Pediatric Clinic, P.A.

Gerald A. Stagg, MD, FAAP
J. Colton Bradshaw, MD, FAAP
Michael D. Henry, MD, FAAP
Joel D. Chapman, MD, FAAP
Marc E. Kimball, MD, FAAP
Dana L. Rice, MD, FAAP
Alban Tomaj, MD

PATIENT

First	Middle	Last	Nickname (if any)	Present Age	Date of Birth

Mailing Address	Social Security #	☐ Male ☐ Female	Primary Phone Number

Race: White, Black / African American, American Indian, Asian, Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino, Non-Hispanic/Non-Latino, Other or Undetermined

City / State /Zip

Preferred Language: English Spanish Other

PARENT/GUARDIAN

Mother's Name	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License#	Alternate Phone	Home Work Cell
	Employer		Email Address	

Father's Name	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License #	Alternate Phone	Home Work Cell
	Employer		Email Address	

Responsible Party (if parent under 18 years of age/Foster parent/Guardian)	Relationship	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License #	Alternate Phone	Home Work Cell
	Employer		Email Address	

INSURANCE

Patient's Primary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone

Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient

Patient's Secondary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone

Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient

EMERGENCY CONTACTS

Name	Phone

SIBLINGS

Name	Date of Birth

Signature of Responsible Party Date

Update Signature Date

Update Signature Date

Update Signature Date

Update Signature Date

2001 N. Jefferson Medical Office Building, Suite 300 Mt. Pleasant, Texas 75455 903-572-9823 FAX 903-572-4812

Pediatric Clinic, P.A.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Printed Name of Patient

_____
Patient's Date of Birth

_____
Printed Name of Parent or Guardian

_____
Signature of Patient, Parent or Guardian

_____
Relationship to Patient

_____
Date

Pediatric Clinic, P.A.

PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, the Pediatric Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a "minor" if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

_____ _____

Patient/Child Patient/Child Date of Birth

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____

Parent/Legal Guardian Date

Pediatric Clinic, P.A.

PATIENT AUTHORIZATION

Patient/Child Name _____Date of Birth_____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".

Initials

MEDICAID ASSIGNMENT OF BENEFITS

☐ I certify that the information I gave in applying for payment of Medicaid benefit is correct. I assign Medicaid benefits payable for Pediatric Clinic, P.A. services to the Pediatric Clinic, P.A.

FINANCIAL RESPONSIBILITY

☐ I will honor the Pediatric Clinic, P.A. payment policy by payment in full at the time services are rendered, unless prior arrangements have been made. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment for services rendered at the Pediatric Clinic, P.A. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that I may be billed for out sourced services (i.e. lab, x-ray, etc.); and I may receive additional billing from another facility. I agree to pay all expenses related to collection, whether by collection agency or by an attorney.

INSURANCE RESPONSIBILITY

☐ I irrevocably assign and transfer to the Pediatric Clinic, P.A. all insurance benefits covering the Pediatric Clinic, P.A. services for the payment of serviced rendered. I understand it is my responsibility for providing a current copy of my insurance card and to comply with all pre-certification requirements.

AUTHORIZATION FOR CARE

☐ I grant permission for the Pediatric Clinic, P.A. to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize the Pediatric Clinic, P.A. to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release the Pediatric Clinic, P.A. from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

AUTHORIZATION FOR USE OF SECURE EMAIL

☐ I acknowledge that I will be contacted through the Pediatric Clinic, P.A Secure Patient Portal if I have given out my email address.

_____ _____

Parent Signature Date

Pediatric Clinic, P.A.

Date: _____

Print Patient Name: _____

Patient DOB: _____

It is my responsibility to provide The Pediatric Clinic with current, valid insurance information. If I do not provide this information within timely filing deadlines, the balance will be my responsibility.

Print Responsible Party: _____

Signature Responsible Party: _____

The Pediatric Clinic allows 30 days to apply/add to insurance. After this time, you will receive statements, by mail, regarding your balance. You can contact us to set up payment arrangements.

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Pediatric Nurse Practitioner
Consent For Treatment

This facility has on staff Pediatric Nurse Practitioners to assist in the delivery of medical care.

A Pediatric Nurse Practitioner is not a doctor. A Pediatric Nurse Practitioner is a registered nurse who has received advanced education and training in the provision of pediatric health care. A Pediatric Nurse Practitioner can diagnose, treat, and monitor common acute and chronic childhood diseases as well as provide health maintenance care. In addition, the Pediatric Nurse Practitioner may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of a Pediatric Nurse Practitioner for my child's health care needs.

I understand that at any time I can refuse to see the Pediatric Nurse Practitioners and request to see a physician.

