1816 Pediatrics
PATIENT REGISTRATION

Patients Full Name (last, First, Middle Initial) : ____

Ethnicity: Hispanic or Non-Hispanic   Race: White/Hawaiian-Pacific Islander/Black/American Indian-Alaskan Native/Asian

Preferred Name: ______________________Patients DOB _____/____/_____   ______Male _____Female

Patients Full Name (last, First, Middle Initial) : ____

Ethnicity: Hispanic or Non-Hispanic   Race: White/Hawaiian-Pacific Islander/Black/American Indian-Alaskan Native/Asian

Preferred Name: ______________________Patients DOB _____/____/_____   ______Male _____Female

Patients Full Name (last, First, Middle Initial) : ____

Ethnicity: Hispanic or Non-Hispanic   Race: White/Hawaiian-Pacific Islander/Black/American Indian-Alaskan Native/Asian

Preferred Name: ______________________Patients DOB _____/____/_____   ______Male _____Female

Patients Full Name (last, First, Middle Initial) : ____

Ethnicity: Hispanic or Non-Hispanic   Race: White/Hawaiian-Pacific Islander/Black/American Indian-Alaskan Native/Asian

Preferred Name: ______________________Patients DOB _____/____/_____   ______Male _____Female

Preferred email for correspondence: ____

Mother's Name: ________________________________ Social Security Number ______/______/______

____

Home Address   City   State   Zip Code

Home Phone # ________________________   Mobile Phone # ___________________________

Father's Name: ________________________________ Social Security Number ______/______/______

____

Home Address   City   State   Zip Code

Home Phone # ________________________   Mobile Phone # ___________________________

INSURANCE INFORMATION

Primary Insurance Company: _____ Insurance Phone # _____

Insurance ID/Policy # _____ Group # _____

Name of Insured _____ Insured's DOB _____

Insured's Social Security # _____

Secondary Insurance Company: _____ Insurance Phone # _____

Insurance ID/Policy # _____ Group # _____

Name of Insured _____ Insured's DOB _____

Insured's Social Security # _____

1816 Pediatrics has my permission to examine and administer treatment as deemed necessary to my child(ren). I agree that all services are rendered on a paid basis only. I authorize the release of information to my insurance if requested.

Signature: _____ Date: _____

1816 Pediatrics

AUTHORIZATION FOR THE RELEASE OF INFORMATIONAND/OR MEDICAL RECORDS

I consent and authorize 1816 Pediatrics to release information contained in any financial or medical records, including but not limited to: diagnosis and treatment/continuity of care, information concerning communicable disease, drug or alcohol abuse, psychiatric diagnosis and treatment, medical history, lab results progress notes, and other related information to insurance companies and its agents, Medicaid or Medicare, or any other entity responsible for paying or processing payment, utilization management, or consulting and/or follow-up care.

1816 Pediatrics is hereby authorized to release any information or records and reports regarding patient care and health status as required by law or regulation.

Information may be transmitted by mail, facsimile, or other electronic medium.

I understand that I may revoke this authorization in writing at any time, except to the extent that action is already in progress.

The undersigned certifies that he or she has read, understands, and accepts this authorization form, and is the legal parent, guardian, or representative of the patient(s).

Signature of Parent or Legal Representative	Date
Printed Name of Parent or Legal Representative	Relationship

1816 PEDIATRICS
CONSENT TO TREAT AND FINANCIAL AUTHORIZATION

CONSENT TO TREAT:

The undersigned consents to any examination or medical treatment, and or services rendered to the patient by the providers of 1816 Pediatrics in their best judgment during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

DIVORCE:

In the case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

FINANCIAL RESPONSIBILITY:

It is agreed that regardless of any and all assigned benefits and or monies the undersigned agree to be responsible for the total charges for services rendered. I agree that any amount that may be my responsibility are due upon request, payable to 1816 Pediatrics. Should this account become delinquent, I agree to pay all expenses including attorney fees. If this account has a credit balance at any time, I agree that it will be applied to any previous outstanding balance prior to any monies being refunded.

