

**NEW BRAUNFELS PEDIATRIC ASSOCIATES, P.A.**  
**1535 E. Common Street, New Braunfels, Texas 78130**  
**Office # (830)625-9153 Fax # (830)609-0572**

Timothy W. Owens, M.D. · Mark D. Statler, M.D. · Jay S. Weinberg, M.D. · Sarah E. Rieger, M.D.  
 Awilda I. Ramos, M.D. · Michelle L. Bernardy, M.D. · Ramona Peck, M.D. · Rachel L. Hayden, PA-C  
 Wendi H. Reagan, C.P.N.P. · Ismaela Gomez, C.P.N.P. · Amy Long, C.P.N.P.

Thank you for choosing our office. In order to service you properly, we will need the following information.

PATIENT INFORMATION					
NAME: Last	First	M.I.	Age	Gender	
Date of Birth	Social Security #		Patient Home Phone #		
Patient Address	City	State	Zip Code		
Child Lives With	Emergency Name & Relationship			Emergency Phone #	
Mother's Name	Home Phone #	Cell Phone #			
Mother's Address	City	State	Zip Code		
Mother's Date of Birth	Social Security #	Driver's License #			
Mother's Employer	Phone #				
Father's Name	Home Phone #	Cell Phone #			
Father's Address	City	State	Zip Code		
Father's Date of Birth	Social Security #	Driver's License #			
Father's Employer	Phone #				
Sibling's Full Names					
INSURANCE INFORMATION					
Name of Policy Holder	Date of Birth	Policy Holder Address	City	State	Zip Code
Name of Insurance Company	Insurance Company Address		City	State	Zip Code
Group #	Policy #	Co-pay Amount			
Name of Policy Holder (Secondary)	Date of Birth	Policy Holder Address	City	State	Zip Code
Name of Insurance Company (Secondary)	Insurance Company Address		City	State	Zip Code
Group #	Policy #	Co-pay Amount			
<p><b>I hereby authorize payment of insurance benefits to Timothy W. Owens, M.D., Mark D. Statler, M.D., Jay S. Weinberg, M.D., Sarah E. Rieger, M.D., Awilda I. Ramos, M.D., Michelle L. Bernardy, M.D., Ramona Peck, M.D., Rachel L. Hayden, PA-C, Wendi H. Reagan, C.P.N.P., Ismaela Gomez, C.P.N.P. and Amy Long, C.P.N.P. I also authorize the above named parties to release information for the purpose of payments of benefits. A photocopy shall be as valid as the original. The parent requesting treatment is responsible for services rendered. Co-payments are due at time of service.</b></p>					
Signature			Date		
Reason for today's visit					
Former Doctor			Referred By		

## BIRTH HISTORY

Mother's age at birth	Length of pregnancy	Medicines taken during pregnancy	
Birth Hospital	# Previous Pregnancies	# Miscarriages	Type of Birth <input type="checkbox"/> Vaginal <input type="checkbox"/> Breech <input type="checkbox"/> Cesarean <input type="checkbox"/> Other _____
Baby's Birth Wt.	Did the baby have:	<input type="checkbox"/> Jaundice <input type="checkbox"/> Trouble Breathing <input type="checkbox"/> Convulsions	<input type="checkbox"/> Did the Baby Cry Immediately?
Mother's Blood Type	Father's Blood Type		

COPY OF IMMUNIZATION RECORD ENCLOSED?  YES  NO

## FAMILY HISTORY

NAME	HEALTH STATUS	(Circle) HAS ANY BLOOD RELATIVE HAD
Father		Allergies Diabetes Rheumatic Fever Kidney Trouble
Mother		Epilepsy Tuberculosis Heart Trouble Thyroid Trouble
Siblings		Asthma Migraine Birth Defects Cancer
		Excessive Bleeding

## HEALTH HISTORY

(Circle) HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

Asthma	Hearing Trouble	Kidney Trouble	Diphtheria	Chest Pains
Jaundice	Mumps	Operations	Hospitalizations	Fainting Spells
Hay Fever	Scarlet Fever	Excessive Bleeding	Eczema	Speech Problems
Rheumatic Fever	Blood Transfusions	Eye Trouble	School Problems	Measles
Serious Accident	Frequent Headaches	Pneumonia	Drug Allergy	Whooping Cough
Convulsions	Frequent Earaches	Chicken Pox	Heart Murmur	Other:

## PLEASE READ THE FOLLOWING CAREFULLY

I HEREBY GIVE LEGAL CONSENT FOR New Braunfels Pediatric Associates to release immunization dates to school nurses, County Health Department, Immtac, and other physician offices for the purpose of updating immunization status, and to know the need for vaccines. This authorization is good unless the parent or legal guardian revokes it. The person(s) listed below have my permission to seek medical attention for my child at New Braunfels Pediatric Associates.