_____ _____

Child's Name (Please Print) Child's Date of Birth

_____

Parent/Guardian Name (Please Print)

_____

Parent/Guardian Signature

_____

Date

2001 North Jefferson Medical Office Building, Suite 300 Mount Pleasant, Texas 75455 903-572-9823

PATIENT HISTORY

Please list any diagnosed medical problems your child has (ADHD, asthma, anemia, diabetes, seizures, etc.).

_____

_____

Please list any surgeries your child has had (appendix, tonsils, tubes, circ, etc.)._____

_____

Does anyone smoke at home? YES NO

LIVING CONDITIONS

Child lives with: MOM DAD STEPDAD
STEPMOM OTHER_____

# of other individuals living in the home: _____

Birth mother's name: _____

Birth father's name: _____

Parent's status: MARRIED NOT MARRIED
SEPARATED DIVORCED

Other caregivers regularly involved: _____

Mother's employment: _____

Father's employment: _____

Age at adoption: _____

Birth Country: _____

ENVIRONMENTAL EXPOSURES

Carpet in home? YES NO

Pets in the home? YES NO

Mold/mildew in home? YES NO

Occupational hazards? YES NO

Hobby hazards? YES NO

Other exposures? YES NO

DAYCARE/EDUCATION

Spends weekdays at home with? _____

Daycare YES NO

Pre-school? YES NO

Days attending daycare per week? _____

Educational level (grade)? _____

Education aides (IEP, 504, etc…)? _____

Home schooled? YES NO

Academic performance:_____

FAMILY HISTORY – MEDICAL PROBLEMS (Cancer, Diabetes, Asthma, High blood pressure, etc.) PATIENT'S…

Mom_____

Dad _____

Sister _____

Brother _____

Maternal Aunt _____

Maternal Uncle_____

Paternal Aunt _____

Paternal Uncle _____

Maternal Grandmother_____

Maternal Grandfather_____

Paternal Grandmother_____

Paternal Grandfather _____

Other family members_____

HISTORIA del PACIENTE

Por favor escriba las problemas medicas diagnoticados de su hijo/a. _____

_____

Por favor escriba alguna cirugía su hijo/a ha tenido (apéndice, anginas, tubos de oido, circuncisión).

_____

¿Alguien fuma en casa? SI NO

CONDICIONES DE VIDA

Niño/a vive con: mama papá padrastro
madrastra otro_____

de otras personas que viven en el hogar: _____

Nombre de la madre biológica: _____

Nombre del padre biológico: _____

Estado de los padres: CASADOS NO CASADOS
SEPARADOS DIVORCIADOS

Otros cuidadores involucrados regularmente: _____

Empleo de la madre: _____

Empleo del padre: _____

Edad en adopción: _____

País de nacimiento: _____

EXPOSICIONES AMBIENTALES

¿Alfombra en casa? Sí NO

¿Mascotas en el hogar? Sí NO

¿Moho en el hogar? Si NO

¿Hay riesgos ocupacionales? Sí NO

¿Riesgos de pasatiempos? SI NO

¿Hay otras exposiciones? Sí NO

GUARDERIA/EDUCACION

¿Pasa días de semana en casa con? _____

¿Guardería? Sí NO

¿Pre-escolar? Sí NO

¿Días asistiendo a la guardería por semana? _____

¿Nivel educativo (grado)? _____

¿Ayudantes de educación (IEP, 504, etc.)? _____

¿Educado en casa? SI NO

Desempeño académico:_____

HISTORIA FAMILIAR – PROBLEMAS MEDICAS (cáncer, diabetes, asma, presión alta,..) PARIENTE AL PACIENTE

Mamá _____

Papá _____

Hermana _____

Hermano_____

Tía maternal _____

Tio maternal_____

Tía paterna _____

Tío paterno _____

Abuela materna_____

Abuelo materno_____

Abuela paterna_____

Abuelo paterno _____

Otros familiares _____

Pediatric Clinic, P.A.

VACCINE POLICY STATEMENT

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox . . . I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of underimmunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 3000 cases of whooping cough in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness (and then passed it on to the infants, who were too young to have been fully vaccinated) had made a conscious decision not to vaccinate.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at the Pediatric Clinic, P.A.** Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and dis-ability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

_____

Signature **Date**

Pediatric Clinic, P.A.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Notice of Privacy Practices

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed on page 3.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist, hospital or clinic. When we refer you to a specialist or other entity, we will share some or all of your medical information with that physician, hospital, or clinic to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

<u>Your Rights Under Federal Privacy Regulations</u>

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed on page 3

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed on page 3.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Suzan Colvin
2001 North Jefferson, Suite 300
Mount Pleasant, Texas 75455
Phone: (903) 572-9823 ext 2021
Fax: (903) 572-4812

This notice is effective on April 14, 2003, and stays in effect until it is replaced by another Notice.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.