children's health
Pediatric Group

2016 Demographics
Patient Information Form

HOW DID YOU HEAR ABOUT US? ☐ Online ☐ Health/School Event ☐ Referral/Word of Mouth ☐ I am a CHST/CMC Employee ☐ Other

PATIENT INFORMATION

Child's Name (Last Name, First Name, Middle Name) ______________________________

Date of Birth (Month/Day/Year) _______/________/________ Male (☐) Female (☐) SSN #________-_______-________

Child's Street Address (City, State, Zip Code): ______________________________

Child Lives With: ☐ Mother ☐ Father ☐ Guardian/Other: __________________ Phone Number:____________________________

Email: ________________________ Preferred Pharmacy Name: _______________________Cross Streets: _____________________

Race (Please select appropriate group):
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Other

Ethnicity (Please select appropriate group):
☐ Latino/Hispanic
☐ Other

PARENT/GUARDIAN INFORMATION

Mother's/Guardian's Name: _____________________________ **Father's/Guardian's Name:** ________________________________

DOB:_____________ Primary Phone: _______________________ DOB: ______________________Primary Phone: ________________

Mother's/Guardian SS# ______________________________ Father's/Guardian SS# ______________________________

Address: ______________________________ Address: ______________________________

Employer: ___________________ Work Phone: _______________ Employer: _____________________Work Phone: _________________

EMERGENCY CONTACT- In case of an emergency, who should we contact?

Name __________________________ Relationship __________________________ Phone _______________________________

Children's Health Pediatric Groupmay disclose *Medical* and *Billing* information to this contact. ☐ YES ☐ NO

INSURANCE INFORMATION

Is the patient covered by insurance? ☐YES ☐ NO

Name of Person Responsible for Paying the Bill ☐ Mother ☐Father ☐Other ____________________________________

Street Address: ☐ Same As Child ☐ Other (City, State, Zip Code)____

Primary Phone Number ________________Cell Phone Number __________________________

PRIMARY INSURANCE

Policy Holder's Name ☐ Child ☐ Mother ☐ Father ☐ Other _________________ Insurance Name_____________________________

Policy Holder's Social Security # (if other than child):________- ________-________ Policy Holder's Date of Birth ______/______/_______

SECONDARY INSURANCE

Policy Holder's Name ☐ Child ☐ Mother ☐ Father ☐ Other _________________ Insurance Name_____________________________

Policy Holder's Social Security # (if other than child):________- ________-________ Policy holder's date of birth ______/______/_______

I certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility and duty to inform Children's Health Pediatric Group should any information contained on this form change in the future.

____________________________	____________________________	________________
Printed Name of Parent/Legal Guardian	Signature	Date

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Children's Health Pediatric Group Patient Preferences and Acknowledgements

NO SHOW POLICY ACKNOWLEDGEMENT

While we understand that situations do arise that may prevent you from making your child's appointment, advance notifications allows us the opportunity to offer the appointment time to other patients in need of medical care. When patient families do not show for their appointments, other patients waiting to be scheduled are unable to receive an appointment.

In order to improve access to care for all patients, failure to cancel or reschedule an appointment by 3 pm the day prior to your appointment, and/or failure to present at the time of the appointment, will result in a "no-show". Multiple no-shows may result in the need to transfer your care to another provider.

☐ I have read and understand the No-Show Policy and acknowledge that I will be held accountable as specified above.

PREFERRED METHOD OF COMMUNICATION

My preferred method of communication regarding patient's medical information is:

☐ Home Phone ☐ Work Phone ☐ Cell Phone

Please check the appropriate box:

☐ Leave a message with detailed information

☐ Leave a message with a call back number

DELEGATION OF CONSENT

We understand that on occasion, the need may arise for someone other than the parent/legal guardian indicated on file to bring in the child for medical care. Below, please indicate those to whom authorization may be given when you are unavailable.

Name ____________________ Relationship to Patient ____________________

Name ____________________ Relationship to Patient ____________________

I authorize the above individuals to consent to any and all medical care/treatment for this child by a Children's Health Pediatric Group healthcare provider. This delegation is valid until I have withdrawn this consent.

