PATIENT INFORMATION - GARLAND PEDIATRIC PRACTICE

Last Name: _____ First Name: _____Middle Initial: _____

Street Address: _____ Apt# _____ City:_____ State: ____ Zip: _____

Date of Birth: _____ Sex: ☐Male ☐Female Home / Cell Phone:(_____) _____

Race: ☐American Indian /Native Alaskan ☐Asian ☐Black /African American ☐Hispanic /Latino ☐Native Hawaiian /Pacific Islander ☐White ☐Other

Email Address: _____ (MyChart Registration)

Pharmacy Name: _____ Zip: _____ Cross Street's_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Plan: _____ ID#: _____ Group: _____

GUARANTOR INFORMATION

Mother: Last Name: _____First Name: _____ DOB: _____ Phone: _____

Father: Last Name: _____ First Name: _____ DOB: _____ Phone: _____

How did you hear about us? _____

CONSENT FOR TREATMENT OF MINOR CHILD

I, _____the parent do hereby consent to any diagnosis or treatment rendered under the general or specific instructions of physicians at Garland Pediatric Practice. This consent is given in advance of any specific diagnosis or treatment being required, and it is given to encourage those persons who other than myself bring my child, and said physician(s), to exercise their best judgment as to the requirements of such diagnosis or medical treatment. This consent shall remain effective until revoked in writing and delivered to said physician or to said persons entrusted with the custody, care and control of said minor child.

Legal Guardian: _____

(print name) *(signature)* *Date*

Consent for Family/ Friend to bring minor: Full Name: _____ / Full Name: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. You have a right to review our Notice of Privacy Practices before signing this consent. By signing below, I acknowledge that I have reviewed or had explained to me Garland Pediatric Practice Notice of Privacy Practices and agree to continue my care under said terms.

_____ _____

Patient or Guarantor Signature **Date**

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE

My signature below authorizes Garland Pediatric Practice to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits due be paid directly to Garland Pediatric Practice. Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. If my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf. I understand that all **fees for professional services shall be paid at time of service and are NON-REFUNDABLE.** I certify that I have read and understand the above information to the best of my knowledge.

_____ _____

Patient or Guarantor Signature **Date**

Sibling #1

Last Name: _____ First: _____ DOB: _____

Insurance Plan: _____ ID: _____ Group: _____

Sibling #2

Last Name: _____ First: _____ DOB: _____

Insurance Plan: _____ ID: _____ Group: _____

Sibling #3

Last Name: _____ First: _____ DOB: _____

Insurance Plan: _____ ID: _____ Group: _____

Sibling #4

Last Name: _____ First: _____ DOB: _____

Insurance Plan: _____ ID: _____ Group: _____

Garland Pediatric Practice

6448 Broadway Blvd,
Garland, Tx – 75043
Phone:(972) 216-8500
Fax:(972) 216-8521

Authorization to Release Medical Records

Patient Name: _____Patient's Date of Birth: _____

Parent's Name: _____ Cell Phone: _____

Address: _____

I, _____ hereby authorize Garland Pediatric Practice to obtain

_____ Entire Record
_____ Immunization Record
_____ Consultation Reports
_____ Other

From doctor/ Clinic: _____

Phone#_____ Fax#_____

Address: _____

I understand that this authorization may include information relating to: Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, Psychiatric Care, Behavioral or mental health services, treatment for alcohol and /or drug abuse and Genetic Testing.

This authorization will expire on _____ or 90 days from the date set forth below. In accordance with the procedures set forth in the Practice's Notice of Privacy Practices, when 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 by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice listed above has acted in reliance upon this authorization. My written revocation must be submitted in the practice above.

Signature of Parent/Legal Guardian Relationship _____

_____ _____

Printed Name Date

Purpose of disclosure: _____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

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

Child's Date of Birth _____ / _____ / _____ *Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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 (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. 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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 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.texas.gov 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 ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac DC

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

Garland Pediatric Practice Financial Policy

Please read each statement carefully

Please initial each item below, sign and date at the bottom to acknowledge that you have read and understand the office policies and procedures related to the responsibilities of the patient.

____If the office is not filing an insurance claim for me, full payment is due at the time of service unless prior arrangements have been approved through the billing department.

____It is my responsibility to present my insurance card to the receptionist at every visit, even if I believe there have been no changes to my plan.

____The office will bill my insurance carrier for all covered services if I am covered by a plan that Garland Pediatric Practice is contracted with as a participating provider. I am required to pay all co-payments at the time of my visit.

____If I do not present my updated insurance card, or give an incorrect insurance card and the claim is denied by the insurance, I will be responsible for any outstanding balance. Garland Pediatric Practice will not re-file the claim for me.

____Should my insurance deny a claim due to diagnoses or coding, the office will not change the initial diagnosis or coding just so my insurance will pay. It is my responsibility to know my benefits and to inform the doctor of such at the time of my visit to best guarantee payment from my insurance.

____I understand that I am financially responsible for any covered or non-covered services as defined by my Insurer which are not paid by my primary insurance.

____If no payment is made on my account after four months, my account will be forwarded to a COLLECTION AGENCY and credit bureau for further action. At this time, I will be notified by mail with a 30-day notice of the discontinuation of care. Prompt payment on my account will avoid this action.

____It is my responsibility to keep all of my information updated with the office such as addresses, phone numbers and responsible party information where statements should be sent.

____When there is a dispute between parents as to who will be responsible for payment, Garland Pediatric Practice will bill the parent that brought the child to their appointment.

____If you receive a Nebulizer machine or Aero-Chamber, this is a completely separate billing entity through an outside vendor. Garland Pediatric Practice is not responsible for statements I receive regarding these items.

Please sign below to indicate you have read, understood, and agreed to all of the above financial policies.

_____ _____

Signature of Responsible Party Date