Bruce R. Lantry, MD, FAAP

FIRST STEPS PEDIATRICS PLLC

9910 W Loop 1604 N #124

San Antonio, TX 78254

Phone: (210) 692-0358

Fax: (210) 692-0359

www.fspediatrics.com

Like us on Facebook

Welcome to First Steps Pediatrics. Our goal is to provide quality comprehensive medical care for children in the San Antonio and surrounding areas. We continue to be advocates for children by ensuring each child's worth and assisting families in raising confident, capable, and healthy members of our community. We will treat each patient and parent with respect and dignity.

OFFICE HOURS

Mon: 8:00am-4:30pm

Tues: 8:00am-4:30pm

Wed: 8:00am-12:00pm

Thurs: 8:00am-4:30pm

Fri: 8:00am-4:30pm*

***Summer hours 8:00am-3:00pm**
We are closed weekends and most holidays

Well-child exams and physicals can be made in advance by calling the office at 692-0358. These appointments take a sufficient amount of time; therefore, there are a limited number available on the daily schedule. Please be 15 minutes early to these appointments.

We do not allow walk-in appointments.

If your child is sick, we schedule same-day sick appointments. Please call as early as possible, preferably 8:00 am, to ensure our schedule can accommodate your needs.

After hours, the main phone line will connect you to our answering service. They will take a message for appointment cancellations and page Dr. Lantry for emergency purposes.
Please call 22-NURSE (226-8773) for medical questions after hours.

Other policies are listed in the waiting room of First Steps Pediatrics. We look forward to taking care of your family.

Practice Administrator:
Elizabeth Erickson-Lantry, RN, BSN

Billing Manager:
Kristy Delgado

FIRST STEPS PEDIATRICS, PLLC

New Patient Questionnaire

This document is very important because it informs this practice of medical history on this patient. Please fill out completely and honestly.

Child's Name:_____ D.O.B. _____

Mothers Name:_____
Age:_____
Occupation:_____

Fathers Name:_____
Age:_____
Occupation:_____

If adults in the household work outside the home, what child care arrangements have been made? _____
_____
_____
_____

Past Medical History

1. Where has your child gone for check-ups until now?
   _____
2. Date of last check-up _____
3. Date of last dental check-up _____
4. Has your child had any allergic reactions to any medications, foods, insect bites? **Yes** **No**
   Which ones?_____
   _____
5. Has your child had any reactions to immunizations? **Yes** **No**
   Which ones? _____
   _____
6. Any hospitalizations other than birth? **Yes** **No**
   Which ones?_____
   _____
7. Any serious injuries/fractures/broken bones? **Yes** **No**
   What kind? _____
   _____
8. Are any medications taken regularly? **Yes** **No**
   Which ones? _____
   _____

Family History

Are the child's parents both in good health?
Yes **No**

Circle any disease that this child's parents, grandparents, brothers, sisters, or aunts, and uncles have had:

Anemia Asthma Allergies
Diabetes Heart Trouble Tuberculosis
Mental Illness Cancer AIDS
High blood pressure Mental Illness
Drug Problems Alcohol Problems
Inherited Illness Venereal disease
Others _____

List age, sex, and general health of brothers and sisters_____
_____
_____

Feeding & Nutrition

1.Is your child's appetite usually good?
Yes **No**

2. Is it good now?
Yes **No**

3. Was there severe colic or any unusual feeding problem during the first three months?
Yes **No**

4. Do any foods disagree with him/her?
Yes **No**

5. For the first 6 months, was (is) he/she breast-fed or bottle fed?
Yes **No**

6. If still on formula, which one do you use?_____

7. Does he/she take vitamins?
Yes **No**

8. Are there any smokers in the household?
Yes **No**

FIRST STEPS PEDIATRICS, PLLC

Review of Systems

1. Has your child had frequent ear infections?
   Yes No
2. Any eye problems?
   Yes No
3. Has he/she had any problems with teeth?
   Yes No
4. Does he/she have frequent colds or sore throats?
   Yes No
5. Is there asthma, pneumonia, or recurrent cough?
   Yes No
6. Does he/she have a heart murmur or any heart problems?
   Yes No
7. Any problems with urination?
   Yes No
8. Any problems with diarrhea or constipation?
   Yes No
9. Have there been any convulsions or other problems with the nervous system?
   Yes No
10. Any eczema, hives, or other skin conditions?
    Yes No
11. Has your child ever been anemic?
    Yes No
12. Please list any other medical problems.