ASSIGNMENT OF BENEFITS AND INSURANCE REQUIREMENTS:

In consideration of goods and services rendered or to be rendered, I irrevocably assign and transfer to 1816 Pediatrics all right, title and interest in benefits or monies payable for goods or services. I understand that in the event that 1816 Pediatrics files a claim on my behalf that the same does not impose any contractual obligation upon 1816 Pediatrics, and that I remain responsible for instituting suit within the applicable statue of limitations. I authorize pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of the patient (and or parent or guardian), or legal agent. I authorize payors listed herein and any other payors to release any and all information requested and or related to my claims to 1816 Pediatrics.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND ACCEPTS THE CONSENT TO TREAT AND AUTHORIZATION, AND IS THE LEGAL PARENT OR GUARDIAN OF THE PATIENTS, OR THE LEGAL REPRESENTATIVE OF THE PATIENTS.

Signature _____Relationship _____Date _____

1816 PEDIATRICS
TEXAS-WIDE IMMUNIZATION REGISTRATION
IMMTRAC CONSENT

I agree that the record of giving each vaccine (past, present or future) can be given to the Texas Department of Health Immunization Tracking System, and to other health care providers, schools, or places that provide child care.

I hereby authorize the Texas Immunization Registry to release such information concerning my child's immunizations to any public health district, local health department, child's healthcare providers, insurance companies, school or child care center, as well as the Texas Department of Human Services.

The above entries to re-release such information in order to promote the availability of accurate, complete and up-to-date immunization records to those entities and individuals who administer and promote immunizations.

I am aware that I may withdraw this consent at any time by contacting:

The Texas Department of Health
Immunization Registry
1100 West 49th Street
Austin, TX 78756

☐ YES ☐ NO

_____
Signature of Parent or Legal Representative of the Patient

Relationship to patient _____ Date_____

Records with "No" consent will not be forwarded to the State-wide Immunization Registry (ImmTrac).

1816 PEDIATRICS
CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Parent or Legal Guardian's Printed Name: _____
Parent of Legal Guardian's Printed Name:_____

I hereby authorize the following person(s) to seek medical care and make decisions in relation to advice rendered from 1816 Pediatrics and/or its employees for my child in my absence:

Printed Name	Relationship
Printed Name	Relationship
Printed Name	Relationship
Printed Name	Relationship

For the Following Period:

☐ _____through _____

☐ Until such time as this authorization is revoked in writing.

_____

Signature Relationship Date

1816 PEDIATRICS
Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) ***Sharing Information for Purposes of Treatment:*** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan;

b) ***Sharing of Information for Purposes of Payment:*** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies).

c) ***Sharing of Information for Purposes of Operations:*** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosure given in reliance on this prior consent will be permissible.

Patient's Name (printed)_____ Date _____

Patient's Signature (or guardian, if a minor) _____ Date _____

1816 PEDIATRICS
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
MUST COMPLETE IN ORDER FOR 1816 TO RECEIVE PAST MEDICAL RECORDS

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

I authorize the following individual or organization to disclose the above named individual(s) health information:
Name
Address
City/State/Zip
Phone #
Fax#

This information may be disclosed TO and used by the following individual or organization:

1816 Pediatrics
2967 Oak Run Pwk.,Suite 305
New Braunfels, TX 78132

Please release ONLY the following requested records:

Problem List	Immunization Record	Medication List
GrowthChart	Drug Allergy History	ADHD History
Last Well Visit		

Purpose for the release:
■ Medical Care ☐ Insurance Purpose ☐ Legal Purpose ☐ Other:

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, Ican contact 1816 Pediatrics.

_____
Signature of Patient or Legal Representative Date

_____
Relationship to patient

1816 PEDIATRICS

FINANCIAL POLICY AND CONSENT FORM

Please read our Financial Policy and Patient Consent Form and initial where indicated.

Your initial by each item indicates your understanding and agreement.

_____**NO SHOW FEE: 1816 Pediatrics will charge a $35.00fee for failure to keep scheduled appointments.** Please call our office 24 hours before a scheduled appointment to cancel or reschedule an appointment that you will not be able to keep. Please be aware that your insurance will not cover any no-show fees.

_____**PATIENT RESPONSIBILITY:** We will submit to primary and secondary plans that we participate with, however, we cannot guarantee payment. It is your responsibility to be familiar with your insurance benefits and confirm our participation. Any services that you receive that are not covered by your plan will be patient responsibility. Please call your insurance if you have any questions.