Patient Name ____________________ Date of Birth ____________________

Signature of Parent/Legal Guardian ____________________ Date ____________________

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Children's Health Pediatric Group General Consent for Treatment and Acknowledgements (1 of 2)

Patient Name: ___________________________ DOB: _____________

Consent for Care and Treatment

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Children's Health Pediatric Group. Treatment provided by medical providers, nurses, and medical assistants at Children's Health Pediatric Group may include evaluation and management, vaccinations, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, quality improvement, and education purposes. I understand that Children's Health Pediatric Group is affiliated with a teaching institution and agree that resident physicians, fellows and students may observe and participate in Patient's care and treatment under appropriate supervision.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Children's Health Pediatric Group. I understand that all supplies, medical devices and other goods provided to Patient are provided by Children's Health Pediatric Group AS IS and Children's Health Pediatric Group disclaims any expressed or implied warranties.

Patient Rights: I have been provided information regarding Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Children's Health Pediatric Group.

Communicable Disease Testing: I agree that if a Children's Health Pediatric Group employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Texas law, Children's Health Pediatric Group may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Children's Health Pediatric Group may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Children's Health Pediatric Group can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN.

Protected Health Information

Notice of Privacy Practices: I have received the Children's Health Pediatric Group *Notice of Privacy Practices.* Any questions or concerns may be directed to Children's Health Pediatric Group Privacy Officer.

Use and Disclosure of information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices I have received. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment (Medical Information). I authorize release of that Medical Information, as part of Patient's medical record. I understand that Children's Health Pediatric Group must keep Patient's medical records for a time period required by law and then may dispose of them as permitted or required by law.

Consent for Electronic Sharing and Health Information Exchange: I authorize Children's Health Pediatric Group to use Patient's Medical Information for Patient's treatment and related services. Unless I object below, I authorize Children's Health Pediatric Group to release and send Patient's Medical Information to Patient's non- Children's Health Pediatric Group health care providers electronically and / or through a Health Information Exchange, an organization that provides services to enable the electronic sharing of health-related information. Medical Information disclosed pursuant to this authorization may be used for treatment, payment and operational purposes. The Medical Information disclosed may become part of my non-Children's Health Pediatric Group health care providers' medical records and may be re-disclosed by the recipient and no longer protected by state or federal privacy laws. I understand that if Patient is also a Patient at Children's, the Medical Information from Children's records may also be released by my signing this authorization.

I understand that I can change my mind and withdraw this authorization at any time, but Children's Health Pediatric Group cannot take back information that has already been electronically shared. This consent is valid unless I have withdrawn it.

☐ I do not want Patient's Medical Information shared electronically with non-Children's Health Pediatric Group health care providers. I understand, however, that if electronic sharing is required by law, Children's Health Pediatric Group must act in compliance with the law.

☐ I do not want Patient's Medical Information shared with Health Information Exchanges. I understand, however, that if electronic sharing with a Health Information Exchange is required by law, Children's Health Pediatric Group must act in compliance with the law. I further understand that certain Medical Information may be shared with a Health Information Exchange in a manner that does not identify Patient.

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Children's Health Pediatric Group General Consent for Treatment and Acknowledgements (2 of 2)

Financial Responsibility

I agree to pay for the full billed charges associated with goods and services provided to Patient regardless of any applicable insurance or benefit payments and understand that all amounts are due upon request and are payable to Children's Health Pediatric Group. Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and / or benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and / or plan limitations, exclusions, and / or failure to comply with insurance and / or plan requirements.

I also agree and understand that if Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre-recorded message calls to my cellular telephone and to any telephone number provided during Patient's registration process from Children's Health Pediatric Group, Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services.

Medicaid Patients Only: I understand that the goods and services that I or Patient request to be provided to Patient may not be covered under Medicaid as being reasonable and medically necessary for Patient's care. I understand that Medicaid or their insuring agent determine the medical necessity of the goods and services that are requested for Patient. If Medicaid determines that certain goods and services are not medically necessary for Patient's care and I request such goods and services be provided despite Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If Patient is a Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of Patient in applying for payment under Medicaid is correct. I authorize the release of medical or other information about Patient to the Social Security Administration, intermediaries, or carriers as needed for related Medicaid claims.

Notice to Patients - Third Party Payer (Health Plan Member) Information

I acknowledge that based on the information I have provided at this time about Patient's insurance or other third-party coverage for Patient,

Children's Health Pediatric Group

☐ IS/ ☐ IS NOT a participating provider under Patient's third-party payer coverage, insurance, or benefit plan.

Assignment of Benefits

I irrevocably assign and convey directly to Children's Health Pediatric Group, and any provider that provides services to Patient at Children's Health Pediatric Group (Providers), all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal / administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payer providing benefits on Patient's behalf for goods and services provided to Patient by Children's Health Pediatric Group and Providers. I also authorize direct payment to Children's Health Pediatric Group for the goods and services Children's Health Pediatric Group and Providers provide to Patient.

