Today's Date: _____ How did you hear about our practice?_____

Pediatrician Preferred: ____ Dr. Schwartz ___ Dr. Horn ___ Dr. Taneja

Patient's Name:_____ Date of Birth: ____/_____/_____
(First) (Middle) (Last)

Gender: __M __F SSN: _____-_____-_____ Patient's Phone (Age 16+): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Custodial Parent: __Mother __Father __Both __Other: _____

Parent/Guardian Information

Primary Email: _____

May we send Protected Health Information (PHI) to this email address? __Yes __ No

Primary Phone**:** _____ May we discuss PHI on this voice mail? __Yes __ No

Parent Name: _____ Date of Birth:_____/_____/_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Parent Name: _____ Date of Birth:_____/_____/_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Home Address (*if different from child*): _____

City: _____ State: _____ Zip: _____

Employer: _____

Sibling Information:

Siblings Name: _____ DOB:_____/____/_____ Gender: __M __F

Siblings Name: _____ DOB:_____/____/_____ Gender: __M __F

Siblings Name: _____ DOB:_____/____/_____ Gender: __M __F

Siblings Name: _____ DOB:_____/____/_____ Gender: __M __F

Emergency Contact Information

Name:_____ Relationship:_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Please list any other individuals allowed to bring the child to appointments.

Name:_____ Relationship:_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Name:_____ Relationship:_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Name:_____ Relationship:_____

Phone: _____ May we discuss PHI on this voice mail? __Yes __ No

Insurance Information:

Policy Holders First and Last Name:_____
Date of Birth: _____/___/_____ SSN: _____-_____-_____ Relation to patient:_____
Name of Primary Insurance Company:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Policy Number: _____ Group Number:_____ Copay: _____
What was the effective date of this insurance? _____
Policy Holder's Employer: _____

******PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. The parent/guardian who is present for office visits is the Billing Guarantor, please see below.******

Financial Responsibility

No Show/Cancellation Courtesy: We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment. If multiple appointments are missed, a $25.00 fee is applied to your child's account per missed appointment. If three or more appointments are missed, it may result in our request for you to find another pediatrician for your child.

Returned Check Fee: There is a $35.00 fee for check returned for any reason and will be added to your additional balance. In addition, we may seek all additional legal remedies provided to us under Texas Law.

Patient Balance Policy: After filing with your insurance company, we will promptly mail you a patient statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing department within 30 days. If you are unable to pay the balance in full, you must contact the billing department to discuss a payment schedule or further arrangements.

Divorce/Child Custody:

Collin County Pediatrics will not honor the specific financial agreements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgement, or the like ("the Arrangements"). Since Collin County Pediatrics is not a party to these arrangements, it is not obligated to the financial terms. In cases of child custody, the parent who presents their child for care and treatment at Collin County Pediatrics is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then Collin County Pediatrics will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the presenting parent. Upon request, Collin County Pediatrics will provide a duplicate copy of your receipt so that the presenting parent or guardian can seek reimbursement where appropriate.

Consent to Treat

I give my consent for diagnosis and treatment to Collin County Pediatrics to provide medical care reasonable by today's standards to my minor child. This includes, but is not limited to: physical examination, evaluation of illness and injuries, routine immunizations, lab testing, and minor procedures. Verbal consent will be obtained prior to each immunization. Vaccine information sheets are available in each exam room. I have had the opportunity to review a copy of the Notice of Privacy Practices which explains how your medical information will be used and disclosed. This is posted in the office and a copy is available upon request. I hereby assign Collin County Pediatrics all right, title, and interest to any benefit payable for medical coverage.

Patient History

Place of Birth:_____ Birth Weight:_____

Pregnancy and/or Birth Problems: _____

Prior Hospitalizations:_____

Prior Surgeries:_____

Food and/or Medication Allergies:_____

List any/all medications your child is currently taking: _____

Child and Family History

Medical Condition	Child YES	Family YES	Explanation (Specify YES answers)
Acid Reflux			
Alcoholism			
Anemia			
Arthritis			
Asthma/Emphysema			
Bleeding Disorder			
Cancer			
Diabetes			
Epilepsy/Seizures			
Glaucoma			
Headaches			
Heart Disease/Failure			
HIV/AIDS			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Dysfunction			
Mental/Psychiatric Illness			
Stroke			
Thyroid Problem			
Tuberculosis			
Ulcers of Stomach			

If your child is prescribed medication, please list a pharmacy preference below.

Name of Pharmacy: _____

Pharmacy Address: _____ Pharmacy Phone Number: _____-_____-_____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ Male ☐ Female

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, 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 (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.

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 ("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;
- 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 ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 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.texas.gov* 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 ImmTrac2 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 • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

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

3555 National Drive, Suite 100
Plano, TX 75025
Phone: 972-731-9900 Fax: 972-731-9907

Release of Medical Records TO Collin County Pediatrics

*****Immediate: Please fax immunizations upon arrival of request*****

Please mail or fax full records to the office location above within 30 days of receiving this request.

Patient Information

Patient Name: _____ DOB: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Release Records FROM (previous pediatrician or facility name): _____

Address: _____

City / State / Zip: _____ Phone: (_____)_____-_____ Fax: (_____)_____-_____

Authorization (please initial each line item below)

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information below is release, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and/or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do sin writing a present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire 90 days from the date on which it was signed.

_____ _____ _____

Name (print) Signature Date

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other (please specify): _____