_____**WELL CHILD VISITS:** Many insurance carriers will now cover well child exams at 100% with no copay or deductible. Often during a well-child exam, other medical problems or conditions are found or discussed that are not covered under the well visit. When this occurs, rather than rescheduling the well child exam, your child's provider may treat or manage the condition during the well child appointment. This includes addressing ongoing medical conditions if they exist. This additional encounter may be subject to your usual office visit charge, copay, or deductible. If so, we will collect the copay at check-out or you will receive a statement in the mail.

_____**GUARANTOR:** We can only bill the parent that signed the financial responsibility paperwork. We are unable to bill anyone who is not listed as the guarantor on the account. It will be the responsibility of the parent to forward the bill to another party.

_____**UPDATED INFORMATION:** Please be certain you have updated all demographic and insurance information at every visit. We are only able to bill the insurance provided to us at the time of service.
If you become aware that the incorrect insurance was billed or you have new insurance that was not provided, you must provide it within 30 days of the date of service. We may not be able to properly submit claims if the information is not provided to us in a timely manner. Payment for services rendered will then become patient responsibility.

Patient Name _____ DOB _____

Signature _____ Date _____

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of the healthcare service you receive from 1816 Pediatrics, health records are generated and maintained describing your care including but not limited to your name, address, phone number, social security number, health history, symptoms, examination and test results, diagnoses, procedures, treatment, and plans for future care or treatment. This information is called "Protected Health Information".

This Notice of Privacy Practices describes how 1816 Pediatrics may use and disclose your information and the rights that you have regarding your health information.

Uses and Disclosures of Health Information without Authorization

When you obtain services from 1816 Pediatrics, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment, and to support the operations of the entity and other involved providers. The following categories describe ways that we use or disclose your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment. For example: Disclosure of medical information about you may be made available to doctors, nurses, technicians, or others who are involved in treating you. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

Your health information will be used for health care operations. For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf if the information is necessary. Examples include external laboratories, billing agencies, and copying services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified on our contract.

Disclosures Required by Law or otherwise allowed without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse, or responding to court orders;
- From public health purposes, such as reporting information about births, deaths, report child abuse or neglect and various diseases, or disclosures to the FDA regarding adverse events related to food, medications, or devices. Generally to prevent or control disease, injury or disability.
- For health oversight activities, such as audits, inspections, or licensure investigations;
- If you are an organ donor, organ procurement organizations for the purpose of tissue donation and transplant;
- For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information.
- To coroners and funeral directors for the purpose of identification, determination of the cause of death, or to perform their duties as authorized by law;
- To avoid a serious threat to your health or safety and the health and safety of the public or another person. Disclosures will be made only to someone who may be able to help prevent threat.
- For specific government functions, such as protection of the President of the United States;
- For Worker's Compensation purposes;
- To military command authorities as required for members of the armed forces;
- To authorized federal officials for national security and intelligence activities as authorized by law;
- We may release Health Information if asked to by law enforcement officials.

Other Allowable Uses and Disclosures without Authorization: Other uses or disclosure of your health information that may be made include:

- Contacting you to provide appointment reminders for treatment or medical care, as well as to recommend treatment alternatives;
- Notifying you of health-related benefits and services that may be of interest to you.
- When appropriate, we may share Health Information with a person involved in your medical care or payment for care (family or friend).

- We will also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- Protected Health Information may be disclosed to provide legally required notices of unauthorized access to or disclosure of your health information
- Health Information may be disclosed in response to a court or administrative order. It may also be disclosed in response to subpoena, discover request or other lawful process.

Uses and Disclosures Requiring Us to Give You an Opportunity to Object and Opt

- Unless you object we may disclose your Protected Health Information to a member of your family, relative, friend or any other person you identify information that directly relates to that person's involvement in your health care. If you object to such disclosure, we may disclose such information if necessary if we determine that it is in your best interest based on our professional judgment.
- We may disclose Protected Health Information to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition during a disaster.

Your Written Authorization is required for Other Uses and Disclosures

The following uses and disclosures require your written authorization:

- Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information
- Under certain circumstances we may disclose Health Information for research if approval is obtained.

