PIGA PRIMARY CARE ASSOCIATES
Specialists in Adult and Pediatric Medicine

**Jonathan C Piga, MD**
**Naomi C Piga, MD FAAP**
**Versallie R Capote-Piga, MD FAAP**

## Patient Demographic Information

Patient Name ______________________________________________
Gender ____________________ Date of Birth: __________ Marital Status: ______
Social Security #: ______________ Driver License #: ______________________
Street Address: _________________________________________________
City: ______________________ State: ______________ Zip Code: __________
Home Phone #: ______________ Cell Phone #: __________________________
Whom can we thank for your referral? _____________________________

Employer Name: __________________________________________________
Employer Address: ________________________________________________
City: ______________________ State: ______________Zip Code: ___________
Work Phone #: ______________ Position: ______________________________

For pediatric patients only*: Information regarding Parent/Guardian/Legal Representative*
Mother's Name ___________________________________________________
Date of Birth: ___________________________________________________
Social Security #: ______________ Driver License #: ______________________
Street Address: _________________________________________________
City: ______________________ State: ______________ Zip Code: __________
Home Phone #: ______________ Cell Phone #: __________________________
E-mail Address: __________________________________________________
Employer Name: _________________________ Work Phone #: ______________

Father's Name ___________________________________________________
Date of Birth: ___________________________________________________
Social Security #: ______________ Driver License #: ______________________
Street Address: _________________________________________________
City: ______________________ State: ______________ Zip Code: __________
Home Phone #: ______________ Cell Phone #: __________________________
E-mail Address: __________________________________________________
Employer Name: _________________________ Work Phone #: ______________

*Billing Responsibility:* (Circle One) *Father Mother Other*
Name if Other: __________________________________________________
Date of Birth: __________________Relationship to Patient______________________
Social Security #: ______________ Driver License #: ______________________
Street Address: _________________________________________________
City: ______________________ State: ______________ Zip Code: __________
Home Phone #: ______________ Cell Phone #: __________________________

### Emergency Information

Emergency Contact Name: ____________________________ Phone #: __________
Address: _______________________________________________________
City: ______________________ State: ______________ Zip Code: __________

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**Insurance Information** *Please skip if you have no insurance coverage*

Insurance Company: ______________________________ Phone #: ____________
Claims Mailing Address: ______________________________________________
City: ______________________ State: ______________ Zip Code: ____________
Policy #: ____________________ Group #: ________________________________
Effective Date: _______________________________________________________
Name of Primary Insured: ______________________________________________
Primary Insured Date of Birth:_________________________ Social Security #: ________

**Preferred Pharmacy Information** *Pharmacy on file for medications and refills*

Name: ______________________________________ Phone #: ______________
Address: _______________________________________________________
City: ______________________ State: ____________ Zip Code: ______________

## Authorization to Release Information and Assignment of Benefits

☐ By checking the box on the left, I certify that information I have reported about my insurance is correct.

☐ By checking the box on the left, I authorize the release of any medical information necessary to process my insurance claims.

☐ By checking the box on the left, I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment be made directly to my doctor or to the party who accepts assignment.

☐ By checking the box on the left, I acknowledge that any insurance billing done is at the discretion of my doctor. I understand that any co-pays, co-insurances and deductions deemed my responsibility are payable in full by me.

☐ By checking the box on the left, I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.

Signature of Patient/Parent/Legal Guardian______________________ Date ___________________

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# Pediatric Health History Form

**Your relationship to child:** ______

**Child's previous doctor/primary care provider:** ______

**Present health concerns:**

**Medicines/Vitamins:**

**Herbs/Home Remedies:**

**Allergies/Reactions to medicines or vaccinations:**

## PREGNANCY & BIRTH

Where was your child born? ______

Is the child yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑ Other:

Please indicate any medical problems during pregnancy

❑ None ❑ Specify: ______

Delivery by ❑ Vaginal birth ❑ Caesarean

If Caesarean, why? ______

Birth weight: ______ Birth length: ______

APGAR score 1 min. ______ 5 min. ______

Please indicate any medical problems during the baby's newborn period ❑ None (If premature, how early?)

