KID CARE PEDIATRICS

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☐ **230 N. Rufe Snow Drive**
Keller, TX 76248
Phone: 817-337-5503
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☐ **6618 Fossil Bluff Dr #116**
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☐ **590 FM 156 South #100**
Haslet, Texas 76052
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Fax: 817-847-1353

PLEASE PRINT

PATIENT REGISTRATION

Patient's Full Name: _____ **Preferred Name:** _____

Date of Birth: _____/_____/_____ Patient Social Security #: _____/_____/_____ ☐ Male ☐ Female

Preferred Email for appointment reminders: _____

Mother's Name: _____ Social Security #: _____/_____/_____

Date of Birth: _____/_____/_____ Employer: _____ Work # _____

_____
Home Address City State Zip

Home Phone #: _____ Mobile Phone # _____

Father's Name: _____ Social Security #: _____/_____/_____

Date of Birth: _____/_____/_____ Employer: _____ Work # _____

_____
Home Address City State Zip

Home Phone #: _____ Mobile Phone # _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Name of Insured:** _____

Insurance Phone #: _____ **ID # or Policy #:** _____ **Group #:** _____

Secondary Insurance Company: _____ **Name of Insured:** _____

Insurance Phone #: _____ **ID # or Policy #:** _____ **Group #:** _____

Kid Care 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. If my account is referred to the collection process, I will pay all fees including attorney fees. I authorize the release of information to my insurance if requested.

Signature: _____ Date: _____

KID CARE PEDIATRICS

Child's Name: _____
Preferred Name: _____
Date of Birth: _____

Previous Medical History: ☐ **None** (asthma, recurrent UTI, seizure, anemia, depression, ear infections, murmur, OTHER)
_____
_____
_____

Surgical History: ☐ **None** (type of surgery and when)
_____

Hospitalizations: ☐ **None** (for what illness and when)
_____

Allergic Reactions: ☐ **None** (to what and when)
Allergy to: _____ Date of reaction: _____
Allergy to: _____ Date of reaction: _____
What happened: ☐ Rash ☐ Difficulty Breathing
☐ Vomiting ☐ Facial Swelling
Other: _____

Medication History: ☐ **None** (list on back if needed)
Daily Medications:
What: _____ Dose: _____
What: _____ Dose: _____
As Needed Medications:
What: _____ Dose: _____
What: _____ Dose: _____

Are Immunizations up to date? ☐ Yes ☐ No
(Please provide our office with a copy)

Developmental Milestones:
Rolling Over Age: _____ Walking Age: _____
Sitting Up Age: _____ Talking Age: _____

School History: ☐ **None**
Name of school: _____
Current grade level: _____
Average grades this school year: A B C Failing
School Problems: _____
Seen by Speech Therapist, Psychologist, or Special Teachers
_____

Family History: (provide history of child's: mother, father, siblings, grandmother, grandfather, uncle, aunt)

Asthma	☐ Yes ☐ No	Who_____
Anemia	☐ Yes ☐ No	Who_____
Cancer *-before 55*	☐ Yes ☐ No	Who_____
Heart disease *-before 55*	☐ Yes ☐ No	Who_____
High cholesterol	☐ Yes ☐ No	Who_____
Stroke	☐ Yes ☐ No	Who_____
Diabetes	☐ Yes ☐ No	Who_____
Epilepsy or seizures	☐ Yes ☐ No	Who_____
Substance abuse	☐ Yes ☐ No	Who_____
Mental illness	☐ Yes ☐ No	Who_____
Developmental disorder	☐ Yes ☐ No	Who_____
Thyroid disease	☐ Yes ☐ No	Who_____
Other: _____		Who_____

Birth History:
Birth weight lb _____ oz _____
Was the baby circumcised? ☐ Yes ☐ No
Was the baby born at term? ☐ Yes ☐ No _____ weeks
Was the delivery ☐ Vaginal ☐ Cesarean? If cesarean, why?
_____
_____

Were there any complications before birth or after birth?
☐ Yes ☐ No Explain _____
_____

Was a NICU stay required? ☐ Yes ☐ No
Explain_____

Normal newborn screen at birth? ☐ Yes ☐ No
Normal hearing screen at birth? ☐ Yes ☐ No

