NEW PEDIATRIC PATIENT REGISTRATION- MANSFIELD OFFICE

Please Print Clearly and Complete Entire Packet

Patient Information

Last Name	**First Name**	**Middle Name**	**Email Address:**	
Address:		**City**	**State**	**ZIPCode**
Home Phone #		**Sex** ☐ **Male** ☐ **Female**		
Date of Birth ____ / ____ / _____	**Age**	**Ethnicity:** ☐ **Hispanic** ☐ **Not Hispanic**		
Which category best describes your **race**? ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Black or African American ☐ White ☐ Asian ☐ Hispanic/ Latino ☐ Other		**Preferred language** ☐ English ☐ Spanish ☐ Sign Language or Auxiliary Aid ☐ Other		

Parent/ Guardian Information (Custodial Parent)

Guardian Relationship to Patient		**Guardian SSN:**	
Last Name	**First Name**	**Middle Name**	**Date of Birth:** ____ / ____ / _____
Address (Street or PO Box)		**City**	**State**	**ZIPCode**
Home Phone #		**Email Address:**	

Parent/ Guardian #2

Guardian Relationship to Patient		**Guardian SSN:**	
Last Name	**First Name**	**Middle Name**	**Date of Birth:** ____ / ____ / _____
Address (if different)		**City**	**State**	**ZIPCode**
Home Phone #		**Email Address:**	

Preferred **Pharmacy** Info

Name: _____

Address: _____

Phone: _____

How did you **hear** about us?

☐ Family/Friend ☐ Insurance ☐ Internet/Website
☐ Location/ Drive ☐ Newspaper/Magazine ☐ Radio ☐TV
☐ Community Event ☐ others

State others: ----------

Insurance information (Primary Insurance)				
Insurance company Name:		**Policy Holder's Name:**		
Policy #	**Group #**	**Policy Holder's SSN:**	**Date of Birth: ____ / ____ / _____**	
Policy Holder's Address		**City**	**State**	**ZIPCode**
Policy Holder's Phone #:		**Policy Holder's Relationship to Patient:**		
Insurance information (Secondary Insurance)				
Insurance company Name:		**Policy Holder's Name:**		
Policy #	**Group #**	**Policy Holder's SSN:**	**Date of Birth: ____ / ____ / _____**	
Policy Holder's Address		**City**	**State**	**ZIPCode**
Policy Holder's Phone #:		**Policy Holder's Relationship to Patient:**		

- **Please provide the person that you would like to list as an Emergency Contact** situation in the event an emergency situation was to take placewhile in our office(s):

Name: _____ Contact Phone: _____

Thank you for choosing Kidsville Pediatrics as your child's pediatrician and as one of our patients we would like you to be aware of our financial policies. Once you have carefully read the following, please sign this document and return to our office staff.

- Most plans have deductibles, coinsurances, and/or copayments that are solely your responsibility at the time of your visit. **Copayments are due at the time services are rendered**. The accompanying parent, grandparent, guardian, including babysitter is responsible for full payment at the time of service. Copayments not collected at the time of visit will be charged a $10.00 fee plus the amount of the co-pay.
- On arrival, you must present your most current insurance card at each appointment. If the insurance company that you present is incorrect, you will be responsible for payment of the full cost of the visit and will be required to submit the charges to the correct plan.
- Certain insurances require you to select a Primary Care Physician or a PCP. Please call your insurance prior to the visit to select our Pediatrician as your PCP. **If they have not been notified you may be financially responsible for this visit and/or your appointment will need to be rescheduled.**
- If our physicians are not on your insurance panel or you do not have insurance, then **payment in full** for services provided are required at the time of visit. For appointments that have already been scheduled, any and all prior balances must be paid prior to being seen.
- Patient balances are billed immediately once your insurance plan's explanation of benefits (EOB) has been received by our office. **Your payment is due within 10 business days of your receipt of your bill.**
- If you are unable to keep your scheduled appointment, we require you to contact our office within **24 hours** before your appointment to reschedule or cancel. This will allow us to have another patient who needs that appointment to come in. If you do not contact us within 24 hours, we will charge a fee of $50.00 for each child that was scheduled to be seen.
- **We reserve the right to discharge any patient or family from the practice after 3 no show appointments.**
- **If you are more than 15 minutes late, you may be required to reschedule your appointment.**
- Any balance over 60 days will be forwarded to a collection agency.
- Please call our office if you have a question about your bill. We are happy to review your bill with you to prevent any misunderstandings.