______

Other problems: ______

## NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes

If so, how long?

Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify:

______

Milk intake now: Type ❑ Cow's milk (❑ Nonfat ❑ 1% fat ❑ 2% fat ❑ Whole) ❑ Soy milk ❑ Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

______

*PATIENT LABEL*

**NAME:** ______

**DATE OF BIRTH:** ______

**AGE:** ______

## SLEEP

Hours per night ______

Naps (number & length) ______

Any sleep problems? ______

## DEVELOPMENT

At what age did your child: Sit alone ______

Walk alone ______ Say words ______

Toilet train (daytime) ______

Girls only: Age at first menstrual period ______

## DENTAL HISTORY

Has child been seen by a dentist? ❑ No ❑ Yes

If so, how often? ______

Date of last visit ______

## IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

❑ Chickenpox ❑ Measles ❑ Mumps

❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB)

## EXPOSURE/HABITS

Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV – hours per day ______

Computers – hours per day ______

Video games – hours per day ______

## PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

______

______

______

Hospitalization/operations (with dates): ______________________

Broken bones or severe sprains: ______________________

## FAMILY HISTORY

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ______________________

High cholesterol ______________________

Cancer, specify type ______________________

High blood pressure ______________________

Heart disease ______________________

Stroke ______________________

Depression/suicide ______________________

Bleeding or clotting disorder ______________________

Genetic disorders ______________________

Asthma/COPD ______________________

Diabetes ______________________

Other: ______________________

## SOCIAL HISTORY

Who lives at home?

| Name | Age | Relationship | Highest Education Level |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are your child's parents ❑ Married ❑ Unmarried ❑ Separated ❑ Divorced

If divorced or separated, when? ______________________

Mother's Occupation ______________________

Mother's Employer ______________________

Father's Occupation ______________________

Father's Employer ______________________

Child care situation ❑ Parents ❑ Others (specify who and how often) ______________________

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual activity ❑ Aggressive behavior

Is violence at home a concern? ❑ No ❑ Yes

Are there guns in the home? ❑ No ❑ Yes

## SCHOOL HISTORY

Did/does your child attend school or preschool?

❑ No ❑ Yes

Current grade ____________

Name of school ______________________

Any concerns about school performance?

______________________

Any concerns about relationship with:

Teachers ❑ No ❑ Yes

Peers ❑ No ❑ Yes

If more than 4 years old: does your child have a best friend? ❑ No ❑ Yes

Sports/exercise: Type ______________________

How often? ______________________

How long (minutes)? ____________

**REVIEW OF SYMPTOMS:** Please check any current problems your child has on the list below:

*General*

____ Fevers/chills/excessive sweating
____ Unexplained weight loss/gain

*Eyes*

____ Squinting/"crossed" eyes/ asymmetric gaze

*Ears/Nose/Throat*

____ Unusually loud voice/hard of hearing
____ Mouth breathing/snoring
____ Bad breath
____ Frequent runny nose
____ Problems with teeth/gums

*Cardiovascular*

____ Tires easily with exertion
____ Shortness of breath
____ Fainting

*Respiratory*

____ Cough/wheeze
____ Chest pain

*Gastrointestinal*

____ Nausea/vomiting/diarrhea
____ Constipation
____ Blood in bowel movement

*Genitourinary*

____ Bedwetting
____ Pain with urination
____ Discharge: penis or vagina

*Musculoskeletal*

____ Muscle/joint pain

*Skin*

____ Rashes
____ Unusual moles

*Allergy*

____ Hay fever/itchy eyes

*Neurological*

____ Headaches
____ Weakness
____ Clumsiness

*Psychiatric/Emotional*

____ Speech problems
____ Anxiety/stress
____ Sleep issues
____ Depression
____ Nail biting/thumb sucking
____ Bad temper/breath holding/ jealousy

*Blood/Lymph*

____ Unexplained lumps
____ Easy bruising/bleeding

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# Notice of Privacy Practices (HIPAA)

