



Murray B. Fershtman, M.D.

PATIENT INFORMATION

(please print clearly)

Patient Full Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) ____-____ Mother's Cell: (____) ____-____ Father's Cell: (____) ____-____
Mother's Name: _____ Father's Name: _____
DOB: ____/____/____ DOB: ____/____/____
Patient lives with: _____
How did you hear about Forest Pediatrics? _____

EMERGENCY CONTACT INFORMATION

(other than persons listed above)

Name: _____ Phone: (____) ____-____ Relationship to patient: _____

PREFERRED PHARMACY INFORMATION

(This information will be kept on file, please notify our office of any changes to this information)

Pharmacy Name: _____ Phone: (____) ____-____
Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

*Insurance information is a necessary part of your child's medical record. We will do our best to direct your child's care and need for any specialist consults, lab work, and other medically necessary testing according to your managed care guidelines. However, **it is the ultimate responsibility of the parent/policy holder to verify that all facilities and specialists that our providers refer you to are within your health plan network.***

PRIMARY INSURANCE

Policy Holder: _____
Date of Birth: ____/____/____ SS# _____
Relationship to Patient: _____
Insurance Company: _____
Claims Address: _____
ID# _____
Group# _____
Address of policy holder: ☐ check here if same as patient

SECONDARY INSURANCE

Policy Holder: _____
Date of Birth: ____/____/____ SS# _____
Relationship to Patient: _____
Insurance Company: _____
Claims Address: _____
ID# _____
Group# _____
Address of policy holder: ☐ check here if same as patient

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

Parent/Legal Guardian Printed Name: _____ Relationship to Patient: _____

Signature of Parent/Legal Guardian: _____ Date: ____/____/____

MEDICAL HISTORY

Patient Name: _____

Date of Birth: ____/____/____

Medication Allergies:

Current Medications:

Surgeries: (list with month & year of procedure)

Hospitalizations:

Childhood Illnesses (check all that apply)

- ☐ Environmental Allergies
☐ Food Allergy
☐ ADHD/ADD
☐ Bed Wetting
☐ Chicken Pox
☐ Seizures/Epilepsy
☐ Febrile Seizures
☐ Diabetes
☐ Kidney Issue
☐ Developmental Delay
☐ Cancer (please list type, age of diagnosis, and status below)

☐ Other

Family History (check all that apply)

	Mom	Dad	MGP	PGP
<input type="checkbox"/> Diabetes	___	___	___	___
<input type="checkbox"/> Heart Issue	___	___	___	___
<input type="checkbox"/> Stroke	___	___	___	___
<input type="checkbox"/> Cancer	___	___	___	___
<input type="checkbox"/> Tuberculosis	___	___	___	___
<input type="checkbox"/> Ulcer	___	___	___	___
<input type="checkbox"/> Arthritis	___	___	___	___
<input type="checkbox"/> Asthma	___	___	___	___
<input type="checkbox"/> Eczema	___	___	___	___
<input type="checkbox"/> Obesity	___	___	___	___
<input type="checkbox"/> Thyroid Disorder	___	___	___	___
<input type="checkbox"/> Sickle Cell	___	___	___	___
<input type="checkbox"/> Seizures/Epilepsy	___	___	___	___
<input type="checkbox"/> Bedwetting	___	___	___	___
<input type="checkbox"/> Allergies	___	___	___	___
<input type="checkbox"/> Hay Fever	___	___	___	___
<input type="checkbox"/> Mental Illness	___	___	___	___
<input type="checkbox"/> Suicide	___	___	___	___

Social History: (check all that apply)

- ☐ Attends Daycare
☐ Exposed to second hand smoke
☐ Pets at home (if so, type?) _____

Prenatal History: (check all that apply)

- ☐ Pregnancy < 9 months ☐ Bleeding (which month?) _____
☐ High Blood Pressure ☐ Serious Illness
☐ Gestational Diabetes ☐ Serious Infection
☐ Previous Miscarriage ☐ C-section (if so, why?) _____
☐ Medications while pregnant (list) _____

Birth History: _____ Adopted

Place of birth: _____ Birth Weight: _____

Length at birth: _____

- ☐ Circumcised ☐ Antibiotics
☐ Jaundice ☐ Breathing Problem
☐ Other Complications: (explain briefly) _____

Child's Family

	Name	Age	Present Health
Mom:	_____	_____	_____
Dad:	_____	_____	_____
Sib #1:	_____	_____	_____
Sib #2:	_____	_____	_____
Sib #3:	_____	_____	_____
Sib #4:	_____	_____	_____
Sib #5:	_____	_____	_____

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

I, _____, understand that as a part of my child's healthcare, Forest Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnosis, 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 Forest Pediatrics' HIPPA Notice of Privacy Practices which is available for review upon my 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 Forest Pediatrics 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 Forest Pediatrics reserves that right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Forest Pediatrics change their notice, I will be notified of such.

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

I understand that as a 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.

I fully understand and accept the terms of this consent.

Patient Name: _____ Patient DOB: _____

Parent/Guardian Printed Name: _____ Relationship to Patient: _____

Signature of Parent/Guardian: _____

Date: _____

Welcome and thank you for choosing Forest 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 office and 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. **Please review and initial the following statements:**

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

_____ **Returned Checks:** You will be charged a \$35.00 returned check fee per occurrence.

_____ **Medical Records Request:** Upon departing from our practice a reasonable fee for providing the requested records will be **\$25.00 up to or for the first 25 pages and .15 cents per page thereafter PER CHILD.**

_____ **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.

_____ **Child Custody/Divorced Parties:** Forest Pediatric does **NOT** get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. Payment is the responsibility of the parent who brings the child in the office for treatment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts and we cannot be placed in the middle.