_____ _____

Printed Name Date

_____ _____

Signature Date

Kidsville Pediatrics PLLC Notice of Privacy Practices

The Health Insurance Portability Act (HIPAA) and the Health Information technology for Economic and Clinical Health (HITECH) Act are federal government regulations designed to ensure privacy and security of patient's protected health information (PHI). They ensure that you are aware of your rights and how your medical information can be used in providing and arranging your medical care.

Kidsville Pediatrics PLLC is furnishing you with its Notice of Privacy Practices, which are available in hard copy or at the company's website or in office at your request. By signing this for, you acknowledge that you have received Kidsville Pediatrics PLLC Notice of Privacy practices.

_____ _____

Signature Date

Consent to Treat

I, _____, parent/legal guardian of: **Patient:**

_____ _____

NAME Date of Birth

Do hereby give my authorization and consent my child (named above) to be seen by **Dr. Naima Garrett** (Kidsville Pediatrics PLLC),and/or any physician or nurse practitioner at Kidsville Pediatrics PLLC, consent to the medical/surgical care, vaccinations, and treatment of my child. Additionally, I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical or surgical procedures, treatments, or immunizations deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations, labwork, or rapid testing that are routinely given at the well visit or any sick visit. The duration of this consent is indefinite and continues until revoked in writing.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

_____ _____

Signature Date

Authorized Person(s):

_____	_____	_____
NAME	Relation to patient	Contact #
_____	_____	_____
NAME	Relation to patient	Contact #

- **Is there any custody agreement we should be aware of? _____**
- **<u>If yes, please provide documentation at the first appointment</u>.**

Medical Release Form

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ Zip Code: _____

Please choose release request:

____Full Record ____Immunization Record Only

INFORMATION REQUESTED FROM (CLINIC NAME)

Name: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____ Fax: (_____) _____

SEND INFORMATION TO

Name: **Kidsville Pediatrics (Mansfield)**

Address: 1759 Broad Park Circle South, Suite 201 Mansfield, TX 76063

Phone: (682) 341-3910 FAX: (682) 400-1288 Email: office@kidsvillepeds.net

I, _____(Name), hereby grant permission for you to release confidential health information about me, or my child, by releasing a copy of my medical record, or a summary of my protected health information, to **Kidsville Pediatrics**.

_____ _____
Printed Name Date

_____ _____
Signature Date

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 (mm/dd/yyyy) _____ / _____ / _____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

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)	**Ethnicity (select only one)**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Recipient Refused	☐ 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 <u>GRANT</u> consent for registration. I wish to <u>INCLUDE</u> 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)

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

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

<u>PROVIDERS REGISTERED WITH ImmTrac2</u>

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.**

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Kidsville Pediatrics PLLC
1759 Broad Park Circle South
Suite 201
Mansfield, TX 76063
682-341-3910

Photo/Video Consent Form

Parent CONSENT

I,_____, _____ First name, Last name DOB , Parent of children named below:

_____ (Full name of child and DOB)

consent to all images and / or video being made of me or my child/dependent not limited to one date of service. I agree that images may be used for social media purposes including Kidsville Pediatrics website, Facebook Page, Newsletter, or Instagram. Kidsville Pediatrics has full rights to use the photo/videos.

I further acknowledge that there were no promises of compensation for such use of medical photo(s) and or video taken by Kidsville Pediatrics, PLLC staff as consented above.

This consent maybe revoked at any time with written request by patient.

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Parent/Guardian Date