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

This office may use and disclose medical and financial information related to your care that may be necessary to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

**The type and amount of information to be used or disclosed is as follows:**

*I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.*

____**All Health Care information.**

____All Health Care Information **excluding** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

**Please circle your response to the following:**

| | | | |
|---|---|---|---|
| May we leave messages concerning **appointments** with a co-worker, receptionist or secretary who regularly answer your calls? | Yes | No | N/A |
| May we leave **messages** on a voice mail at your home? | Yes | No | N/A |
| May we leave **messages** on a voice mail at work? | Yes | No | N/A |
| May we discuss **appointments/treatment** with other parent/guardian/caregiver/family members? | Yes | No | N/A |

Who? ___________________________________________________________

For minor patients less than 17 years of age, all treatment and medical information will be discussed with both biological parents unless otherwise specified.

I understand that I have a right to revoke this authorization at any time. I understand that I need to inform the office, in writing, of any changes in my directives. I understand that this HIPAA notice will be kept in my file. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

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I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that without disclosure, I will be responsible for payment of services when they are rendered and will file my claims directly to my own insurance company. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

**For Pediatric Patients:**
I authorize the release of immunization records that have been requested verbally to schools/camps/daycares. I understand that there is a **$2 fee** per request. ______________ (initial here)

Name of patient: ____________________________________________ Date of birth: ___________________________

Signature of patient/legal representative: ___________________________________________________________________

Date: ___________________________________

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## REQUEST FOR RELEASE OF MEDICAL RECORDS

**Requesting only: (circle one)** Immunization records Physical form
Insurance information All records
Labs/x-rays other: ________________

**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:_____________**

**Please send records requested (circle one) TO FROM**

Clinic/Hospital/ School name: ___________________________________________
Address: _________________________________________________________________
Phone: __________________________________________________________________
Fax: ____________________________________________________________________

Reason for records release: ______________________________________________
For period of: _____________________________________________________________

Patient name: _________________________________ DOB: ____________________
Address: _________________________________________________________________
City, State, Zip code: _____________________________________________________
Social security: ___________________________________________________________

Responsible party name (printed): __________________________________________
Signature: ________________________________________________________________
Date: ____________________________________________________________________

**The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners**

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## WAIVER FOR SERVICES PROVIDED BY PIGA PRIMARY CARE ASSOCIATES

Piga Primary Care Associates provides several services to patients that may not be covered by insurance or covered fully. These services are offered as a convenience for families, but they are not required in order for a patient to receive care in the office. Insurance companies vary according to what services they cover and how much they pay for the service. Examples include EKG, spirometry, hearing testing and vision testing. Patients always have the right to choose if they would like to have the procedures performed in our office. If a patient wishes to have the service performed elsewhere, the appropriate instructions and lab request or prescription will be given if needed. Patients may elect to have the service performed in our office, but will need to pay the fee if it is not covered.

We appreciate you selecting Piga Primary Care Associates for your family's health care needs. As a provider for your company's health plan, we are committed to quality health care. Services recommended for our patients may not be a benefit of your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, immunizations, immunization administration, procedures, and laboratory tests, will be your responsibility and will be billed to you. Our routine schedule of these services follows the recommendations of the American Academy of Pediatrics and the American College of Physicians.

Well/annual exams cover preventive care. Anything that is discussed outside of preventive care, including, but not limited to, the treatment of chronic conditions may incur fees that may be applied to your co-pay, deductible or co-insurance. These fees are the responsibility of the patient.

By signing below, you agree to take full financial responsibility for the cost of the indicated medical services or procedures if not covered by your insurance.

Patient's name_______________________________________ DOB_________________

Patient or Guardian's signature_________________________ Date_________________

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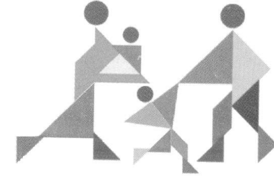

## Office Billing Policies

### Appointments

Patients are seen by appointment only. You may call our office to schedule an appointment anytime during normal business hours. Should you have any special issues or complex medical problems to discuss with the doctor, please inform our staff when making the appointment so that adequate time is allotted to address them. Time will be available each day for sudden illness and same-day sick visits.
Please arrive on time for your appointment. When you arrive, please inform us of any changes to insurance, address, or responsible party. You will be asked to present a current insurance card at every visit. If you are late for an appointment or you walk-in without an appointment, you will be seen when the schedule allows. If you are more than 30 minutes late, you may be asked to reschedule.

