NEW BRAUNFELS PEDIATRIC ASSOCIATES, P.A.

1535 E. Common Street, & Annex Bldg. 1533 E. Common Street, New Braunfels, Texas 78130
& 237 Hunters Village, New Braunfels, Texas 78132
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., Ramona Peck, M.D.,
Michelle L. Bernardy, M.D., Kristen Roeder, M.D., Whitney Morgan, M.D., Rachel L. Hayden, PA-C.,
Wendi H. Reagan, RN, CPNP, Ismaela Gomez, DNP, RN, CPNP, Kristen Roach, RN, CPNP, Sherry Martinez, RN, CPNP

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	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 #	Mother's Email Address		
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 #	Father's Email Address		
Sibling's Full Names				
Reason for today's visit				
Former Doctor		Referred By		

INSURANCE INFORMATION

(Please present insurance card at time of visit)

Name of Primary Insurance Company	Insurance Company Address	City	State	Zip Code
Name of Policy Holder	Date of Birth	Policy Holder Address	City	State	Zip Code
Group #	Policy #	Co-pay Amount		

Name of Secondary Insurance Company	Insurance Company Address	City	State	Zip Code
Name of Policy Holder	Date of Birth	Policy Holder Address	City	State	Zip Code
Group #	Policy #	Co-pay Amount		

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., Ramona Peck, M.D., Michelle L. Bernardy, M.D., Kristen Roeder, M.D., Whitney Morgan, M.D., Rachel L. Hayden, PA-C, Wendi H. Reagan, RN, CPNP, Ismaela Gomez, DNP, RN, CPNP, Kristen Roach, RN, CPNP and Sherry Martinez, RN, CPNP. 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.

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., CMPE, CMM, CPC, CPEDC at (830) 625-9153, ext. #215.

Signature **Date**

Patient Name: _____ DOB: _____

Preferred Language

___ English
___ Spanish
___ Other

Ethnicity (check one only)

___ Hispanic or Latino
___ Not Hispanic or Latino

Race (check all that apply)

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

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

New Braunfels Pediatric Associates, P.A.

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of New Braunfels Pediatric Associates, P.A. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Parent or Legal Guardian: _____ **Date:** _____

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

PLEASE READ THE FOLLOWING CAREFULLY

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., Ramona Peck, M.D., Michelle L. Bernardy, M.D., Kristen Roeder, M.D., Whitney Morgan, M.D., Rachel L. Hayden, PA-C, Wendi H. Reagan, RN, CPNP, Ismaela Gomez, RN, DNP, CPNP, Kristen Roach, RN, CPNP and Sherry Martinez, RN, CPNP or their medical representative, to perform the required medical treatment considered advisable for the patient. I hereby authorize my physician to instruct his/her physician's assistant and/or nurse practitioner to assist him/her in certain aspects of my child's medical care. I understand that a physician's assistant and nurse practitioner are not licensed physicians 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.

Parent or Legal Guardian **Date**