Pediatric Healthcare Associate of Waxahachie
M. Jean Strength, M.D.
1710 W. 287 BUSINESS SUITE 100
WAXAHACHIE, TX 75165
972-937-1221

Vaccine Policy

Read below if you do not vaccinate

Patient Name: _____ Date of Birth: _____

The physicians and staff of Pediatric Healthcare Associates of Waxahachie care about your child's health. Protecting your child from vaccine preventable illness is one of the most important things we can do to ensure your child lives a healthy life. It is the recommendation of our facility that all children should follow the vaccine schedule as published by the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC).

To best protect your child, as well as all our patients, we **do not** accept patients whose parents do not vaccinate their children according to the recommended vaccine schedule. Patients who are behind on receiving the recommended vaccines will be given the opportunity to catch up through a timetable provided by their physician.

While we respect your right as a parent to make medical decisions for your child, those parents who do not wish to comply with the recommended vaccine schedule will be asked to seek medical care elsewhere.

Required vaccines:

- Dtap/Tdap
- Hepatitis A
- HiB
- Polio
- Prevnar
- Hepatitis B
- Measles, Mumps, Rubella
- Meningococcal meningitis
- Varicella
- Rotateq

***This does not include the COVID, HPV, or Influenza vaccine.**

I acknowledge that I have read and understand the information above.

Parent/Guardian Signature: _____ Date: _____

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(972)937-1221
(972)937-8934 fax

PATIENT INFORMATION Male or Female (circle one) Date: _____

Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

MOTHERS INFO: Drivers License#: _____ Email: _____

Name: _____ DOB: _____ SS#: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work#: _____ Cell: _____

FATHERS INFO: Drivers License#: _____ Email: _____

Name: _____ DOB: _____ SS#: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work#: _____ Cell: _____

EMERGENCY CONTACT (someone not living in your household)

Name: _____ Relation: _____ Phone: _____

Work#: _____ Cell: _____ Other: _____

I certify this information is true and correct to the best of my knowledge. I agree to notify you of any changes in my status of the above information.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Pediatric and Adolescent Medicine
M. Jean Strength, M.D.
1710 W. 287 Business Suite, 100
Phone: 972-937-1221
Fax: 972-937-8934

PATIENT QUESTIONNAIRE

Patient Name: _____

Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment and health care operations):

_____ _____

_____ _____

_____ _____

Please list the family members of significant others, if any, whom we may inform about medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone number: _____
Name: _____ Phone number: _____

Please print the telephone number where you want to receive calls about your appointments, labs and x-ray results, or other health care information if other than your telephone number: _____

* I am fully aware that a cell phone is not a secure and private line.

Can confidential messages/text (i.e. appointment reminders) be left on your telephone answering machine or voice mail?

_____ yes _____ No

Date: _____ Parent/Guardian Signature: _____

PAYMENT POLICY

Insurance. We participate in most insurance plans. If you are not insured by a plan we do business without insurance, payment is expected at each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card or we cannot verify your coverage, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Non-Covered Services. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by insurances. You must pay for these services in full at the time of visit.

Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat emergency care only.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

PARENT/GARDIAN SIGNATURE: _____

DATE:_____

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Dr. Mary J Strength, M.D.
Tel: 972-937-1221
Fax: 972-937-8934

CANCELLATION/NO SHOWS:

We require 24-hour notice if you are unable to make your appointment and reserve the right to charge you if you fail to contact our office in a timely manner.
After two failed appointments, the Dr. has the right to release you from her care and refuse to approve any further medication refills.
If you are late for your appointment, we have the right to reschedule your appointment as this delay affects not only the physicians but also others that may come after you.

PRESCRIPTIONS:

If you need a refill on a prescription, you may need to call your pharmacy and request a refill. They will contact our office for approval.
We require 48 hours' notice when requesting medication refills of any kind.

FINANCIAL POLICY:

We collect patient copay and/or deductibles prior to you seeing the physician. Please be prepared to pay. We accept Cash, Check, MasterCard, Visa, American Express and Discover.