_____ **Consent to Seek Treatment of a Minor:** We understand that there will be times when a person who does not hold legal guardianship of a child must bring them in to be evaluated/treated by our physicians. Should this occur, our office will require written consent from a parent/legal guardian giving said non-guardian permission to seek treatment of their minor child without the parent/guardian being present.

_____ **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.

It is the parent/guardian's responsibility to contact the insurance company and confirm that the child's doctor is "IN NETWORK" with their specific insurance plan. If our doctors are "OUT OF NETWORK", the parent will be responsible for any charges not covered by their "OUT OF NETWORK" benefits.

_____ **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 your 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 Arrivals:** As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are **more than 15 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 2-hour notice of cancellation by you. **If an appointment is missed without at least 2-hour prior notice, you will be charged a \$25.00 fee.** This fee is not payable by your insurance company and will be your responsibility.

____ **After Hour Calls:** Our physicians are available to answer your calls after regular office hours. There is a **\$25.00 fee per call for this service.** However, the fee will be waived if you are advised to go to the ER, you follow up in the office the following business day if your child is 3 months old or younger.

____ **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 SSN:** _____

I have read, understand and agree to the above Forest 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: _____ **Date:** ____/____/____

Name of Patient: _____ **Patient DOB:** ____/____/____



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Consent to Treat

General Consent to Treat:

Patient(s) Name:

I hereby authorize (when I am unavailable to give consent) the following individual(s):

Whose relationship to this child is

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

I understand that my child will NOT be seen at Forest Pediatrics if accompanied by someone that is not listed on this consent form.

Parent/Guardian Printed Name: _____

Relationship to patient: _____

Parent/Guardian Signature: _____

Date: _____



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Authorization for Disclosure of Confidential Information

Patient Full Name: _____
Patient Full Name: _____
Patient Full Name: _____

DOB: ____/____/____
DOB: ____/____/____
DOB: ____/____/____

*I hereby authorize my
child/children's medical
records to be released from:*

Name of Medical Practice, Physician, Clinic, or Hospital

Address: _____
City, State, Zip: _____
Ph: _____ Fax: _____

To be released to:

☐ **Forest Pediatrics**
3115 College Park Dr. Suite 104
Conroe, TX 77384
Phone: (936) 321-5030
Fax: (936) 271-5033

☐ **Name:** _____
Address: _____
City, State, Zip: _____
Phone: _____ **Fax:** _____

For the purpose of:

☐ Continuing or transfer of medical care
☐ Legal Matters

☐ Proof of Immunization
☐ Insurance Review or Underwriting

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

☐ Complete Medical Record
☐ Lab Reports Only
☐ Other: _____

☐ Immunizations Only
☐ Progress Notes Only

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

I, the parent/legal 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 the above named medical practices, physician, or facility from all liability and damage resulting from the lawful release of my protected health information.

Signature of Parent/Legal Guardian

Date



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NEWBORN VISIT POLICY

It is the responsibility of patient's parent/guardian to notify the insurance subscriber's employer and insurance company of the child's birth. This **MUST** be done **within 30 days** after the child's birth date.

If the newborn child has not been added to the insurance policy within the 30 days following birth, any claims within that time period will be denied by the insurance company and the patient's parent/guardian will be responsible for the total balance.

If your insurance plan is a Health Maintenance Organization (HMO), you will also be required to assign a "primary care physician" to your child.

PATIENT PRINTED NAME

PATIENT DOB

PARENT/GUARDIAN PRINTED NAME

RELATIONSHIP TO PATIENT

SIGNATURE OF PARENT/GUARDIAN

DATE

Rev 1/18

**FOREST PEDIATRICS
IMMTRAC IMMUNIZATION REPORTING CONSENT**

Patient Name: _____

DOB: ____/____/____

I, as the parent/guardian of the above mentioned patient, authorize Forest Pediatrics' providers and affiliates to release my child's immunization information to DSHS via American Medical Software interface and I further understand that DSHS will include this information in the state of Texas' 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.

_____ I certify that I have read and understand the scope of my consent and that I authorize the above practice.

_____ I do not authorize Forest Pediatrics to report my child's immunizations to the ImmTrac Registry.

Print Parent/Guardian Name

Signature of Parent/Guardian

Date



Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

- Child's Name: _____
Last Name First Name MI
- Child's Date of Birth: ____ / ____ / ____
MM DD YYYY
- Parent, Guardian, or Individual of Record: _____
Last Name First Name MI
- Primary Provider's Name: _____
Last Name First Name MI
- To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

* Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.

** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.

*** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.

MEMORIAL HERMANN INFORMATION EXCHANGE "MHIE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION



Purpose: The MHIE is a health information exchange network developed by Memorial Hermann Health System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHIE and we seek your permission to share your health information with other Exchange Members via the MHIE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHIE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHIE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHIE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth
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Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Health System providers (collectively the "Provider") to other participating providers in the MHIE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHIE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, (INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE).

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHIE Exchange Members to access your health information. Exchange Members of the MHIE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHIE notice of revocation. The MHIE notice of revocation is available by calling 713-456-MHIE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the time frame in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Patient / Guardian Signature Print Name Relationship to patient Date

Patient unable to sign due to: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include this Consent in the individual's records.

Official Use Only:

**MEMORIAL
HERMANN**
**Information Exchange Patient
Consent For The Use
And Disclosure**

