My *PRIMARY* Hometown Pediatrician is to be… *(circle one)* ***Dr. Chandler*** ***Dr. John*** ***Dr. Moore*** ***Dr. Smith***

Hometown Pediatrics

PATIENT INFORMATION
(Please Print Clearly)

Patient Name: _____ Date of Birth: _____ Sex: *(circle)* Male Female

Ethnicity: (circle) Hispanic Non-Hispanic Race: _____ Language Spoken at Home: _____

Social Security #: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Father's Cell Phone #: _____ Mother's Cell Phone #: _____

Father's Name: _____ Email: _____

Employer: _____ Work #: _____

Mother's Name: _____ Email: _____

Employer: _____ Work #: _____

Emergency Contact

(Other Than Listed Above)

Name: _____ Relationship to patient: _____ Best Contact #_____

Pharmacy to Electronically Send Prescriptions

Pharmacy Name: _____ Phone #: _____

Address: _____ City:_____ State:_____ Zip:_____

Insurance Information

Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults, lab work and other tests according to your managed care guidelines. However, our office deals with many different plans and ***it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.*** *Please verify their participation* ***BEFORE*** *services are rendered to receive network benefits from your insurance company.*

Primary Insurance	Secondary Insurance
Policy Holder: _____	**Policy Holder:** _____
DOB: _____ **SS#:** _____	**DOB:** _____ **SS#:** _____
Relationship to Patient: _____	Relationship to Patient: _____
Insurance Company: _____	Insurance Company: _____
Address: _____	Address: _____
Phone #: _____ Effective Date: _____	Phone #: _____ Effective Date: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____

****Whom may we thank for referring you to Hometown Pediatrics?** _____

By signing below, I hereby authorize Hometown Pediatrics to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your child's care. I have read and understand the Hometown Pediatrics Financial Policy.

Parent/Guardian Printed Name:_____ **Signature:** X_____

Relationship to Patient: **Date:**

Hometown Pediatrics

FINANCIAL POLICY

Welcome and thank you for choosing Hometown Pediatrics for the medical needs of your child. We are dedicated to providing the best possible care for your child, and we want you to completely understand our financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible.

Co-payments, unmet portions of your deductible, coinsurance, and previous balances are due at time of service.

Appointments: Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

Self-pay Accounts: Patients with no insurance will be expected to pay at the time of service.

Insurance: The patient is expected to present an insurance card at each visit. If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is a contract between you and your insurance company. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges. Any non-covered charges are due upon receipt of a statement from our office within 30 days.

Referrals: It is the responsibility of the patient to know their insurance plan's procedures for referrals. If your plan requires a referral, it will be necessary for you to inform us of that prior to you scheduling an appointment with a specialist. We kindly ask that you notify our office 5 (five) business days prior to non-urgent referral visits.

Late Arrival: As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are ***more than 20 minutes late***, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

No-Shows or Missed Appointments: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. ***If an appointment is missed without 24-hours prior notice, you will be charged a $25.00 fee.*** This fee is not payable by your insurance company and will be your responsibility.

Child Custody/Divorce Cases: This office will not bill a divorced spouse for the patient's service. It will be the responsibility of the parent or guardian that brings the child in for all co-pays, deductibles, coinsurances, or balances. It is the parents' obligation to work out agreement themselves or through the court system.

Late Fee Charge: The office reserves the right to charge a 1.5% late fee on all unpaid balances that are 60+ days overdue. This will accumulate on balances only until paid in full.

Responsible Party: In order to be HIPPA compliant, we must have the responsible party sign this form. If the responsible party is anyone other than the Primary Insurance carrier, we must have the following:

Responsible Party's DOB:_____ **Responsible Party's SS#**_____

I have read, understand and agree to the above Hometown Pediatrics Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.

Responsible Party's Printed Name:_____ **Signature:** X_____

Date_____ **Name of Patient:**_____ **d.o.b.:**_____

Hometown Pediatrics

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my child's healthcare, Hometown Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Hometown Pediatrics' *Notice of Information Practices* which is available for review upon request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Hometown Pediatrics, P.A. 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. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hometown Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hometown Pediatrics change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

***Please initial one of the following.

_____ If I choose to give Hometown Pediatrics a picture of my child, I **give** them permission to hang the picture in the office.

