Children Of Texas
PEDIATRICS

10350 Bandera Rd. Suite 210 San Antonio, Texas 78250 Town & Country Center

Office: 210.688.0088
Fax: 210.688.0089

Welcome To Our Office!

Patient's Birth Name _____ **Date of birth** ___-___-___ **Sex: M / F**

Address _____ City _____ State ____ Zip code _____

Home phone ___-___-_____ Cell phone ___-___-_____ Other ___-___-_____

Parent/Guardian Information:

Father's Name _____ Date of birth ___-___-___

Address _____ City _____ State ____ Zip code _____

Social Security # ___-___-_____ Driver's License # _____ **Cell phone** ___-___-_____

Employer _____ Position _____ Phone ___-___-_____

Marital Status: M S W D SEP *(please circle one)*

Mother's Name _____ Date of birth ___-___-___

Address _____ City _____ State ____ Zip code _____

Social Security# ___-___-_____ Driver's License # _____ **Cell phone** ___-___-_____

Employer _____ Position _____ Phone ___-___-_____

Primary Insurance _____ **Guarantor/Policy holder** _____

ID# _____ **Group #** _____ **Effective date** ___-___-_____

Secondary Insurance _____ **Guarantor/Policy holder** _____

ID# _____ **Group #** _____ **Effective date** ___-___-_____

Siblings (*Please list all children):*

1. _____ M / F Date of birth: ___-___-_____
2. _____ M / F Date of birth: ___-___-_____
3. _____ M / F Date of birth: ___-___-_____
4. _____ M / F Date of birth: ___-___-_____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for all non-covered services. I also authorize the physician to release any information required to process this claim and for Quality Assurance checks made by insurance companies.

Signature: _____ **Date:** ___-___-_____

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10350 Bandera Rd. Ste 210 San Antonio, TX 78250
Phone: (210) 688-0088 Fax: (210) 688-0089

Name of Patient _____ Date of Birth _____

MEDICAL HISTORY

Name of person filling this form		Today's date	
Birth History	Gestational Age:	Hospital:	City:
Birth Weight:	Birth Length:	Blood Type:	
Type of Delivery	Complications		
Did Baby have any problems at or immediately after birth?			
List age when baby cooed or laughed:			
Held head up:	Walked	Toilet trained:	

HOSPITALIZATIONS - Reason:	Date: / /	to: / /	
Chronic Illness:	When Diagnosed: Date / /	Specialists:	

SURGICAL HISTORY - Reason:	Date: / /	to: / /	
Circumcision: Yes	No	Other:	

MEDICATIONS TAKEN DAILY:

ALLERGIES TO MEDICINES: **ALLERGIES TO FOOD:**

IMMUNIZATIONS UP TO DATE?

Any smokers in household?

CHILD'S AND FAMILY'S HEALTH HISTORY

Has Child/Family had any history of, or difficulty with any of the following:

	Child	Family Member	Relationship to Child
ADHD	☐	☐	
AIDS/HIV	☐	☐	
Allergies	☐	☐	
Anemia	☐	☐	
(Including Sickel Cell & Thalassemai)	☐	☐	
Asthma	☐	☐	
Attention Problems	☐	☐	
Bed Wetting	☐	☐	
Birth Defects	☐	☐	
Bladder Problems	☐	☐	
Bleeding Excessive	☐	☐	
Cancer	☐	☐	
Cerebral Palsy	☐	☐	
Chicken Pox	☐	☐	
Constipation	☐	☐	
Convulsions	☐	☐	
Diarrhea	☐	☐	
Diabetes	☐	☐	

	Child	Family Member	Relationship to Child
Drug/Alcohol abuse	☐	☐	
Ear infections	☐	☐	
Eczema	☐	☐	
Epilepsy	☐	☐	
Fainting	☐	☐	
Gall Bladder Disease	☐	☐	
Gastro Reflux Disease	☐	☐	
Heart Problems	☐	☐	
Heart Attack	☐	☐	
(before age 55)	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Hepatitis	☐	☐	
Hyperactivity	☐	☐	
Kidney Disease	☐	☐	
Lead Poisoning	☐	☐	
Learning Problems	☐	☐	
Liver Disease	☐	☐	