I authorize Patient's plan administrator, insurer, and / or attorney to release to Children's Health Pediatric Group and Providers any and all Plan documents, summary benefit description, insurance policy, and / or settlement information upon written request from Children's Health Pediatric Group or Providers needed to claim medical benefits.

Under this assignment, I convey to Children's Health Pediatric Group and Providers all of my rights to claim (or place a lien on) benefits related to goods and services provided by Children's Health Pediatric Group Providers to Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. Children's Health Pediatric Group has the right to (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. Children's Health Pediatric Group may bring suit against any such benefit plan, plan administrator or insurance company in my name with derivative standing. This assignment is not and shall not be construed as an obligation of Children's Health Pediatric Group to pursue such interest and rights.

I certify that I have read and understand the information in the Consent for Care and Treatment, Protected Health Information, Financial Responsibility, Notice to Patients - Third Party Payer (Health Plan Member) Information, and Assignment of Benefits.

Signature of Patient or Legally Authorized Representative	Date	Time
Printed Name of Patient or Legally Authorized Representative	Date	Time
Relationship to Patient		
Witness	Date	Time

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name **Child's Middle Name**

__ / __ / ____ ***Children under 18 years only.*** **Child's Gender**: ☐ **Male** ☐ **Female**

Child's Date of Birth

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: ______________________________
Printed Name

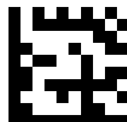
______________________ ______________________________
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012



PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.* ***DO NOT fax to ImmTrac. Retain this form in your client's record.***

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Release of Information Policy

Children's Health[sm] Pediatric Group has a legal and ethical responsibility to preserve the confidentiality of patient information that we retain in our medical records. To comply with the Health Insurance Portability and Accountability Act of 1996, we are required to have patients sign a written release of information form before providing our patient records to other individuals or agencies.

- Authorization to release medical records is valid for 180 days and requires a specific Medical Authorization (see following page).
- Requests made are processed in order of receipt. If the situation warrants, priority will preempt order of receipt.
- We do not provide copies of records to persons on a walk-in basis. *Children's Health Pediatric Group requires a formal request for medical records be made in advance and there may be a turn-around time of 48 hours or more, depending on size of the medical record.*
- Children's Health Pediatric Group reserves the right to charge a minimum of $25 for the duplication of medical records and completion of camp and school forms.
- In order to reduce the potential liability associated with the faxing of medical records and the risk of violating patient confidentiality, Children's Health Pediatric Group is only able to fax patient records to other healthcare facilities and providers.

It is illegal to deny a patient their records or refuse the transfer of their records because their account has not been paid.

Normas generales de Liberacion de Informacion

Children's Health Pediatric Group tiene la obligación legal y ética de conservar la confidencialidad de la información del paciente contenida en nuestros registros médicos. Para dar cumplimiento al Acto de Práctica Médica en Texas de 1981, es requerido que nuestros pacientes firmen una solicitud de liberación de información antes de poder entregar esos registros a otro individuo o agencia.

- La autorización para distribuir registros médicos es valida durante un año y requiere una solicitud específica y una Liberación Médica.
- Las solicitudes son tramitadas en orden de recepción. Sin embargo, si la situación lo amerita, prioridad anticipara orden de recepción.
- No proporcionamos copias de registros a personas que se presentan directamente. Aviso avanzado es necesario y puede tardar hasta 48 horas o mas dependiendo del volumen.
- Children's Health Pediatric Group se reserva el derecho de cobrar a la parte responsable el costo ($25.00) de la copia de registros médicos así como el llenado de formularios para campamentos o escuelas.
- Con el propósito de reducir el posible riesgo relacionado con el envio de dichos registros por fax y para proteger la confidencialidad del paciente, Children's Health Pediatric Group sólo enviara registros de pacientes a otras instalaciones médicas y proveedores.

Es ilegal negarse a entregar o transferir los registros de un paciente debido a adeudos. Sin embargo, antes de enviar los registros, un médico de Children's Health Pediatric Group debe estudiar los registros y/o ser informado de la solicitud.

Please sign to acknowledge you have read and understand this Children's Health[sm] Pediatric Group

Release of Information Policy

Por favor firme para decir que usted ha leído y entiende la Poliza de Liberacion de Informacion Children's Health Pediatric Group

Parent or Legal Guardian Signature
Firma del padre o tutor legal: ____

Patient Name: Date:
Nombre del paciente: ______________________________ Fecha:________________________