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

YOUR INDIVIDUAL RIGHTS UNDER HIPAA

1. You have the right to request restrictions or limits on certain uses and disclosures of your protected health information. By example, you may wish to restrict your employer from knowing about medical condition. Regardless of your request, please know that the HIPAA rules allow our office to share Protected Health Information with the Covered Entities.
2. You have the right to receive your Protected Health Information in a confidential communication from our office, such as the U.S Mail.
3. You have the right to inspect and copy your Protected Health Information. Copies of your Protected Health Information are available for a reasonable fee paid to our office to cover our expenses of producing them. If your Protected Health Information is maintained in an electronic format, you have the right to request an electronic copy or have your information transmitted to another individual or entity. We may charge a reasonable, cost based fee for this.
4. You have the right to request that we amend your Protected Health Information. In some cases, we may require these requests to be in writing and be supported by a reason for the change. Generally, this will not apply to such routine changes as address and phone number listings.
5. You have the right to receive, upon request, an accounting of your Protected Health Information that we have provided to Non-Covered entities.
6. If you have read and responded to this notice through electronic media such as our practice website (if any) or e-mail, you have the right to receive a paper copy of this notice upon request.
7. You have the right to be notified upon any breach of any of your unsecured Protected Health Information.

If you would like to exercise any of these rights, please contact Bertha Gomez at (817) 337-5503, to request that necessary arrangements be made for you.

1816 Pediatrics is required by law to maintain the privacy of your Protected Health Information and to provide you with this notice of our legal duties and privacy practices as they apply to your Protected Health Information. We are also required to abide by the terms of this notice, which is currently in effect.

In the future, we reserve the right to change the terms contained in this notice and make any new provisions effective for all of the Protected Health Information we maintain. In the event we elect to change the terms of this notice, a new notice will be posted in our office and on our practice website (if any). In addition, you may receive notification by direct mail, e-mail, or other such communication as our practice may implement from time to time.

Should you ever believe your privacy rights have been violated, we request you to file a complaint with our office by contacting Bertha Gomez at (817) 337-5503. You may also register your complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. As part of our commitment to you, we value your privacy and take every precaution in our practice to preserve your right to that privacy.

Any complaints you file will be used strictly to improve our operating procedures and in no way will you be retaliated against for filing a complaint. Should you have any questions or concerns, please contact 1816 Pediatrics at (817) 337-5503 to obtain further information.

I understand that I have the right to privacy of my Protected Health Information as maintained by 1816 Pediatrics. By my signature below, I certify that I have read and understand my rights to the privacy of my Protected Health Information as well as the terms and conditions of this notice.

Patient/Legal Representative Signature:

Name of Legal Representative: _____ Relationship to Patient _____

Patient Name _____ DOB _____ Date: ____/____/_____

1816 Pediatrics

NOTICE TO PATIENT REGARDING USE OF A PROVIDER NOT IN NETWORK
(please initial by each section below)

_____If your physician has provided a list of specialists, it is important that you confirm with the specialist and your insurance company that the provider is in network with your insurance. Please be aware that if you choose a provider that is out of network:

_____The out of network facility or provider will not be restricted to seeking payment from your insurance.

_____The out of network hospital, facility or provider may bill the patient for amounts other than deductibles, co-pays, co-insurance, and services not covered by your benefit plan. You may have higher out-of-pocket costs when using an out of network provider based on your benefit plan. Note that if you do not have out of network benefits under the terms of your benefit plan and you receive services from an out of network provider, you may be responsible for the entire cost of the service.

_____Your physician has NO affiliation or financial ownership interest in or with the out of network hospital, facility or provider.

_____You may still choose an out of network provider knowing that all of the above applies.

_____You acknowledge that you have the right to a copy of this form.

Signature of parent of legal guardian _____ Date _____

Patient Name _____ Date of Birth _____

1816 Pediatrics Immunization Policy

At 1816 Pediatrics we are dedicated to providing the highest quality of evidence based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious disease, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyze reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect your child. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At 1816 Pediatrics we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, 1816 Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others.

Please be advised that if you desire an “alternate” vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of 1816 Pediatrics, the AAP, the AAFP and the ACIP. Because we believe that this decision puts your child at risk for vaccine preventable disease and increases health risks for others, 1816 Pediatrics respectfully declines to be your children’s pediatricians. Thank you.