During pregnancy, did mother:
Use tobacco? ☐Yes ☐No Drink alcohol? ☐ Yes ☐ No
Use drugs or medications? ☐Yes ☐No
What _____ When_____

Travel History:
Has your child traveled outside the United States in the last 3 months? ☐ Yes ☐ No
If so, where to and when? _____

Social History:
Pets in the home? ☐ No ☐ Yes
If so, what kind and how many? _____
Pool at home? ☐ No ☐ Yes
Guns in home? ☐ No ☐ Yes -Are they secured? ☐Yes ☐No
Smoke exposure? ☐ No ☐ Yes
Daycare? ☐ No ☐ Yes How many days_____

Who lives in the home? ☐ Mom ☐ Dad ☐ Stepmother
☐ Stepfather ☐ Grandmother ☐ Grandfather
☐ _____
How many siblings? _____ Siblings ages_____

Are there any custody concerns? ☐ No ☐ Yes (explain)
_____
_____

Let us get to know you:
Is there anything you would like us to know about your child?
_____
_____

How long has your family lived in this area? _____

Where did you live before coming to this area?
_____

Who was your last doctor?
Name:_____
Address: _____
_____
Phone #: _____

KID CARE PEDIATRICS
AUTHORIZATION FOR THE RELEASE OF INFORMATION AND/OR MEDICAL RECORDS

I consent and authorize Kid Care 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.

Kid Care 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

KID CARE 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 Kid Care 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.

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 Kid Care 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 Kid Care Pediatrics all right, title and interest in benefits or monies payable for goods or services. I understand that in the event that Kid Care Pediatrics files a claim on my behalf that the same does not impose any contractual obligation upon Kid Care 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 Kid Care 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

KID CARE 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 Date

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

CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Parent or Legal Guardian's Printed Name: _____
Parent or 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 Kid Care 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

230 N. Rufe Snow Drive
Keller, Texas 76248
817-337-5503

6618 Fossil Bluff Dr #116
Fort Worth, Texas 76137
817-847-6420

590 FM 156 South #100
Haslet, Texas 76052
817-439-0303

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)

_____ _____
Witness (optional) Date

HOW DID YOU FIND OUT ABOUT US AND/OR WHO MAY WE THANK FOR REFERRING YOU TO KID CARE PEDIATRICS?

CHECK ALL THAT APPLY

Do you have other children that are patients of Kid Care Pediatrics? ☐ Yes ☐ No

- ☐ Friend(s) or Relative(s): _____ (Name of Relative/Friend)
- ☐ Previous patient
- ☐ Sibling is a patient
- ☐ Physician Referral: _____ (Name of Physician)
- ☐ Discovered while driving by
- ☐ Online yellow pages
- ☐ Tarrant County Medical Society Referral Line
- ☐ Baylor Grapevine Physician and Services Directory
- ☐ St. Elizabeth Ann Seton Church Bulletin
- ☐ Insurance Company Website
- ☐ Internet: _____ (which site)
- ☐ Other: (Business Cards, Flyer, Daycare, Pharmacy, etc.) _____

☺ ☺ ☺ COME GROW WITH US! ☺ ☺ ☺

Thank you for the opportunity to provide medical care to your child(ren)!

Please consider telling others about your pleasurable experience here at KID CARE PEDIATRICS.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name _____Date of Birth_____
Social Security #_____ (optional)

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:

☐ Kid Care Pediatrics
230 N. Rufe Snow Dr
Keller, TX 76248
817-337-5503
Fax 817-337-0110

☐ Kid Care Pediatrics
6618 Fossil Bluff, Suite 116
Ft. Worth, TX 76137
817-847-6420
Fax 817-847-6412

☐ Kid Care Pediatrics
590 FM 156 S., Suite 100
Haslet, TX 76052
817-439-0303
Fax 817-847-1353

Please release the following:
___Entire Record
Or: ___Newborn Hospital Assessment Record ___Laboratory Results ___X-Rays
___EKG Report ___EEG Reports ___Operative Reports
___Therapy Reports ___Obstetrical Reports ___Psychological Reports
___Most Recent History and Physical ___Other (specify) _____

Purpose for the release:
___Medical Care ___Insurance Purpose ___Legal Purpose ___Other:_____

I understand that my medical record may contain information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.
___**YES, I consent** ___**NO, I do not consent to the release of this information**

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 I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____

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, as provided in CFR-164.524. 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 Kid Care Pediatrics.