	Child	Family Member	Relationship to Child
Mental Disorder	☐	☐	
Mononucleosis	☐	☐	
Measles	☐	☐	
Mumps	☐	☐	
Pneumonia	☐	☐	
Psychological Problems	☐	☐	
Rheumatic Fever	☐	☐	
Seizures from Fever	☐	☐	
Sinus Problems	☐	☐	
Speech Problems	☐	☐	
Tuberculosis	☐	☐	
Thyroid Disease	☐	☐	
Urinary Disease	☐	☐	
Vision Problems	☐	☐	
Worms	☐	☐	
Other:	☐	☐	
Other:	☐	☐	
Other:	☐	☐	

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PEDIATRICS

NAME:

DOB:

MEDICATION LIST

	START	DISCON'T

	START	DISCON'T

PROBLEM LIST

PROBLEM	DATE	TREATMENT / OUTCOME

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____

Signature of Patient or Personal Representative

_____

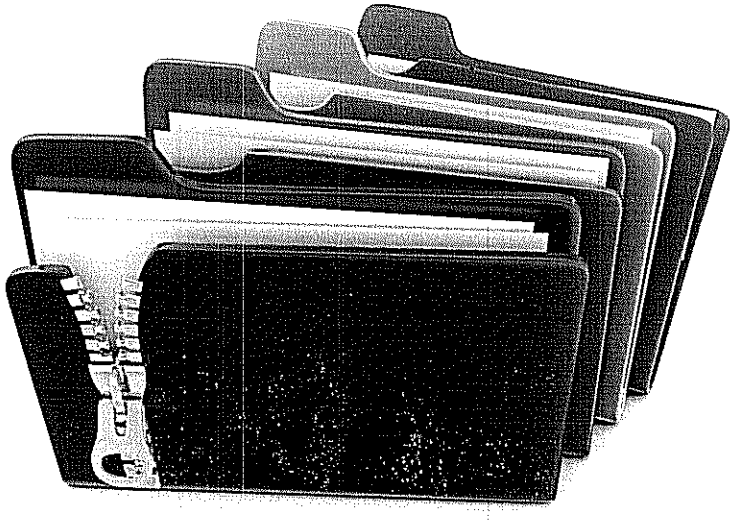
Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority



Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

CHILDREN OF TEXAS PEDIATRICS, P.A.
Patient Financial Policy sheet

To reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. This is a brief summary; more detailed policies are available, upon request. If you have any questions regarding our policies, see our Practice Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Please know that the parent/guardian has ultimate financial responsibility for the patient. For your convenience we accept VISA, Mastercard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This office's policy is to collect the co-payment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand this summarization of the financial policies of this practice. I have been informed that the full financial policy is available for my review, upon request. I understand that the practice reserves the right to amend any stated policy from time to time and I agree to be bound by policy terms.

_____
Printed name of the Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date

CHILDREN OF TEXAS PEDIATRICS

10350 Bandera Road, Suite 210 San Antonio, TX 78250
Phone: (210) 688-0088 Fax: (210)688-0089

MEDICAL RECORD AUTHORIZATION FOR RELEASE

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

I authorize and request the disclosure of the protected health information specified below:

___ Complete medical records to include all office notes, correspondence and labs
___ Immunization record only
___ Records of care from the indicated date(s):_____ to _____
___ Other, please specify _____

Reason for Release of Information:

___ Change of Physician ___ Coordination of Care
___ Other, please specify _____

To:_____
Address: _____
_____
Phone: _____
Fax: _____

From: _____
Address: _____
_____
Phone: _____
Fax: _____

I understand the information to be released may include information relating to sexually transmitted diseases, positive or negative test results for AIDS/HIV, antibodies to AIDS or infection with any other other causative agent of AIDS with the rest of the medical records. I have the right to revoke this authorization in wirting at any time except to the extent information has been released in reliance upon this authorization. Revocation must be sent to **CHILDREN OF TEXAS PEDIATRICS** at the the address listed above. I understand that you will provide copies of medical information within 15 business days from receipt of this request and that a fee for preparing and furnishing may be charged according to the ruling set forth by the Texas State Board of Medical Examiners.

_____ _____
Signature of Patient or Legal Representative *Date*

_____ _____
Printed Name *Relationship to Patient*

AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF SIGNATURE