Name	Relationship to Child
Name	Relationship to Child
Name	Relationship to Child

As the parent or legal guardian of the child designated above, I hereby authorize Timothy W. Owens, M.D., Mark D. Statler, M.D., Jay S. Weinberg, M.D., Sarah E. Rieger, M.D., Awilda I. Ramos, M.D., Michelle L. Bernardy, M.D., Ramona Peck, M.D., Rachel L. Hayden, PA-C, Wendi H. Reagan, C.P.N.P., Ismaela Gomez, C.P.N.P. and Amy Long, C.P.N.P. or their medical representative, to perform the required medical treatment considered advisable for the patient. I hereby authorize my physician to instruct his/her nurse practitioner to assist him/her in certain aspects of my child's medical care. I understand that a nurse practitioner is not a licensed physician and may diagnose and treat an illness, injury or medical condition, only under the supervision and direction of a medical physician. I further understand that I may revoke this authorization at any time, and I may request to be seen by my physician. I realize that no guarantees can be made as to the eventual outcome of the medical treatment advised or performed. However, I may expect the medical treatment advised or performed to be sound by accepted medical standard. I also hereby agree to pay all charges incurred in the care of my children. There will be a charge for copies of medical records.

Parent or Legal Guardian	Date
Witness	Date

# Patient Orientation & Financial Policy Form

Please initial that you have read and understand each line and sign the bottom of this form.

## Things to know and do before any appointment:

1. \_\_\_\_\_ Be sure all spaces are filled out on new patient forms and review consent forms carefully and fill out completely.
2. \_\_\_\_\_ In building #1 we have 3 waiting rooms, well, sick and newborns under 2 months of age. Please wait in the appropriate room until you are called back.
3. \_\_\_\_\_ Please add your newborn to insurance within 30 days of birth.
4. \_\_\_\_\_ Please check on family and baby's deductible amounts.
5. \_\_\_\_\_ **Wellness exams: CHECK IMMUNIZATION COVERAGE**; ask if policy has a waiting Period, age limit, dollar limit and if they are covered at 100%. Some vaccines that are recommended but not required are not covered by insurance. Please verify this information If patient is subject to limitations or if immunization coverage is not a 100% then we suggest patient get vaccines from the Vaccine for Children program. VFC is more cost effective. The fee is presently \$14.00. During your wellness visit if another problem or diagnosis is discovered, discussed and treated there may be an additional charge.
6. \_\_\_\_\_ In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. FOR EXAMPLE: If child does not pass the hearing screen a more extensive exam called "evoked otoacoustic emissions" is done to determine if there is a hearing problem. The fee is \$95.00 for this exam....which insurance might not cover.
7. \_\_\_\_\_ **Appointments:** Every visit requires an appointment. If you *walk in* we will see you as time allows, unless it is an emergency. If patient is worked in to a full schedule there is a **\$20.00** fee for interrupting the regular appointment hours.
8. \_\_\_\_\_ Check if your insurance policy runs on a plan year or calendar year, because when your child comes in for a wellness exam, you want to make sure that even though your child is another age or has had another birthday, you may only have one check-up per calendar year or plan year.
9. \_\_\_\_\_ If parent is going to have double coverage for patient, please remember that you still have to add patient to both policies. The primary policy will belong to the parent whose birthday month comes first in the year. If parents have double coverage with a group and self policy then the group policy will be primary.
10. \_\_\_\_\_ If insurance is **Medicaid**, parent needs to make sure that he/she notifies Medicaid of baby being born and provide New Braunfels Pediatric Associates, with proof of coverage within 90 days. If staff is not able to prove eligibility with Medicaid then patient is considered **private pay** and all fees are due at time of service. Parent needs to elect New Braunfels Pediatric Associates as their primary doctor in order for Medicaid to pay for visits. This also applies to Community First and Community First Chip policies.
11. \_\_\_\_\_ As an advocate for our young patients, NBPA will not intervene in any custody dispute or financial responsibility dispute between parents or other responsible parties. Practice will send **BILL** to the address provided; however, we cannot look to more than one party for financial responsibility.
12. \_\_\_\_\_ **Pay Discount** NBPA provides a prompt payment discount to those patients who pay for all services at the time of service, thereby avoiding billing and collection costs by the Practice. This will only apply to patients who have a zero previous balance. The discounted amount that the practice will offer is 20% off the total services rendered.
13. \_\_\_\_\_ **Co-payments, Deductibles and Coinsurance** NBPA shall not waive co-payments, coinsurance or deductibles for any patient. These amounts are contractual agreements between guarantor and their insurance plan, and between practice and our insurance plans. These contractual arrangements specifically prohibit us from waiving these charges for any reason. We do accept payments over the phone with any major credit card.
14. \_\_\_\_\_ **Payment Plan:** All balances are due at time of service. If an account is placed on a payment plan the parent would need to make monthly payments and not add to the amount already owed.
15. \_\_\_\_\_ **Minor Patients:** For all services rendered to minor patient, we will look to the adult accompanying the patient as the agent for the responsible party. They will be responsible for applicable charges or co-pays at the time of service. Remember, we cannot see a minor without a parent's presence. Do not send your minors in for a visit alone.
16. \_\_\_\_\_ **Returned check** for insufficient funds incurs a fee of \$30.00.
17. \_\_\_\_\_ **Refunds:** Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued only after all outstanding claims have been processed and paid to us in full. All refunds are done on a semi-monthly basis.