_____ DL# _____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

KID CARE PEDIATRICS POLICY PAGE

We want to welcome you to Kid Care Pediatrics. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about your child's healthcare.

Appointments:
-Call the office at (817) 337-5503, (817) 847-6420 or (817) 439-0303 twenty four hours prior to an appointment if the appointment is not going to be utilized/if the visit is being cancelled or postponed.

We reserve the right to charge $25 for no show appointments without 24 hour cancellation notice.

Please be aware patients that arrive more than 5 minutes late for their appointments may be asked to reschedule.

Payments:
We collect all co-pays, deductibles and co-insurance at the time of service according to the benefit quote that our office obtains from your insurance company.

We have a $30.00 fee for all returned checks.

After Hour Calls:
There is a $15.00 processing charge for all after hours urgent nurse triage calls.

For prescription refills, ask the pharmacy to forward a medication refill request to our office. For patients that are seen at the Keller office use (FAX # 817 337-0110) and for patients that are seen at our Fort Worth office use (FAX # 817-847-6412) and for patients seen at our Haslet office use (FAX # 817-847-1353) or call the office for a refill request with 24-48 hours prior notice if possible in order to ensure a timely response. (Keller Phone # 817-337-5503) (Fort Worth Phone # 817-847-6420)(Haslet Phone# 817-439-0303)

Holidays:
The office is closed for all major holidays. For urgent and emergency care, parents are to use the Cook Children's URGENT CARE and EMERGENCY CARE GUIDELINES.

Inclement weather:
For inclement weather office hours, please check our website at www.kidcarepediatrics.com. For urgent and emergency care when the office is closed due to inclement weather, please use the URGENT CARE and EMERGENCY CARE guidelines previously listed.

Kid Care Pediatrics physicians see patients from 0 – 18 years of age. Once 18 years of age, patients are referred to physicians that care for adults.

Vaccines:
Kid Care Pediatrics providers believe in the efficacy of vaccines and strongly recommends patients receive state and school mandated immunizations. Elective vaccines are also offered. For families who will be refusing/declining vaccines for their children, Kid Care Pediatrics will kindly refer families to the Tarrant County Medical Society (PH# 817 732-2825) to search for other medical practices in agreement with an anti-vaccine medical philosophy.

_____
Initials

BILLING POLICIES

Newborns

- Please be aware that not all plans cover newborns with automatic coverage and patients may be asked to pay for the visit in full if our office staff is not able to verify coverage for the date of service.

- Newborn charges are often put to patient responsibility because the baby has not been added to the health plan. It is the parent's responsibility to contact our office once the baby is added to the policy so that we may submit the charges to the correct insurance and they are processed correctly. If the parent fails to contact the office within filing time limits, the charges will remain patient responsibility. **Please call your insurance to add newborn within 30 days. Failure to add newborn child within 30 days may result in the child being denied coverage until the next enrollment period for the plan.**

Well Child Exams

- Please be aware that a physician may bill a sick office visit (99202-99205, 99212-99215) in addition to a previously scheduled preventative visit. Per CPT coding rules the well child visit code applies only to preventative medical care but does not include any issues related to chronic diseases or acute illness. Insurance companies process these claims according to their policy guidelines and the patient may have a balance due for the unrelated sick office visit.

- All labs, hearing screen and vision screen are billed separate from the preventative office visit. Please be aware that each policy processes these charges according to your benefit guidelines and the patient may receive a bill for these services.

- We recommend that you bring with you any school forms, physical forms and medication forms to the well child visit to avoid any processing fees if the forms are not provided at the time of the appointment.

- We charge a nominal processing fee to complete School Physical forms, Medication Forms, Day Care forms if the form is not given to the Provider at the time of the appointment. You may request a copy of fee schedule from the staff.

