

# PF-100 New Patient Information

## Patient's Name

First: \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Preferred Phone Number: \_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Insured Name

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employment Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

## Father's Name (if different than Insured Name)

First: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Mother's Name (if different than Insured Name)

First: \_\_\_\_\_ Last: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Information Release Authorization

I authorize BestNest Pediatrics to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to BestNest Pediatrics. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician to access my chart for utilization management review.

First (Print): \_\_\_\_\_ Last: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Stacy L. Terry MD**

4040 Legacy Drive #201 Frisco, TX 75034

972-668-6705 tel 972-668-7308 fax

www.bestnestpediatrics.com

## PF-500 Request to Transfer Medical Records

TO: Name of Practice: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State \_\_\_\_\_, \_\_\_\_\_  
Fax: \_\_\_\_\_

Please forward or fax a copy of :

- \_\_\_ my complete medical record  
\_\_\_ copy of examination notes and problem lists  
\_\_\_ Other: \_\_\_\_\_

to:

**BestNest Pediatrics**

ATTN: Stacy L. Terry MD  
4040 Legacy Dr., Suite 201  
Frisco, TX 75034

**972-668-7308 fax**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Thank you for your prompt attention.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date



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## **PF-1000 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.**

### **Uses and Disclosures**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### **Additional Uses of Information**

**Appointment Reminders.** Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

### **Practice Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

### **Contact Person**

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer  
Stacy L. Terry, MD  
4040 Legacy Dr., Suite 201  
Frisco, TX 75034  
972-668-6705

### **Effective Date**

This Notice is effective on or after April 14, 2003.

  
**Stacy L. Terry MD**  
4040 Legacy Drive #201 Frisco, TX 75034  
972-668-6705 tel 972-668-7308 fax  
www.bestnestpediatrics.com

**PF-2000**

**Acknowledgement of Receipt of Notice of Privacy Practices**

Our practice reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient

# PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

## Information to Be Used or Disclosed

The information covered by this authorization includes:

\_\_\_\_\_ all Information In my files, or

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## Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

\_\_\_\_\_ education, discussion of treatment plan, medical decision making, or

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## Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

BestNest Pediatrics, and

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Name of person/organization

## Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

\_\_\_\_\_

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Name of person/organization

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Name of person/organization

## Expiration Date of Authorization

This authorization is effective unless and until revoked by the patient or the patient's personal representative.

## Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

## Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

## Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.



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**Effect of Refusing Authorization**

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

\_\_\_\_\_  
Treatment conditioned on authorization

**Signature**

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient Representative to Patient