_____
_____
_____
_____
_____
_____
_____

Development/Behavior

1. At what age did your child sit alone?
   _____
2. At what age did he/she walk alone?
   _____
3. Did he/she say many words by the time they were 1 ½ years old?
   Yes No
4. How does this child compare to others his or her age?
   _____
5. Does he/she have any problems sleeping?
   Yes No
6. What grade is he/she in? _____
7. Has he/she had any trouble in school?
   Yes No
8. Does he/she get along with other children?
   Yes No

Circle if your child has any of the following:

nail biting	thumb sucking
nightmares	speech problems
bad temper	bed wetting
hyperactivity	

problems with toilet training
problems with discipline
others: _____

Are you concerned about any of these?

_____
_____
_____
_____

Please list anything else that is not included on this form that you feel the doctor/nurse should know in order to better treat the child.

_____
_____
_____
_____
_____
_____
_____
_____

First Steps Pediatrics, PLLC Patient Information Sheet

Patient Information:

Last Name First MI D.O.B. SSN

Street address Apt/Unit # City State Zip Code

Phone number Email Address (Used for appointment reminders)

We are required to ask the following information by federal regulations. If you wish not to disclose this information, or if this is unknown, please write decline or unknown.

Race of Child Ethnicity of Child Primary Language Spoken by Child

(Examples of Race: American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian, Other Island Pacific, White, etc.)
(Examples of Ethinicity: Non-Hispanic, Hispanic, Latino, Mexican American, Puerto Rican, Cuban)

Guarantor: This is the person who is financially responsible for the patient's account.

Last Name First MI D.O.B. Social Security # Relationship to Child

Street Address Apt/Unit # City State Zip Code

Home Phone Cell Phone Work Phone Driver's License # / State

Primary Insurance Policy Holder and Policy Information:

Last Name First MI D.O.B. Social Security # Relationship to Child

Street Address Apt/Unit # City State Zip Code

Home Phone Cell Phone Work Phone

Insurance Company Address Phone Number for Providers

Policy Number Group Number Effective Date

Secondary Insurance Policy Holder and Policy Information:

Last Name First MI D.O.B. Social Security # Relationship to Child

Street Address Apt/Unit # City State Zip Code

Home Phone Cell Phone Work Phone

Insurance Company Address Phone Number for Providers

Policy Number Group Number Effective Date

NOTICE OF HEALTH INFORMATION 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 see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. Requests for restrictions on disclosures to your health plan for health care items or services paid out of pocket must be accepted.
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 and HB 300 (paper or electronic).
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- receive a notice of a breach of "unsecured" protected health information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose or sell your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

6. **Funeral Directors –** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

8. **Marketing –** We may contact you to provide appointment reminders or face- to- face information about treatment alternatives or other health-related benefits and services that may be of interest to you.

9. **Food and Drug Administration (FDA) –** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.

10. **Workers' Compensation –** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

11. **Public Health –** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

13. **Schools** - We may disclose childhood immunization records to schools.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of _____ and will remain in effect until revised. T*

First Steps Pediatrics, PLLC
CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by First Steps Pediatrics, PLLC for the purposes of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of First Steps Pediatrics, PLLC. I understand that diagnosis or treatment by Bruce R. Lantry, M.D. may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. First Steps Pediatrics, PLLC is not required to agree to the restrictions that I may request. However, if First Steps Pediatrics, PLLC agrees to a restriction that I request, the restriction is binding on First Steps Pediatrics, PLLC and Bruce R. Lantry, M.D.

I have the right to revoke this consent, in writing, at any time, except to the extent that Bruce R. Lantry, M.D. or First Steps Pediatrics, PLLC has taken action in reliance on this consent.

My "protected healthcare information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review First Steps Pediatrics, PLLC Notice of Privacy Practices prior to signing this document. The First Steps Pediatrics, PLLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of First Steps Pediatrics, PLLC. The Notice of Privacy Practices for First Steps Pediatrics, PLLC is also posted in the waiting room and in the triage area. The Notice of Privacy Practices also describes my rights and the duties of First Steps Pediatrics, PLLC with respect to my protected health information.

First Steps Pediatrics, PLLC reserves the right to change the privacy practices that are described in Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at a time of my next appointment.

_____

Signature of Parent or Guardian Date

_____

Printed name of Parent or Guardian Relationship to Patient

_____

Printed name of Patient Date of Birth

First Steps Pediatrics, PLLC
Patients Financial Policy

(Updated October, 2011)

First Steps Pediatrics, PLLC is dedicated to providing the best possible care and service to you and regards the understanding of your financial responsibilities as an essential part of care and treatment.