MEDICAL INSURANCE CARD:

A copy of your Medical Insurance card is required **at every visit**. When asked for copies please provide this information as it is your responsibility to provide the insurance card. Your insurance may not cover the full cost of your charges, regardless of insurance, payment remains your personal responsibility and is due before you see the physician.

NURSE PRACTITIONER CONSENT FOR TREATMENT:

A nurse practitioner is not a Doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training and can diagnose, treat, and monitor common acute and chronic disease, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other minor injuries. **PLEASE UNDERSTAND, YOU WILL EITHER SEE DR. STRENGTH, JAMES HAY (NP) OR KYLIE STEEN (NP).**

_____

Parent/Guardian Signature

PEDIATRIC HEALTHCARE ASSOCIATES OF WAXAHACHIE

Patient Medical History and Information Sheet

Name: _____ DOB: _____
Allergies: _____

LIST ALL CURRENT MEDICATIONS **LIST ALL SURGERIES**

Name of Medication Dosage	Surgery Date of Procedure
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

Has your child had all the immunizations necessary for his or her age? ___ yes ___ no

Has your child ever been hospitalized for medical (nonsurgical) problem? If so list below

_____

_____

Please list previous diagnosis from any other physician?

_____

_____

Social History:
Child Lives with _____ Parents: Divorced Married Foster Single
Siblings' # _____ Boys _____ Girls

Notes:

_____

_____

_____

PEDIATRIC HEALTHCARE AND ASSOCIATES OF WAXAHACHIE
Dr. Mary J Strength

DEVELOPMENTAL HISTORY

Patient Name: _____ DOB: _____

Please FILL OUT to best of your knowledge

Pregnancy and newborn history:

Did you carry your child for the full 9 months? If no, how long? _____

Child's birth weight _____ Birth Length _____ Inches _____

Medications during pregnancy _____

Problems during pregnancy:
Illness _____ Infections _____ Other _____

Labor: Length of labor _____ hours. Any difficulties? _____

Delivery:_____ Vaginal _____ C-section If C-section, why? _____

Any difficulties? _____

Did your child come home from the hospital with you? _____ Yes _____ No

Any special care needs in infancy? _____ Yes _____ No

Growth and developmental milestones:

At what age did your child?

Sit _____ Say first words _____ *Stand* _____

Walk _____ Speak in sentences _____ Toilet train _____

FAMILY HISTORY

Please recall family members to the best of your ability back to the patient's grand parents.

Condition	Father	Mother	Father's Parent	Mother's Parent	Siblings	Children
Arthritis						
Asthma						
Bleeding Disorder						
Cancer						
Diabetes						
Heart Disease						
Hypertension (high blood pressure)						
Kidney Disorder						
Thyroid Disease						
Other						

FAMILY HISTORY – NEUROLOGICAL DIAGNOSIS

Brain Tumor						
Cerebral Palsy						
Dementia/Alzheimer's						
Depression						
Epilepsy						
Learning Disability (such as dyslexia)						
Manic-depression						
Mental Illness						
Mental Retardation						
Migraine Headache						
Multiple Sclerosis						
Muscle Disease						
Nervous Breakdowns						
Neurofibromatosis						
Parkinson's Disease						
Peripheral Neuropathy						
Seizures						
Stroke						
Tuberous Sclerosis						

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth / / **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("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.

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.state.tx.us 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 ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/18/2012

TEXAS Department of State Health Services

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

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* No Disc *

Authorization for Release of Medical Records

All information must be filled out properly. Please allow 15 days for records to be completed. Thank you.

Release Records From: (please print)

Physcian/Provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Release Records To: (please print)

Physcian/Provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Patient Information: (please print)

Patients Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Social Security Number: _____

Please state the reason records are being released:

_____
_____
_____

Parent/Legal Guardian Signature: _____ **Date:** _____

Office Use Only:

Date Received: _____ Provider/Administrator Initials: _____
Date Copied: _____ Date Mailed/Pt notified to pickup: _____