_____ If I choose to give Hometown Pediatrics a picture of my child, I **do not give** them permission to hang the picture in the office.

I fully understand and accept the terms of this consent. **Signature:** X_____

Printed Name:_____ **Relationship to patient:** *(circle one)* ***Father Mother Guardian***

Date:_____ **Name of Patient:**_____ **Patient d.o.b.:**_____

Hometown Pediatrics
PEDIATRIC HISTORY

Patient's Name _____ **Date of Birth** _____ **Allergies to Meds** _____

Pregnancy Complications

(check Yes or No)	Yes	No
Pregnancy less than 9 months		
High blood pressure		
Gestational diabetes		
Medications *(if yes, list)*		

(check Yes or No)	Yes	No
Bleeding *(if yes, which month)*		
Serious illnesses		
Serious infections		
Previous miscarriages		
C-section *(if yes, why?)*		

Birth History

Place of birth: _____

Birth weight: _____ Length _____

Length of labor: _____

Adopted: No ___ Yes ___

Birth Problems

(check Yes or No)	Yes	No
Jaundice		
Breathing problems		
Antibiotics		

Other problems *(explain)* _____

Breastfed: _____ Formula fed _____

Developmental History

At what AGE did your child…	Yes	No
School Problems?		

Smile: _____ Roll over: _____ Sit alone: _____

Walk alone: _____ 1st word with meaning: _____ Use 3 word sentence: _____

Bladder trained: _____ Bowel trained: _____ Ride tricycle: _____ Tie shoes: _____

Medications Child Takes Routinely:

_____

_____

_____

Hospitalizations & Operations:

1 _____ Date _____

2 _____ Date _____

3 _____ Date _____

Childhood Illnesses

(check Yes or No)	Yes	No	Date
Allergies			
Asthma			
Bed wetting			
Chickenpox			
Convulsions/epilepsy			
Diabetes			
Kidney disease			
Measles			
Meningitis			
Mumps			
Pneumonia			
Rheumatic fever			
Scarlet fever			
Sickle cell trait or disease			
Whooping cough			

Other Serious Illnesses	Date(s)
1.	
2.	
3.	
4.	
5.	

Hometown Pediatrics
PEDIATRIC HISTORY (Continued)

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

Child's Family

	full name	Age	Present Health or cause of death
Mother:			
Father:			

	full name	circle	DOB	
Sib #1:		*M F*		
Sib #2:		*M F*		
Sib #3:		*M F*		
Sib #4:		*M F*		
Sib #5:		*M F*		
Sib #6:		*M F*		
Sib #7:		*M F*		

Social History

(Check "No" or "Yes")	No	Yes	No./day
This teen patient smokes?	___	___	____
This teen patient drinks?	___	___	____
Household with smokers?	___	___	____
Pets? *(If "Yes", please list…)*	___	___	

_____

Family History

*(Check **if disease is present**)*	Mother's Side	Father's Side
Diabetes	____	____
Heart trouble	____	____
Heart attack	____	____
Stroke	____	____
Cancer	____	____
Tuberculosis	____	____
Ulcer	____	____
Arthritis	____	____
Obesity	____	____
Suicide	____	____
Mental Illness	____	____
Thyroid problems	____	____
Sickle cell	____	____
Seizures/epilepsy	____	____
Bedwetting	____	____
Allergies	____	____
Hay fever	____	____
Asthma	____	____
Other: _____	____	____
Other: _____	____	____

Notes:

_____

_____

_____

_____

_____

_____

_____

Hometown Pediatrics

1595 Lake Front Circle

(281) 292-8980 (Office) **The Woodlands, TX 77380** **(281) 292-8070 (Fax)**

Kristie R. Chandler, MD, FAAP **Veronica M. Gonzalez, MD** **Tony John, MD, FAAP**

Sarah E. Moore, MD, FAAP **Mona A. Smith, MD, FAAP**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

I do hereby authorize my child's medical records <u>from</u>: | ***Name of Medical Practice, Physician, Clinic or Hospital***

Address _____

City, State, Zip _____

Phone Number _____ Fax _____

…to be released <u>to</u>:

Hometown Pediatrics, P.A.
1595 Lake Front Circle
The Woodlands, TX 77380-3604

281-292-8980 (Office) 281-292-8070 (Fax)