Your Insurance

We have contracts with most major health plans to accept an assignment of benefits. This means we will bill those plans for which we have a contract and will only require you to pay the authorized co-payment/deductible at the time of service. It is the policy of our office to collect this co-payment/deductible at the time services are rendered. Any amount due at the time of service that is not collected will be assessed a $15.00 billing fee.

In the event that your health plan determines an amount to be "patient responsibility" or applied to a deductible/co-insurance, you will be responsible for payment of such service. Payment is due upon receipt of a statement from our office. Balances over 30 days will be assessed a $15.00 re-billing fee. Any balances not paid in full within 90 days will be forwarded to our collection agency. Any fees associated with collecting your debt will be your responsibility.

Although we will make every attempt to collect from your insurance company, if we do not receive payment from your insurance company within 90 days of claim submission, the total amount due for the specified date of service will be due from the guarantor.

Private Pay

We provide patients without health insurance "private pay" discount. Our office must be contacted prior to services being rendered to discuss the terms and conditions of this discount. For patients with out-of-network insurance, claims will not be submitted by the office and the full amount will be due at the time of service. You may then personally file the claim to your insurance company.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient or the parent/guardian for payment (including any past due balances). We will not get involved in arrangements made between divorced parents or custodial agreements.

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 at will by the practice.

_____

Signature of Parent or Guardian Date

_____

Printed name of Parent or Guardian Relationship to Patient

_____

Printed name of Patient Date of Birth

FIRST STEPS PEDIATRICS, PLLC OFFICE POLICIES

(Updated October, 2011)

Appointments

1. Due to our busy schedule, we do not allow walk-ins, only scheduled appointments.
2. Well exams, follow-ups, physicals, and shot appointments may be scheduled in advance. Sick visits will be scheduled only on a same day basis.
3. As a courtesy, we allow 10 minutes for lateness. After 10 minutes we reserve the right to reschedule (this includes both sick and well appointments).
4. Cancellations must occur 2 hours before the scheduled appointment time or a $50 fee per appointment time is incurred. This fee must be paid before other elective visits are scheduled.
5. Missed appointments incur a $50 fee. The 2nd missed appointment will receive a warning letter and an additional $50 fee. The 3rd missed appointment will incur an additional $50 fee and termination from the practice. (Our after hours answering service is instructed to take appointment cancellations and will inform us by fax. During office hours if the receptionist is unavailable, your call will forwarded to our voice mail system.) Fees must be paid before other elective visits are scheduled.
6. Parent or Legal Guardian must accompany all patients to all appointments. (In the event that a secondary caretaker brings the patient in for an office visit, there must be written consent from parent or legal guardian before the patient is examined. Verbal consent will not be accepted.)

The following individuals are authorized to schedule appointments and/or accompany my child to their appointments:

Name_____ Phone #_____ Relationship to Child_____

Name_____ Phone #_____ Relationship to Child_____

Name_____ Phone #_____ Relationship to Child_____

Name_____ Phone #_____ Relationship to Child_____

Phone Call Policies

1. The physician will only speak to parents or legal guardians regarding patient's health. All phone calls will be returned the same day; however, times may vary depending on availability. If you cannot wait for a return phone call, an appointment must be made or the patient should be taken to emergency care.
2. Please remove call block from your phone when expecting a call back. The phone lines are private; therefore, physicians and nurses cannot get through otherwise. Please be available for your requested call backs.

Insurance/Billing Policies-Also refer to the financial policy provided to you.

1. We do accept most private insurances. It is the responsibility of the guarantor to provide proof of the insurance and verification information. If this information is unavailable at the time of the appointment or the insurance cannot be verified, then the guarantor, at the time services are rendered, can pay for the full amount of the office visit and seek reimbursement from their insurance company, or utilize the private pay option. (If the private pay option is used you cannot bill your insurance company for reimbursement due to the discount available for private pay patients. This is insurance fraud and could have legal ramifications.) For further information regarding your insurance please contact the business office at (210) 692-7787.
2. All Payments are due at the time of service. There is a $15 administration fee for co-pays or deductibles not paid at the time of service. Private pay patients should be prepared to pay for the entire office visit.
3. Copies of billing records will incur a $15.00 charge per patient unless requested at the time of service.