18. \_\_\_\_\_ **Collections:** As of 6/28/07, I understand that I will be legally responsible for all collections costs involved with the collection of account if in default on this agreement.
19. \_\_\_\_\_ **Hospital Charges:** We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of bill from our office.
20. \_\_\_\_\_ **After hour Appointments:** All appointments scheduled after 5:00 p.m. and on Saturdays will incur a \$20.00 fee in addition to the office visit fee.
21. \_\_\_\_\_ **Running late to appointment:** If your are later than 15 minutes, we may have to reschedule your appointment. On the other hand, if we are running behind, we will notify you so that you will have the opportunity to reschedule, or wait if you choose.
22. \_\_\_\_\_ **No Show:** The account will incur a \$25.00 fee if the appointment is missed or not cancelled within 24 hours. A no show letter will be issued and if the problem continues, you will be Released from the practice, and must find a new physician for your children.
23. \_\_\_\_\_ **Medical Records:** When transferring to another doctor a fee of \$27.00 will apply. If records are going to a specialist or all you need is a copy of the summary sheet and shot record no fee will apply. If patient is 18 years old they have to sign a record release themselves. All transfers will require a signature on all medical release forms.
24. \_\_\_\_\_ **Attention Deficit Disorder:** All appointments for ADD are required to have all paper work given to them filled out in full or visit may have to be rescheduled. Please come to the office 30 minutes before your appointment to allow staff times to review these forms. All rewrite prescriptions will acquire a \$5.00 charge but if prescription is lost or stolen controlled prescriptions must be, by law, reported to the Department of Public Safety and the local law enforcement agency and a \$25.00 fee will apply if lost script cannot be returned to our office. Other guidelines are all included in the packet given when appointment is scheduled.
25. \_\_\_\_\_ **Nurse Calls:** The nurses should call you back in the order that the calls are received. If your problem is an emergency, call and speak to the receptionist and they will get the message from you and talk to a nurse at that time.
26. \_\_\_\_\_ **After Hour's Emergencies:** Please use "Call-a-Nurse" at 1-877-647-7440 first. They will advise you to call the medical exchange to speak to the doctor if it is a problem that the doctor needs to handle. Let the medical exchange (830) 608-3402 know that you already spoke to a nurse at Call-a-Nurse first. Another option is to call our office at (830) 625-9153 and our answering service will take your information and have a doctor call you back.

Patient's Name & Date of Birth (Print) \_\_\_\_\_

Siblings Name(s) & Date of Birth \_\_\_\_\_

Parent/Guardian Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. For any extenuating or unusual circumstances, please contact clinic administrator Mary Owens, R.N., CMM, CPEDS, CPC at (830) 625-9153, ext. #215.





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

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have 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**

\_\_\_\_\_  
**Printed name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Personal Representative's Authority**

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**PATIENT SURVEY FORM**

**We value our patients and invite your comments, suggestions or complaints about the care we provide. By evaluating the strengths and weaknesses of our practice, you will assist us in providing better healthcare to our patients.**

**Please take a moment to comment on the services provided to you.**

	<b>Yes</b>	<b>No</b>
1. <b>Was the staff friendly and courteous? Which particular staff member(s) assisted you in making your visit memorable?</b>	_____	_____
2. <b>Do you feel that our office hours are convenient?</b>	_____	_____
3. <b>Is it easy to make an appointment?</b>	_____	_____
4. <b>Do we see you on time for you appointments?</b>	_____	_____
5. <b>Do you feel that we spend enough time with you?</b>	_____	_____
6. <b>Were our explanations clear and were all of your Questions answered to your satisfaction?</b>	_____	_____
7. <b>Does our staff return telephone calls to you in A timely fashion?</b>	_____	_____
8. <b>Do we meet your expectations?</b>	_____	_____

**Do you feel that there is one specific area in which we can improve?**

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**What service(s) would you like to see us provide that we are not offering?**

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**Signature (optional):** \_\_\_\_\_

**Thank you for your comments.**

**Please complete this form to update our demographics information.**

**Preferred Language**

- English
- Spanish
- Other

**Race (check all that apply)**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race

**Ethnicity (check one only)**

- Not Hispanic or Latino
- Andalusian
- Argentinean
- Asturian
- Balearic Islander
- Bolivian
- Canal Zone
- Canarian
- Castillian
- Catalanian
- Central American
- Central American Indian
- Chicano
- Chilean
- Colombian
- Costa Rican
- Criollo
- Cuban
- Declined
- Dominican
- Ecuadorian
- Gallego
- Guatemalan
- Hispanic or Latino
- Honduran
- La Raza
- Latin American
- Mexican
- Mexican American
- Mexican American Indian
- Mexicano
- Nicaraguan
- Panamanian
- Paraguayan
- Peruvian
- Puerto Rican
- Salvadoran
- South American
- South American Indian
- Spaniard
- Spanish Basque
- Uruguayan
- Valencian
- Venezuelan

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_