PATIENT INFORMATION

Legal Name: _____
Last First Middle Preferred Name

Birth Sex: ☐ Male ☐ Female DOB: _____

_____
Address Apt. # City State Zip

_____
Home Phone Mobile Phone

Lives with Child: ☐ Parent/Legal Guardian 1 ☐ Parent/Legal Guardian 2

_____ Relationship: _____ Mobile: _____
Parent/Legal Guardian 1 Full Name

Email: _____ DOB: _____ Legal Sex: ☐ Male ☐ Female

_____
Address (if different from patient) Apt. # City State Zip

_____Relationship: _____ Mobile: _____
Parent/Legal Guardian 2 Full Name

Email: _____ DOB: _____ Legal Sex: ☐ Male ☐ Female

_____
Address (if different from patient) Apt. # City State Zip

Parent Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed

Race: ☐ Asian ☐ Black ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ White ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline Preferred Language: _____

INSURANCE INFORMATION

Primary Carrier _____ Subscriber Name _____ Subscriber DOB _____ HMO? ☐ Yes ☐ No

Phone # _____ Policy # _____ Group # _____

Employer: _____

Secondary Carrier _____ Subscriber Name _____ Subscriber DOB _____ HMO? ☐ Yes ☐ No

Phone # _____ Policy # _____ Group # _____

Employer: _____

How did you hear about our office?

☐ Internet ☐ Facebook ☐ Drive-by ☐ Insurance ☐ Hospital ☐ Friend/Family ☐ Other: _____

_____ _____
Parent Signature Date

Patient's Name _____ **Today's Date**_____

BIRTH HISTORY

Date of Birth_____Birth Length _____Birth Weight _____

Delivery: ☐ Vaginal ☐ Cesarean If Cesarean, why? _____

Born at term: ☐ Yes ☐ No If early, weeks gestation? _____

Did mother have any illness or problems with pregnancy? ☐ Yes ☐ No Explain _____

Did baby have any problems right after birth? ☐ Yes ☐ No Explain _____

During pregnancy did mother do any of the following? ☐ Smoke ☐ Drink alcohol ☐ Use drugs or medication

Did baby go home with mother from the hospital? ☐ Yes ☐ No Explain if no _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical conditions? ☐ Yes ☐ No Explain_____

Has your child had serious injury or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery(s)? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicine or drugs? ☐ Yes ☐ No Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain_____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

Is your child currently in school? ☐ Yes ☐ No If yes please answer the following:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade? ☐ Yes ☐ No Explain _____

How is he/she doing in academic subjects? _____

Is he/she in special or resources class? ☐ Yes ☐ No Explain _____

Condition	Patient	Explain	Family History	Family Member
Pregnancy	Y N DK			
Chicken Pox	Y N DK			
Frequent ear infections	Y N DK		Y N DK	
Problems with ear or hearing loss	Y N DK		Y N DK	
Nasal allergies	Y N DK		Y N DK	
Problems with eyes or vision	Y N DK		Y N DK	
Asthma, bronchitis, or pneumonia	Y N DK		Y N DK	
Heart problems or heart murmur	Y N DK		Y N DK	
Anemia or bleeding disorder	Y N DK		Y N DK	
Blood transfusion	Y N DK		Y N DK	
Immune problems, HIV or AIDS	Y N DK		Y N DK	
Organ transplant	Y N DK		Y N DK	
Malignancy/bone marrow transplant	Y N DK		Y N DK	
Chemotherapy	Y N DK		Y N DK	
Frequent abdominal pain	Y N DK		Y N DK	
Constipation requiring dr visits	Y N DK		Y N DK	
Frequent UTIs/kidney disease	Y N DK		Y N DK	
Congenital cataracts/retinoblastoma	Y N DK		Y N DK	
Metabolic/Genetic disorders	Y N DK		Y N DK	
Urologic malformations	Y N DK		Y N DK	
Bed-wetting (after 5 years old)	Y N DK		Y N DK	
Sleep problems; snoring	Y N DK		Y N DK	
Skin problems (ex: acne, eczema)	Y N DK		Y N DK	
Frequent headaches	Y N DK		Y N DK	
Convulsions, epilepsy, seizure, neurological issue	Y N DK		Y N DK	
Obesity	Y N DK		Y N DK	
Thyroid or other endocrine problems	Y N DK		Y N DK	
High blood pressure	Y N DK		Y N DK	
Diabetes	Y N DK		Y N DK	
History of serious injuries/fractures/concussion	Y N DK		Y N DK	
Use of alcohol or drugs	Y N DK		Y N DK	
Tobacco use	Y N DK		Y N DK	
ADHD/anxiety/depression/mental illness/mood	Y N DK		Y N DK	
Developmental delay	Y N DK		Y N DK	
Dental decay	Y N DK		Y N DK	
Tuberculosis	Y N DK		Y N DK	
High cholesterol/takes medication	Y N DK		Y N DK	
Liver disease	Y N DK		Y N DK	
History of family violence	Y N DK		Y N DK	
Sexually transmitted infections	Y N DK		Y N DK	
For Girls Problems with periods	Y N DK		Y N DK	
Has had first period	Y N DK		Start Date:	
Cancer	Y N DK		Y N DK	Age:
Other chronic conditions	Y N DK		Y N DK	

