:_________________________ Relation_________________________

Phone:_________________________ Referred by:______________________

Authorization To Release Information & Assignment of Benefit

I authorize the release of an medical information necessary to progress this claim, I permit a copy of this authorization to be used in the place of the original.

Date:____________ Signature:_____________________

I hereby authorize Shalom Pediatrics to apply for benefits on my behalf for covered services rendered by the physicians or the physician's order. I request that the payment from my insurance company to be made directly to Shalom Pediatrics.

Date:____________ Signature:______________________

I acknowledge that the payment is due at the time if treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatments of a minor/child. I accept full financial responsibility for all charges not covered by my insurance. I have been provided of the Privacy Notice and have had the opportunity to object to the disclosures of any health insurance.

Date:_____________ Signature:________________________

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RX HUB FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Shalom Pediatrics to access my pharmacy benefits data electronically through RxHub. This consent will enable Shalom Pediatrics to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

______________________________ ______________
Patient Name (PRINTED) Date of Birth

______________________________ ______________
Patient/Guardian Signature Date

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CONSENT FORM FOR TREATMENT AND VACCINE ADMINISTRATION

By signing below, I give consent for (patient) to have any treatment or vaccines needed, which has been ordered by my physician. I acknowledge that an adverse reaction can occur. Although any reaction is rare, the most common reaction could be an area of local swelling and redness at the site of administration of vaccine. Rarely more severe reactions occur.

By signing below you give your consent and acknowledge that you have read the above information provided to you and that you fully understand the possibility an adverse reaction may occur.

Patient's Name:______________________________DOB:___________________
Patient's Name:______________________________DOB:___________________
Patient's Name:______________________________DOB:___________________

_____________________________ _____________________
Parent's Signature Date

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HIPPA NOTICE OF PRIVACY PRACTICE

Signing below means that you have received and understood this notice. You may also request a copy.

_______________________________ ________________

Patient/Parent/Guardian Signature Date

RECORDS/FORMS REQUEST POLICY

Our office is happy to complete medical records and forms request from our patients. However, because of the volume of documents requested by our patients and/or representatives and in accordance with applicable fees governed by the Texas State Board of Examiners, we have made the decision to charge for these services.

Listed below, are the charges for requested forms:

TYPE OF FORM	PAGES 1-20	AFTER PAGE 20, PRICE PER PAGE
Disability Form	$25.00	N/A
Itemized Billing Form	$25.00	$.50
X-Rays/MRI Films	$25.00	$25.00
Medical Records	$25.00	$.50
Immunizations cards or copy	$5.00	N/A
Medical Records Subpoena/Affidavits	$15.00	$.50
Billing Records Subpoena/Affidavits	$15.00	$.50
Postage/Delivery Expenses	$8.00	N/A
Notary Fees (Per Authorization)	$15.00	N/A

Please Note: Although a form may not be listed above, does not necessarily mean that it is a no charge item.

The patient is responsible for the cost, and we ask the payment be received in advance of releasing or faxing any form or record.

***We will make every attempt to fill your Record/Form request as quickly as possible but do require A minimum of 5 business days before completion.**

Signature below is only acknowledging that you have read and understood the records/forms policy.

_______________________________ ________________

Patient/Parent/Guardian Signature Date

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Notice of Privacy Practice Acknowledgement

I hereby acknowledge that I have received a copy of a Notice of Privacy Practice from: Shalom Pediatrics and that I understand these policies. I consider these policies to be fair and realize that I should require any special exception to these policies; this practice will do their best ability to accommodate you're needs.

Patient's Name:____________________________
Date of Birth:______________________________
Parent's Signature:__________________________
Date Received:_____________________________
Witness's Signature:_________________________

Dr. Ogunlana, Own an ownership or investment interest in Doctor's Hospital at Renaissance,LTD. I am referring you to Doctor's Hospital at Renaissance for treatment or testing. If you object to the referral or have any questions about the notice, please let me know. This notice is given to you as required by the federal law and the hospital's rule and regulations.

Receipt acknowledgement: ____________________________Date:_____________
Parent Signature