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

Gerald A. Stagg, MD, FAAP
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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

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**