Health History Completed By:_____**Date:**_____

Communication Consent

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

Preferred Communication Method (Mark all that apply):

☐ No Preference ☐ Mail ☐ Phone ☐ Voicemail ☐ Email ☐ Patient Portal ☐ Accept Text Messages

By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from Pediatric Healthcare Associates, PA

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT, PARENT OR LEGAL GUARDIAN.

☐ I give **Pediatric Healthcare Associates, PA** my permission to leave **detailed phone messages** regarding my child's **medical care and test results.**

_____ _____

Parent Signature Date

Consent & Authorizations for Services

☐ AUTHORIZATION FOR TREATMENT: I authorize Pediatric Healthcare Associates, P.A. to provide treatment to the below named patient.

☐ REFERENCE LABORATORY SERVICES: I understand that Pediatric Healthcare Associates, P.A. utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent for Pediatric Healthcare Associates, P.A. to provide demographic and insurance information as necessary for billing purposes.

☐ ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay and hereby assign directly to Pediatric Healthcare Associates, P.A. all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

☐ AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize release of copies of pertinent medical records to providers outside of Pediatric Healthcare Associates, P.A. who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

☐ AUTHORIZATION FOR RELEASE FOR QUALITY IMPROVEMENT: Texas Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose. It is likely that PHA will NOT participate in any research or quality improvement with a third party.

☐ AUTHORIZATION FOR REVIEW OF PRESCRIPTION HISTORY: I authorize Pediatric Healthcare Associates, P.A. to access my electronic records of previously prescribed medications through the external electronic prescribing network, Surescripts.

☐ USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION: My insurer may share my past, current and future health and account records with Pediatric Healthcare Associates, P.A. about services I've received from Pediatric Healthcare Associates, P.A. and other care providers unrelated to Pediatric Healthcare Associates, P.A. These records may be used by Pediatric Healthcare Associates, P.A. as needed to manage or coordinate my care and to improve the quality of that care. By signing this form, I am consenting to treatment, and agreeing to all above policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____

Parent Signature Date

Financial Policy

☐ Payment is due regardless of who brings the child in for the service, Grandparents, caregivers, aunts, etc., payment is expected.

☐ In the event that a guardian shares custody of patient, the guardian present at the time of service is responsible for payment in full at that time. If you have a court order requiring treatment costs be shared, it is the responsibility of the guardians to make appropriate arrangements prior to treatment.

☐ Insurance must be provided and active in order to utilize your benefits. If insurance cannot be determined as active, patient will be considered Private Pay for that visit.

☐ Financial responsibility is determined from the benefits we receive from your insurance company. Your insurance determines if you have a copay, deductible and/or co-insurance.

