

**Dr. Lara Varisco Leonhardt, MD**

Child’s Name: Date of Birth:

Gender: Male Female Child’s Social Security #

Street Address:

City, State, Zip Code:

Telephone:

 Primary Alternate

**Parent/ Guardian Demographics**

Father’s Name: Mother’s Name:

Date of Birth: Date of Birth:

Social Security #: Social Security:

Employer Name: Employer Name:

Work Phone: Work Phone:

Cell Phone: Cell Phone:

Email: Email:

Pharmacy Name/ #:

Who Referred you to us:

Emergency Contact Name: Phone:

**Assignment of Insurance Benefits**

I hereby authorize direct payment of surgical/ medical benefits to Dr. Lara Leonhardt for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, ie: labwork, blood tests, x-rays, etc., that are not covered by insurance will be my financial responsibility.

**Authorization to Release Information**

I hereby authorize Dr. Lara Leonhardt to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Patient Name (Please Print) Date

Parent/ Guardian Name (Please Print) Signature

**General Consent to Treat**

I am the parent/ guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient), I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. Lara Leonhardt and his/her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, physician assistants, and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

**Delegation of Consent**

I hereby authorize (when I am unavailable to give consent) the following individual(s) to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Those Whom Consent is Delegated:

Name Relation to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­Signature of Parent/ Guardian ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Relation to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Review of Notice of Privacy Practices**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. The Health Insurance and Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This document contains a condensed version of our policies. A more complete version is contained in our Medical Office Policy and Procedure Manual, which you may view at any time.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

The following are the policies we have adopted, in brief:

1. Treatment: We are permitted to use and disclose your medical information to those involved in your treatment.
2. Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you.
3. Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.
4. Disclosures That Can Be Made Without Your Authorization: There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object.In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization. The following are situations where we may disclose your medical information without your authorization:
	1. Public Health, Abuse or Neglect, and Health Oversight
	2. Legal Proceedings and Law Enforcement
	3. Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
	4. Those instances required by law
5. Your Rights under Federal Law: The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights. Those rights are s follows
	1. You may request that we restrict how your protected medical information is used. We, however, do not need to agree to this restriction
	2. You may request that we send your protected health information by alternative means or to an alternative location.
	3. You may inspect and/or copy your health information within a designated record set; request must be in writing. There are limitations regarding the information you may inspect or copy. Texas law requires us to release this information within 15 days or your written request received by our office. We will inform you if access has been denied or limited. HIPAA permits us to charge a reasonable cost-based fee for such information.
	4. You may request and amendment of your medical information, however, we are not required to do so.
	5. You may request an accounting of certain disclosures that are for means other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative.
6. Appointment Reminders, Treatment Alternatives, and Other Benefits: we may contact you by telephone, mail, email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

**Complaints:** If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

**Our Promise to You:** We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

**Questions and Contact Person for Requests:** If you have any questions or want to make a request pursuant to the rights described above, please contact: ­­­­­­­­­­­­­­­­­­­­

Dr. Lara Leonhardt

Bee Well Pediatrics, PA

7660 Woodway, Suite 200

Houston, Texas 77063

Phone: 713-333-2253

Fax: 713-333-2256

This notice is effective January 1, 2010.

**Acknowledgement of Review of Notice of Privacy Practices**

I have read and reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Description of Personal Representative’s Authority

**Cancellation and Missed Appointment Policy**

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of medical care.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their appointment with a 24-hour notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

* First missed appointment: there will be no charge
* Any appointment following: $25 fee will be billed to your account.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_