1816 Pediatrics Form Fees

FMLA Paperwork (allow 7 days)	$35.00 per set of forms
Physician Letter (allow 3-5 business days)	$15.00
School forms/Daycare forms/ Camp forms (allow 3-5 business days)	$10.00
Sports Physical Forms	$45.00
Medical Records (for Patient) (allow 3-5 business days)	$25.00
Medical Records (for Third Party) (Allow 2 weeks for processing)	$25.00 and $0.50 a page after 50 pages.

Name Relationship Date

1816 Pediatrics Office Policies

Please Read The Following Information

Thank you for choosing 1816 Pediatrics as your healthcare provider. The following is a summary of our Office Policies, which we require you to read and sign prior to treatment.

- Due to frequent changes in health insurance, we require that you provide proof of insurance coverage for every visit. If you do not have insurance, or if we are unable to verify your insurance coverage or are on a plan in which we do not participate, full payment is required at the time of your visit.
- The parent/guardian is responsible for payment of all fees. Please discuss any financial problems with us to avoid any misunderstandings or call our office.
- All co-payments and deductibles are due at the time of service. These fees cannot be waived. For your convenience, we accept, Visa/Master Card and Discover (including debit cards).

Non-Contractual Insurance

- For insurances with which we do not have a contractual relationship with, you will be responsible for your entire bill at the time of service. We will provide a copy of your bill, at each visit, so you will be able to file your claim with your insurance company.

Continuity of Care

- All children should be evaluated by their primary care physician, as part of a routine physical, according to current AAP guidelines. We require all our patients to follow these guidelines so that we can monitor their development and growth. Failure to do so may result in dismissal from our practice.

Contractual Insurance

- Please be aware that some of these services may be non-covered services and not considered reimbursable under your insurance plan. You are personally responsible for these services.
- We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance we will attempt to resolve it on your behalf. Your insurance policy is a contract between you and your insurance company: therefore, your balance is your responsibility.

Administrative Fee

- Participation forms such as camp, school, sports, and WIC are subject to processing fee of $10.00.
- Shot and physical forms will be processed without charge if done at the time of the well visit.
- Family Medical Leave will be charged $35.00 and you must allow up to 7 business days.

- Physician letters will be charged $15.00

Delinquent Accounts

- If there is an outstanding balance on your account, a payment plan may be arranged with our billing department prior to your visit. Failure to resolve any past due accounts will result in referral to a collection agency.

Consent to treat//Financial Authorization

- I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of 1816 Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice.

Transferring of Medical Records

- 1816 Pediatrics is the owner of you/your child's medical records. However, you are the legal guardian of your records and may request their release at any time with proper documentation. To obtain a copy, the fee is $25.00, and $0.50 a page after 50 pages. Allow 2 weeks for processing.

Patient Behavior

- Patient(s) must respect 1816 Pediatrics employees as well as other patients.
- Patient(s) must adhere to all office and financial policies.
- No food, profanity or smoking is permitted at any 1816 Pediatric office.
- **All patients are asked to please check out before leaving the office.

New Patients

- We ask all new patients to please arrive at least thirty minutes in advance to fill out all new patient paperwork. Picture ID of legal guardian and Insurance ID card are required before any service is provided. New patients must also bring or have sent, all relevant paperwork from your previous pediatrician, including immunization records, laboratory results, medication history and all other medical records. All patients under the age of 18 years must be accompanied by a parent or legal guardian.

Immunizations

- I acknowledge that I received, reviewed, and agree to comply with the 1816 Pediatrics Immunization Policy.
- I agree and give the Texas Immunization Registry the authorization to release any information concerning my child's immunizations.

E-scribing

- I voluntarily authorize 1816 Pediatrics to allow E-Prescribing for patient's prescription, which allow healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as this child is a patient at this office.

Recording/Photo

- 1816 Pediatrics does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recording or photos of any kind during the visit. I understand the policy and agree to comply.

Scheduling and Appointments

- Due to frequent changes in health insurance coverage's and personal demographics you must be prepared to show us your insurance card and ID upon arrival for each visit.
- Patients are seen by appointment only. We realize that children sometimes need immediate attention, if this is the case; you must call our office prior to arrival.
- Since well visits take more time in our schedule than sick visits, they must be scheduled separately. If your child is scheduled for a sick appointment, please do not ask us to perform a well check-up during the same visit, as we will not be able to do so unless clinically approved by a physician.
- We also ask that no more than two siblings be scheduled at the same time, as our appointment schedule will not allow for more.