☐ Verification of insurance is not a guarantee of payment; you are still responsible for all services provided to your child, until your insurance processes and pays PHA for our services.

☐ Acceptable forms of payment include cash, check, Visa, MasterCard, Discover and American Express. PHA is willing to offer payment holds or payment plans on large balances. A fee of $25.00 will be assessed to all returned payments.

Cancellation and No Show Policy

☐ **$75.00** fee will apply to all **Well Child Visits** and **ADD/ADHD** visits, cancelled on same day as appointment or No Showed to appointments.

☐ **$50.00** fee apply to all other No Show appointments.

_____ _____

Parent Signature Date

Notice of Privacy Practices Acknowledgement

☐ I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this Information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

☐ I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of **Notice of Privacy Practices**. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

☐ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. Please scan the QR Code for a copy.

_____ _____

Parent Signature Date

Vaccination Policy

As of October 1, 2013, Pediatric Healthcare Associates, PA, no longer accepts NEW patients that do not adhere to the standard immunization schedule based on the recommendations of AAP (American Academy of Pediatrics). Exceptions to this policy should be discussed with your child's provider regarding any deferment or delay in the vaccination schedule.

CDC and AAP recommended Immunization Schedule example:

Patient Age	Immunizations
2 months	Rotavirus, DTaP, Hib, PCV20, IPV, Hep B
4 months	Rotavirus, DTaP, Hib, PCV20, IPV, Heb B
6 months	Rotavirus, DTaP, Hib, PCV20, IPV, Heb B
12 months	PCV20, MMR, Varicella, Hep A
15 months	DTaP, Hib
18 months	Hep A
4-6 years	Dtap, IPV, MMR, Varicella
11-12 years	TDaP, Meningococcal
11-12(or later)	HPV#1,2,3
16 years	Meningococcal

☐ I understand and agree to the above Pediatric Healthcare Associates, PA vaccination policy.

_____ _____

Parent Signature Date

Authorization for Medical Care to Minors

I_____the parent or legal guardian of the minor

Child _____DOB_____

do hereby authorize the below individual(s) to consent to medical treatment of my child, in my absence at Pediatric Healthcare Associates, P.A..

Name of the adult person(s) authorized to bring minor child in for medical treatment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I agree that the above authorization for medical care to my minor child will be in effect until I revoke it in writing.

Signature; _____ Date: _____

Forensic Services Agreement

This Forensic Services Agreement (the "Agreement") must be signed by any patient or guardian of a patient ("you") before you can become eligible to receive treatment or services from Pediatric Healthcare Associates.

Pediatric Healthcare Associates only provides in-office pediatric medical services to patients seeking treatment. Pediatric Healthcare Associates reserves the right, in Pediatric Healthcare Associates' sole discretion, to decline to provide any services to client in any fashion or venue apart from a regularly scheduled in-office visit.

Pediatric Healthcare Associates does NOT provide forensic legal services to any parties, NOR does Pediatric Healthcare Associates desire to provide such services for clients, their families, or their adverse or potentially adverse parties.

Pediatric Healthcare Associates does NOT conduct forensic custody evaluations, social studies, or other forensic evaluations for patients for use in legal proceedings, whether in court or out of court.

Pediatric Healthcare Associates ONLY provides pediatric medical treatment to patients who seek to improve their health or to identify and treat medical issues. Pediatric Healthcare Associates will not, under any circumstances, begin providing treatment to your child and later assume an engagement for forensic services, whether intentionally or unintentionally.

Pediatric Healthcare Associates understands, however, that your life circumstances may change, and you may (or a court or another party involved in litigation with or against you may) compel or otherwise seek to have Pediatric Healthcare Associates personnel appear for a deposition, court testimony, or appear for some other legal proceeding. PEDIATRIC HEALTHCARE ASSOCIATES CANNOT CHARGE YOUR INSURANCE FOR THESE PURPOSES AND SERVICES. Due to insurance reimbursement restrictions, to the extent you (or any other party involved in litigation with or against you) wish to secure Pediatric Healthcare Associates' services for any reason (other than for an in-office visit for pediatric medical treatment), including services or appearances in anticipation of a lawsuit or after the commencement of a lawsuit or any and all matters compelled by lawful subpoena or court order pertaining to client matters (collectively referred to hereafter as "Forensic Services"), you must pay, in full and in advance, for such requested services according to the terms of this Agreement. To the extent any such Forensic Services are reimbursed or covered by your insurance, it is your sole responsibility to file any required or necessary paperwork to recover any fees charged by Pediatric Healthcare Associates for Forensic Services.