Medical Records Policy

1. All requests for medical records must be in writing.
2. Medical records from a previous physician may be requested by completing the appropriate form provided by our office.
3. Medical records may be transferred to a new physician by completing the appropriate form provided by the new physician or our office. A fee of $25 for the first 20 pages and $.25 for each additional page will be assessed for copies of medical records. This fee must be paid in advance. Additionally, fees associated with mailing records must be paid in advance. Records will be mailed or ready for pick-up within 15 business days from the request.
4. Copies of vaccine records, no obtained during an office visit, will incur a $5.00 charge.

Forms Policy

1. There are various forms that might be required by schools, daycares, sports programs, etc. Please bring these forms to your physicals and well check-ups in order to be filled out and signed by Dr. Lantry.
2. If the form is received within 30 days after your child's well check up or physical, there will be no charge for the completion of the form. However, if your child's last check up was more than 30 days ago, **there will be a $10.00 charge.**
3. **All FMLA forms** will incur a $10.00 charge.
4. *Forms cannot be filled out for patients who have not been seen for a physical or well check up within the past 12 months.*

Picture/Birth Announcement Policies

1. Pictures and birth announcements given to First Steps Pediatrics become the property of First Steps Pediatrics and could be proudly displayed in the office.
2. We kindly ask that if you do not wish to have these displayed please indicate this on the announcement or photo.

Receipt of Office Policies

I hereby certify that I have read and understand the Office Policies of First Steps Pediatrics, PLLC, updated October, 2011. I have been given an opportunity to have my concerns and questions addressed. I agree to follow the office policies, to the best of my ability, in order to remain in the care of Dr. Bruce R. Lantry.

I also agree that this office may bill my insurance for services rendered and agree to pay all co-pays or deductibles at the time of service. If I have a private pay account, I understand the total amount due will be collected at the time of service. If collection becomes necessary, I understand I will pay all costs, including collection agency fees and attorney fee, associated with collecting your balance.

_____

Signature of Parent or Guardian **Date**

_____

Printed name of Parent or Guardian **Relationship to Patient**

_____

Printed name of Patient **Date of Birth**

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Please release medical records to: **First Steps Pediatrics, PLLC**
9910 W Loop 1604 N #124
San Antonio, TX 78254
(210) 692-0358

Please release medical records from: _____
Physician's Name or Name of Practice where records are coming from

_____
Physician's Address with suite number City State Zip Code

I hereby request and authorize the physician or practice listed above, to release a copy, summary, or narrative of my medical records, as indicated by the checkmark(s) below, or otherwise confidential information.

- ❑ Complete record
- ❑ Records of care from the following dates: _____to_____
- ❑ Records concerning the following conditions:_____
- ❑ Other, please specify:_____

Patient Name: _____ Date of Birth: ___/___/____
Please Print

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:

Initials: _____Date: ___/___/___

The reason or purpose for this release of information is as follows:

- ❑ Insurance
- ❑ Moving
- ❑ Other:_____

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization before any medical records can be requested.

_____ ____/____/____
Parent's Signature Date

_____
Print Name

Notice: Texas State Law requires that within 15 days upon receipt of medical records request, a physician shall furnish copies, summary, or narrative of the requested records, including records received from another physician or healthcare provider involved in the care or treatment of a patient.

FIRST STEPS PEDIATRICS, PLLC

Vaccination Schedule

Newborn:	HepB#1 (if not given in hospital)
2 weeks:	Newborn screen#2 (@ TNI)
1 month:	HepB#2
2 month:	Pentacel#1 (DTaP#1, HIB#1, IPV#1), PCV7#1, RotaTeq#1
4 month:	Pentacel#2 (DTaP#2, HIB#2, IPV#2), PCV7#2, RotaTeq #2
6 month:	Pentacel#3 (DTaP#3, HIB#3, IPV#3), PCV7#3, HepB#3, RotaTeq#3
9 month:	Hgb (screen for anemia); shots only if behind
12 month:	MMR#1, Varicella#1, HepA#1
15 month:	DTaP#4, PCV7#4, HIB#4
18 month:	HepA#2 (must be 6 mos. from HepA#1)
2 year:	Shots only if behind (check for HepA #2)
3 year:	Shots only if behind
4 year:	DTaP#5, IPV#4, MMR#2, Varicella#2
5-10 year:	Shots only if behind
11 year :	Meningococcal, TDaP, Gardasil*(females and males)
16 year :	Meningococcal#2

*Patients receiving Gardasil - need to schedule shot-only appointments 2 and 6 months after the first dose to receive the 2nd and 3rd doses.