Late Policy/Walk-in Appointments

- We are always looking for ways to improve our practice and provide high quality health care to your children while also trying to make sure your waiting time is kept to a minimum. Therefore, when you arrive late for your child's appointment, it is considered as missed. However, our front office staff will gladly search to see if there are any future appointments, on that day, that we can schedule your child in. You may be asked to reschedule, especially if it is a visit that requires a significant amount of the physician's time (i.e. well check, evaluations and new patient visits.) We are always trying our best to balance your needs with the needs of our other patients, please be mindful of this. This is why it is imperative you arrive 15 minutes prior to your appointment.

No-Show/Cancellations

- If you are unable to keep your appointment, you must notify our office at least 24 hours in advance so that another patient may be given this time. If not, a No-Show/Cancellation fee of $35.00 will be charged to your account.

Prescription Refills

- You should call your pharmacy to request a refill for your child. If you have any issues, please contact our office during normal office hours, and have your child's name, date of birth, medication and pharmacy telephone number available when you call so we may assist you more efficiently.

After Hours Care

- IF YOU HAVE AN EMERGENCY DIAL 911. If you need to see a physician after hours you must report to a local urgent care center. In the event you MUST speak to a physician after our hours of operation and cannot wait until the next business day, you may call our office at 830-626-1816 and our answering service will instruct you further as to how to get in touch with one of our physicians.

Referrals

- For all non-emergency referrals, please contact our office at least one week in advance. In the event your child may need to see a specialist, your HMO or POS insurance company requires that you be referred by one of our primary care physicians (PCP). If we have referred your child to a specialist and their office requires authorization from your insurance company you must contact us one week in advance so we can obtain authorization. If you have been admitted to the emergency room and a physician has instructed you to see a specialist, the first appointment should be made with one of our physicians to ensure proper documentation will start the referral process and proper care is provided.

Patient Name _____ **DOB**_____

Patient Name _____ **DOB**_____

Patient Name _____ **DOB**_____

Patient Name _____ **DOB**_____

Patient Name _____ **DOB**_____

Parent/Guardian Name (print): _____

Signature of parent or legal guardian: _____

Today's Date: _____

Initial History Questionnaire

Name of Patient: _____ Birth date: _____ Age: _____

Form Completed by: _____ Date: _____ Relationship: _____

HOUSEHOLD

Please list all those living in the child's home

Name	Relationship To child	DOB	Health Problems	What is the child's living situation if they are not with both biological parents?
				○ Lives with adoptive parents?
				○ Lives with foster family?
				○ Joint custody?
				○ Sole custody?
				If one or both parents are not living in the home, how often does the child see the parent(s) not in the home

BIRTH HISTORY (for children under age 2 only) ⬭ **Don't know birth history**

Birth Wt _____ Was baby born term? **Yes No** How many weeks at time of delivery _____
Were there any prenatal or neonatal complications? **Yes No** If yes, explain: _____
Was NICU stay required? **Yes No** If yes, explain: _____
Was the delivery **Vaginal Cesarean** If Cesarean, why? _____
During pregnancy, was child exposed to: **Tobacco: Yes No Alcohol: Yes No Drugs or Medications: Yes No**
If yes to any above, please explain: _____
Did mother take prenatal vitamins: **Yes No** Did baby go home with mother from hospital? **Yes No** If no, explain _____
_____ How long was baby breastfed: _____ Is baby: **Breastfed Formula**

GENERAL DK = Don't know

Do you consider your child to be in good health? **Yes No DK Explain**: _____

Does your child have any chronic medical conditions? **Yes No DK Explain**: _____

Has your child had any surgeries? **Yes No DK Please list dates/ages**: _____

Has your child been hospitalized ? **Yes No DK Please list dates/ages**: _____

Is your child allergic to medications or drugs? **Yes No DK Please list medication and reaction type (hives, rash, etc.)** _____

Do you feel your family has enough to eat ? **Yes No DK Explain**: _____

BIOLOGICAL FAMILY HISTORY DK=Don't Know **(Include parents, grandparents, parents' siblings & immediate family)**