…for the purpose of: ☐ ***continuing or transfer of medical care*** ☐ ***proof of immunization***
☐ ***insurance review or underwriting*** ☐ ***legal matters***

Release information concerning the ***following dates***: from _____ to _____, and to include:

☐ ***complete medical records*** in your possession to include illness(es) and/or treatments

<u>or</u> ☐ medical records ***limited to the following specific types of information***:

_____

<u>Also,</u> I ☐**DO** or ☐**DO NOT** (*check one & initial* _____) consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing

I, the parent/guardian, agree that ***a photocopy or facsimile (fax) of this authorization may be considered valid***, this authorization shall be ***valid for 120 days from the date of signature***, and that ***this authorization can be revoked in writing at any time prior to the expiration date***.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless Hometown Pediatrics, PA from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Printed Name _____ **Signature:** X _____

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

Last Name

For Clinic/Office Use

First Name

Middle Name

Gender: Male Female

Date of Birth

Address

Apartment #

Telephone

City

State

Zip Code

County

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (# C-7). The ImmTrac Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

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

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

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

Individual (or individual's legally authorized representative): _____
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. EF11-13366
Revised 05/18/12

TEXAS Department of State Health Services

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.

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE VACUNAS (ImmTrac)
FORMULARIO DE CONSENTIMIENTO PARA ADULTOS

ImmTrac Texas Immunization Registry

(Favor de escribir claramente con letra de molde)

Apellido

For Clinic/Office Use / Sólo para uso de la clínica/oficina

Primer Nombre

Segundo Nombre

Género: ☐ **Hombre** ☐ **Mujer**

Fecha de Nacimiento

Dirección

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Condado

ImmTrac, el registro de vacunas de Texas, es un servicio gratuito del Departamento Estatal de Servicios de Salud de Texas (DSHS). El registro de vacunas es un servicio seguro y confidencial que consolida el récord de las vacunas para propósitos de salud pública (ej. darles a todos los médicos que tratan a un paciente un lugar central para ver el récord de las vacunas de dicho paciente). Con su consentimiento, su información de las vacunas se incluirá en ImmTrac. *Para un familiar menor de 18 años de edad, uno de los padres, el tutor legal o el custodio administrador puede dar el consentimiento de participación con llenar el Formulario de Consentimiento de ImmTrac para menores de edad (# C-7). El Formulario de Consentimiento de ImmTrac (# C-7) se puede bajar del sito www.ImmTrac.com.*

El Departamento Estatal de Servicios de Salud de Texas le invita a participar voluntariamente en el registro de vacunas de Texas.

Consentimiento para registrar y dar a conocer el recórd de las vacunas a las personas/entidades autorizadas

Entiendo que, al dar mi consentimiento a continuación, autorizo dar a conocer la información de mis vacunas al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de las vacunas del estado, ImmTrac. Una vez que mi información de las vacunas esté en ImmTrac, pueden por ley accederla:

- el médico u otro proveedor de salud de Texas legalmente autorizado para administrar vacunas para el tratamiento del individuo como paciente;
- la escuela de Texas en la que el individuo está inscrito;
- el distrito de salud pública o el departamento de salud local de Texas, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- la agencia estatal que tenga la custodia legal del individuo;
- el pagador actualmente autorizado por el Departamento de Seguros de Texas para operar en Texas, con respecto al récord de las vacunas relacionadas con el individuo cubierto según la póliza del pagador.

Entiendo que puedo retirar mi consentimiento en cualquier momento.

Con mi firma a continuación, DOY mi consentimiento para el registro. Deseo INCLUIR mi información de las vacunas en el registro de vacunas de Texas, ImmTrac.

Individuo (o el representante legalmente autorizado del individuo): _____

Nombre en letra de molde

_____ _____

Fecha **Firma**

Notificación de privacidad: con ciertas excepciones, tiene derecho a pedir y a ser informado sobre la información que el estado de Texas reúne sobre usted. Tiene derecho a recibir y examinar la información al pedirla. También tiene derecho a pedir a la agencia estatal que corrija cualquier información que se determine es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la notificación de privacidad. (Referencia: Código gubernamental, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (800) 252-9152 • (512) 776-7284 • Fax: 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. EF11-13366
Revised 05/18/2012

TEXAS Department of State Health Services

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.***