CHILDREN OF TEXAS PEDIATRICS, P.A

WELCOME TO OUR OFFICE

Patient's Birth Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code_____

Phone _____ SEX : M / F

PARENT'S / GUARDIAN'S INFORMATION:

Father's Name _____ Date of Birth _____ Policy holder Yes / No

Address _____ City _____ Zip Code_____ Phone _____

Social Security # _____ Driver License # _____ Cell _____

Employer _____ Job Position _____

Work Address _____ Zip Code _____ Work Phone _____

Marital Status (circle): M S W D SEP

Mother's Name _____ Date of Birth _____ Policy holder Yes / No

Address _____ City _____ Zip Code_____ Phone _____

Social Security # _____ Driver License # _____ Cell _____

Employer _____ Job Position _____

Work Address _____ Zip Code _____ Work Phone _____

Primary Insurance _____ **ID #** _____ **Group #** _____

Secondary Insurance _____ **ID #**_____ **Group #** _____

Referred To Our Office By _____ Phone _____

Children's Full Names (List All Children):

		(Circle)	
1.	_____	M / F	DOB _____
2.	_____	M / F	DOB _____
3.	_____	M / F	DOB _____
4.	_____	M / F	DOB _____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for 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** _____

Children of Texas Pediatrics
10350 Bandera Road, Suite #210
San Antonio, Texas 78250

Name: _____ Date: _____

MEDICAL HISTORY

BIRTH HISTORY

Hospital:		Date of Birth:
Birth Weight:	Birth length:	Blood Type:
Type of Delivery	Complications	
Did Baby have any problems at or immediately after birth?		
List age when bay cooed or laughed:		
Held head up:	Walked:	Toilet trained:

PAST HOSPITALIZATIONS - Reason:	Date: / /	to / /

PAST SURGICAL HISTORY - Reason	Date: / /	to / /

MEDICATIONS:
ALLERGIES TO MEDICINES:
IMMUNIZATIONS UP TO DATE?
Any smokers in household?

CHILD'S AND FAMILY'S HEALTH HISTORY

Has Child/ Family has any history of or difficulty with any ofth following:

	Child	Family Member	Relationship To Child		Child	Family Member	Relationship To Child		Child	Family Member	Relationship To Child
ADHD	☐	☐		Drug/Alcohol abuse	☐	☐		Mental Disorder	☐	☐	
AIDS/HIV	☐	☐		Ear infections	☐	☐		Mononucleosis	☐	☐	
Allergies	☐	☐		Eczema	☐	☐		Measles	☐	☐	
Anemia	☐	☐		Epilepsy	☐	☐		Mumps	☐	☐	
(Including Sickel Cell & Thalassemia)				Fainting	☐	☐		Pneumonia	☐	☐	
Asthma	☐	☐		Gall Bladder Disease	☐	☐		Psychological Problems	☐	☐	
Attention Problems	☐	☐		Gastro Reflux Disease	☐	☐		Rheumatic Fever	☐	☐	
Bed Wetting	☐	☐		Heart Problems	☐	☐		Seizures from Fever	☐	☐	
Birth Defects	☐	☐		Heart Attack	☐	☐		Sinus Problems	☐	☐	
Bladder Problems	☐	☐		(before age 55)	☐	☐		Speech Problems	☐	☐	
BleedingExcessive	☐	☐		High Blood Pressure	☐	☐		Tuberculosis	☐	☐	
Cancer	☐	☐		High Cholesterol	☐	☐		Thyroid Disease	☐	☐	
Cerebral Palsy	☐	☐		Hepatitis	☐	☐		Urinary Disease	☐	☐	
Chicken Pox	☐	☐		Hyperactivity	☐	☐		Vision Problem	☐	☐	
Constipation	☐	☐		Kidney Disease	☐	☐		Worms	☐	☐	
Convulsions	☐	☐		Lead Poisoning	☐	☐		Other: _____	☐	☐	
Diarrhea	☐	☐		Learning Disabilities	☐	☐		Other: _____	☐	☐	
Diabetes	☐	☐		Liver Disease	☐	☐		Other: _____	☐	☐	

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. If you have any questions regarding these policies, please discuss them with our office 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.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, Mastercard, 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 the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____
Printed name of the Patient

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

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

CHILDREN OF TEXAS PEDIATRICS, P.A.

Notice of 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.

This medical facility 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. We may change our policies and this notice at any time and have any 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 our office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, and 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. When we refer you to that physician, we will share some or all of your medical information with that physician 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 we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services 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, Children of Texas can 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.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or 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 which rely on that authorization.
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.

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 (e.g. births and deaths), 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.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations 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:

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

We also may 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 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

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 person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

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

Dr. James A. Donnel, Jr.

Children of Texas Pediatrics

Dr. Jose D. Clay-Flores

10350 Bandera Rd. Suite #210
San Antonio, TX 78250
P:210-688-0088
F:210-688-0089

Medical Record Release Form

This authorizes you to provide a copy, summary, or a narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- ☐ Complete Record
- ☐ Immunization Record
- ☐ Records of care from the following dates: _____ to _____
- ☐ Other, please specify: _____
- ☐ Confer orally with person(s) listed below about my medical information: _____

_____

Patient Name: _____ Date of Birth: _____

Physician transferring from:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ Fax: _____

The reasons or purpose for this release of information are as follows:

_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV Infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: _____ **Date:** _____

I understand that you will provide copies of medical information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient (parent, if minor) Signature: _____ Date: _____