Have family members had the following:

Nasal Allergies or other allergies	Yes	No	DK	Who	Comment
Asthma or other lung disease	Yes	No	DK	Who	Comment
Heart disease or heart condition	Yes	No	DK	Who	Comment
High blood pressure	Yes	No	DK	Who	Comment
High cholesterol	Yes	No	DK	Who	Comment
Diabetes/endocrine disorders	Yes	No	DK	Who	Comment
Cancer	Yes	No	DK	Who	Comment
Anemia	Yes	No	DK	Who	Comment
Bleeding disorders	Yes	No	DK	Who	Comment
Epilepsy or convulsions	Yes	No	DK	Who	Comment
Mental /developmental disorder	Yes	No	DK	Who	Comment
ADD/ADHD	Yes	No	DK	Who	Comment

Biological Family History DK=Don't Know (Cont.)					
Liver Disease	Yes	No	DK	Who	Comment
Gastrointestinal disorder	Yes	No	DK	Who	Comment
Kidney disease	Yes	No	DK	Who	Comment
Bed Wetting (>10 Yrs)	Yes	No	DK	Who	Comment
Hearing impairment	Yes	No	DK	Who	Comment
Vision impairment/eye disorder	Yes	No	DK	Who	Comment
Immune Problems (HIV/AIDS)	Yes	No	DK	Who	Comment
Alcohol /Drug Abuse	Yes	No	DK	Who	Comment
Mental Illness (Depression/Anxiety)	Yes	No	DK	Who	Comment
Tuberculosis	Yes	No	DK	Who	Comment

Additional family history_____

PASTMEDICALHISTORY DK=Don't Know

Does your child have or has your child ever had:

Chickenpox	Yes	No	DK	When
Sinus infections	Yes	No	DK	Explain
Ear infections	Yes	No	DK	Explain
Phayrngitis/tonsillitis	Yes	No	DK	Explain
Infectious illnesses (Aids/HIV/Hepatitis)	Yes	No	DK	Explain
Allergies/seasonal /food allergies	Yes	No	DK	Explain
Animals	Yes	No	DK	Explain
Outdoor allergens	Yes	No	DK	Explain
Indoor allergens	Yes	No	DK	Explain
Respiratory problems/asthma	Yes	No	DK	Explain
Heart problems	Yes	No	DK	Explain
Gastrointestinal problems (GERD)	Yes	No	DK	Explain
Urinary tract infections/kidney reflux	Yes	No	DK	Explain
Vision problems	Yes	No	DK	Explain
Hearing problems	Yes	No	DK	Explain
Skin conditions (eczema/psoriasis)	Yes	No	DK	Explain
Anemia or bleeding problem	Yes	No	DK	Explain
Blood transfusion	Yes	No	DK	Explain
Neurologic problems (ADHD/ADD)	Yes	No	DK	Explain
Mental health concerns	Yes	No	DK	Explain
Orthopedic problems	Yes	No	DK	Explain
Endocrine problems (diabetes)	Yes	No	DK	Explain
Thyroid/other endocrine problems	Yes	No	DK	Explain
If female, any problems w/ periods?	Yes	No	DK	Explain
Obesity/overweight	Yes	No	DK	Explain
Alcohol/drug/tobacco use	Yes	No	DK	Explain
ADHD/Anxiety/Depression	Yes	No	DK	Explain
Developmental delay	Yes	No	DK	Explain
Convulsions/seizures/neuro problems	Yes	No	DK	Explain
Frequent headaches (daily/weekly)	Yes	No	DK	Explain
Sleep problems/snoring	Yes	No	DK	Explain
History of fractures/concussions	Yes	No	DK	Explain
High blood pressure	Yes	No	DK	Explain
History of family violence/abuse	Yes	No	DK	Explain

Girls only: Has had her first period Yes No Age of first period if applicable:_____

Any other significant problems:_____

Provider name: _____ **Patient ID#** _____

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

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

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

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender ☐ Male ☐ Female

Telephone _____ Email address _____

Child's Address _____ Apartment # / Building # _____

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	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ Signature _____ Date _____

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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • https://www.dshs.texas.gov/immunize/immtrac/
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 •Austin, TX 78714-9347