Current Insurance

- We verify insurance benefits prior to your child being seen by our providers. We ask that you present your current insurance card at every visit so that the office staff may copy it. Failure to update our office with correct insurance information on the date of service will result in the charges being billed to the patient. We are not able to bill new insurance if it is not provided to us in a timely manner.

- Our office staff is only given a quote of benefits by your insurance company. It is never a guarantee of payment. We do our best to verify all vaccines and office visit co-pays and deductibles; however ANY portion that is applied to patient responsibility by the insurance company is due in full at the time of service. If you have any questions about your benefits we recommend you contact your insurance company so that they can explain your benefit package to you. Similarly you can ask our staff about the benefits that were quoted.

Vaccines

- If your health plan provides no vaccine coverage or you do not have health insurance, please let the staff know. We may be able to refer your child to the county health department for vaccines.

Payment

- We collect payment (fees, co-pays and deductibles) at the time of service. Statements will be mailed out monthly for any portion due that insurance may apply and payment in full is expected on receipt. Please review statements to insure accuracy from all parties. **We accept cash, personal check and all major credit cards (Amex, Visa, MC and Discover) for your convenience.** Credit card payments can be paid online at www.kidcarepediatrics.com/payments**.**

- We charge a processing fee for FMLA letters and Letters of Medical Necessity.

Current Information

- The parents must update new address and phone information with the front office staff. Failure to do so will result in statements being undeliverable and accounts possibly being sent to collections.

Refunds

- Refunds must be requested from the office for any credit balance you may have on your account. They will not be automatically issued. Please allow ten business days to process. Refund will not be processed by credit card transactions. All refunds will be issued by paper check.

Collections

- Accounts that remain unpaid will be sent to a collection agency for further collection proceedings and will result in patients being dismissed from the practice. The account will be assessed a $25.00 collection fee.

- If you have a question about your account please call our office at 817.337.5503 and speak to someone in the billing department. We are happy to assist you in any way that we can.

_____

Parent Signature Date

KID CARE 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.**

_____ **BILLING FEE: All insurance co-pay and deductible amounts are due in full at the time of service. Your account will be charged a $10.00 billing fee if you do not pay your co-pay or deductible on the day of your visit.**

_____ **NO SHOW FEE: Kid Care Pediatrics will charge a $25.00 fee 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.

_____ **COLLECTIONS FEE**: Please be aware that if there has been no attempt to settle a balance on a patient account after 60 days of which it becomes due, the account will be accessed a $25.00 collection fee.

_____ **NSF CHECKS:** There will be a $30.00 fee for all checks returned to us for non-sufficient funds. Additionally, we will no longer accept checks and will request payments by cash or credit card.

_____ **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 Kid Care 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 Kid Care 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 Kid Care 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.

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

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.

Kid Care 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 Kid Care 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 Kid Care 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:_____/_____/_____

Effective Date of Notice: Sept 10, 2013

Kid Care 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 hospital, 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**

Advanced Practice Nurse Consent for Treatment

Patient's name_____ Patient's DOB_____

This facility has on staff an advanced practice nurse to assist in the delivery of medical pediatric care. An advanced practice nurse is not a physician. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my child's health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

Parent/Guardian Signature_____ Date_____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
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)

Questions? (800) 252-9152 • (512) 458-7284 • 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 07/22/08

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.

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO

ImmTrac
Texas Immunization Registry

(Favor de escribir claramente con letra de molde)

For Clinic/Office Use

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

Fecha de Nacimiento del Niño(a) / / * *Solamente niños menores de 18 años.*

Género: ☐ **Masculino** ☐ **Femenino**

Dirección del Niño(a), Calle

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Municipio

Nombre de la Madre

Nombre de Soltera de la Madre

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizó que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac"). Una vez que la información del menor esté en ImmTrac, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro médico o proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

Al firmar abajo, YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño(a) en el registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: _____

Escriba con letra de molde

_____ _____

Fecha **Firma**

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a **http://www.dshs.state.tx.us** para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code,* sección 552.021, 552.023, 559.003 y 559.004)

¿Tiene preguntas? (800) 252-9152 • (512) 458-7284 • 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 07/22/08

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.***