If you are running late for an appointment, please call our office so we may help you find an appointment that better fits your schedule. If we are not notified or you walk-in without an appointment, you will be seen when the schedule allows. If you are more than 30 minutes late, you may be asked to reschedule.
If you cannot keep an appointment, please provide notice 24 hours in advance. Appointments missed without notification hinder us from seeing other patients who may be ill. After 3 "no shows", you will be billed a $25 fee per missed appointment.

### After-Hours Telephone Calls

We believe that our patients should have 24-hour access to medical advice should an urgent situation arise. Beginning December 15, 2011, all pediatric after-hours telephone calls will be answered by a specially trained pediatric nurse. In addition, one of our physicians is on-call everyday and can be reached by the triage nurse for complex problems. Please limit after hours calls to urgent problems that cannot or should not wait until the office reopens. Routine problems (such as colic, reflux, diaper rash, appetite, sleep, development, etc.), prescription refills, medication dosages and prior authorizations will not be entertained after hours. These problems are best handled when the physicians have the office staff and patient charts available during regular business hours and can give uninterrupted service. All after-hours calls incur a charge of $15.00 per call which is applied to the patient's account.  Our practice is billed for every after hours call that is placed, and we pass only a portion of this cost on to our patients. Please allow 30 minutes for your call to be returned. We ask that you keep your phone line clear and disable the anonymous call block feature

### Immunization Records

An updated shot record will be provided free of charge after every check-up. Any additional copies requested will be subject to a $2.00 charge per immunization record.



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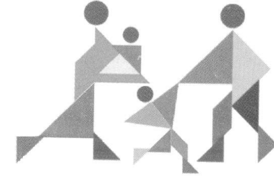

## Prescriptions

Antibiotics are not prescribed over the phone. Since there are many things that could be wrong, we prefer to examine each patient for proper diagnosis.

Prescription refill requests are handled most efficiently by calling your pharmacy directly to request a refill. If refills remain from the original prescription, the pharmacy simply fills your prescription. If there are no refills remaining, the pharmacy will contact our office for authorization to fill the prescription.

Refills on controlled substances, such as ADHD medications and some pain medications, require 48 hours to complete and you must pick up these prescriptions at our office. Please note that, by law, a prescription for a controlled substance must be filled within 7 days, so a $5.00 charge applies if a new prescription has to be written.

“Lost prescriptions” – if a 90-day/mail order prescription is lost, a $5 fee will be charged.  All mail order prescriptions will be given to the patient and it is the patient’s responsibility to submit the prescriptions along with the necessary forms to the pharmacy.

## Medical Records

If you are moving or need a copy of your medical record for other purposes, please make your request at least 2 weeks in advance. An Authorization to Release Medical Information Form must be signed prior to release and a $25.00 fee will be charged per record.

Because of privacy concerns, we will only fax medical records when requested by other physicians or medical facilities. Immunization records can be faxed with a verbal request only from the parent or legal guardian of the patient.

## Forms (sports, school, camp, FMLA, etc.)

Please be advised that we complete these forms only if a complete check-up or physical examination has been done in the past year. Due to the number of forms we receive, we require at least 48 hours for completion. FMLA forms and Medicare Medical Necessity Certifications are subject to a $10.00 charge. These forms are available for pick-up only.

## Year end/ Summary Statements

All requests for Summary Statements required 48 hours to complete.  There is a $10 fee per family account per year. Please note that if you would like the statement faxed to you, you must provide written authorization per HIPAA.

I understand the above listed policies and I acknowledge the associated fees.

Patient’s name________________________________________ DOB_________________

Patient or Guardian’s signature__________________________ Date_________________




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