Your Payment Obligation to Pediatric Healthcare Associates in the event Forensic Services are requested by parent/patient/legal guardian are as follows:

- Pediatric Healthcare Associates requires payment upfront for a minimum three-hour time commitment by Pediatric Healthcare Associates for any Forensic Services. You must pay Pediatric Healthcare Associates a minimum, non-refundable, three- hour retainer ($900 or $1,200 as outlined above) prior to Pediatric Healthcare Associates' preparation or travel for the provision of Forensic Services.

- Pediatric Healthcare Associates will charge you in quarter-hour (15 minute) increments for Forensic Services.

- Pediatric Healthcare Associates will charge you for any travel time and waiting time incurred by Pediatric Healthcare Associates in the course of provision of these Forensic Services, in addition to any time actually spent providing Forensic Services.

- Pediatric Healthcare Associates will charge you the full costs associated with any travel for the provision of Forensic Services, in addition to fees for Pediatric Healthcare Associates' time in the provision of Forensic Services (as outlined above). You will be responsible for paying 100% of all travel costs incurred by Pediatric Healthcare Associates.

Further, to the extent possible, you also agree to give the nurse, staff member, or licensed physician twenty-one (21) days' advanced notice of your need for Forensic Services from Pediatric Healthcare Associates, another party's or court's need for Forensic Services from Pediatric Healthcare Associates, or any event requiring our attendance.

Client understands, agrees, and consents that Pediatric Healthcare Associates may disclose client's confidential information or Protected Health Information ("PHI") in the possession of Pediatric Healthcare Associates as reasonably necessary to comply with the requirements of any lawful subpoena or court order.

☐ You agree to pay Pediatric Healthcare Associates $300 per hour for Forensic Services provided by registered nurses and staff members and/or $400 per hour for Forensic Services provided by licensed physicians.

Parent Signature: _____ Date: _____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2) Minor Conset Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's date of Birth:____/_____/_____ Child's Gender: ☐Female ☐Male Telephone:_____

Child's Address _____ Apartment # _____ City, State, Zip Code _____

Mother's First Name _____ Mother's Maiden Name _____ Email Address _____

Race (select all that apply)			**Ethnicity (select only one)**
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific	☐ Whit	☐ American Other Race	☐ Not Hispanic or Latino
☐ Islander			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an <u>Immediate Family Member</u> of a First Responder.

I am an IMMEDIATE FAMILY MEMBER of a First Responder.

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 _____ Signature _____ Date _____

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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **<u>Retain this form in your client's record.</u>**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*

Authorization to Release Confidential Medical Information

I hereby request that _____ _____medical records be released to:
Patient Name **Date of Birth**

Pediatric Healthcare Associates, P.A.
3701 Eldorado Parkway, Ste. A
McKinney, TX 75070

Phone: 972-548-7888
Fax: 972-562-1170

My records are being transferred from:

Facility or Provider Name:_____

Street Address:_____

City:_____ State: _____ Zip-code:_____

Phone:_____ Fax:_____

Reason for request of records: ☐Transferring Providers ☐Specialist Consultation ☐Personal Use

Please Release: ☐Entire Chart/Health History ☐Test Results ☐Growth Chart & Immunization Records

☐Other:_____

As the guardian of the patient named below, I give permission to release all medical, mental, and social information to the facility listed. All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, telephone messages, and records received by other medical providers. All laboratory records, radiology and diagnostic reports. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Parent Printed Name:_____ Parent Signature: _____Date:_____