My *PRIMARY* Hometown Pediatrician is to be… ☐ *Dr. Chandler* ☐ *Dr. John* ☐ *Dr. Moore* ☐ *Dr. Smith* ☐ *Dr. Hathaway*

Hometown Pediatrics

PATIENT INFORMATION
(Please Print Clearly)

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Race: _____ Language Spoken at Home: _____

Social Security #: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Mother's Cell Phone #: _____ Father's Cell Phone #: _____

Mother's Name: _____ Mother's Date of Birth: _____

Employer: _____ Work #: _____

Father's Name: _____ Father's Date of Birth: _____

Employer: _____ Work #: _____

Emergency Contact

(Other Than Listed Above)

Name: _____ Relationship to patient: _____ Best Contact #_____

Pharmacy to Electronically Send Prescriptions

Pharmacy Name: _____ Phone #: _____

Address: _____ City:_____ State:_____ Zip:_____

Insurance Information

Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults, lab work and other tests according to your managed care guidelines. However, our office deals with many different plans and ***it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.*** *Please verify their participation* ***BEFORE*** *services are rendered to receive network benefits from your insurance company.*

Primary Insurance	Secondary Insurance
Policy Holder: _____	**Policy Holder:** _____
DOB: _____ **SS#:** _____	**DOB:** _____ **SS#:** _____
Relationship to Patient: _____	Relationship to Patient: _____
Insurance Company: _____	Insurance Company: _____
Address: _____	Address: _____
Phone #: _____ Effective Date: _____	Phone #: _____ Effective Date: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____

****Whom may we thank for referring you to Hometown Pediatrics?** _____

By signing below, I hereby authorize Hometown Pediatrics to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your child's care. I have read and understand the Hometown Pediatrics Financial Policy.

Parent/Guardian Printed Name: _____ **Signature:** X _____

Relationship to Patient: _____ **Date:** _____

Rev 4/18

Hometown Pediatrics

FINANCIAL POLICY

Welcome and thank you for choosing Hometown Pediatrics for the medical needs of your child. We are dedicated to providing the best possible care for your child, and we want you to completely understand our financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible.

Co-payments, unmet portions of your deductible, coinsurance, and previous balances are due at time of service.

Appointments: Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

Self-pay Accounts: Patients with no insurance will be expected to pay at the time of service.

Insurance: The patient is expected to present an insurance card at each visit. If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is a contract between you and your insurance company. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges. Any non-covered charges are due upon receipt of a statement from our office within 30 days.

Referrals: It is the responsibility of the patient to know their insurance plan's procedures for referrals. If your plan requires a referral, it will be necessary for you to inform us of that prior to you scheduling an appointment with a specialist. We kindly ask that you notify our office 5 (five) business days prior to non-urgent referral visits.

Late Arrival: As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are ***more than 20 minutes late***, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

No-Shows or Missed Appointments: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. ***If an appointment is missed without 24-hours prior notice, you will be charged a $25.00 fee.*** This fee is not payable by your insurance company and will be your responsibility.

Child Custody/Divorce Cases: This office will not bill a divorced spouse for the patient's service. It will be the responsibility of the parent or guardian that brings the child in for all co-pays, deductibles, coinsurances, or balances. It is the parents' obligation to work out agreement themselves or through the court system.

Late Fee Charge: The office reserves the right to charge a 1.5% late fee on all unpaid balances that are 60+ days overdue. This will accumulate on balances only until paid in full.

Responsible Party: In order to be HIPPA compliant, we must have the responsible party sign this form. If the responsible party is anyone other than the Primary Insurance carrier, we must have the following:

Responsible Party's DOB:_____ **Responsible Party's SS#**_____

I have read, understand and agree to the above Hometown Pediatrics Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.

Responsible Party's Printed Name:_____ **Signature:** X_____

Date:_____ **Name of Patient:**_____ **Patient d.o.b.:**_____

Rev 4/18

Hometown Pediatrics

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my child's healthcare, Hometown Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available with in Hometown Pediatrics' *Notice of Information Practices* which is available for review upon request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Hometown Pediatrics, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hometown Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hometown Pediatrics change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

***Please initial one of the following.

_____ If I choose to give Hometown Pediatrics a picture of my child, I **give** them permission to hang the picture in the office.

_____ If I choose to give Hometown Pediatrics a picture of my child, I **do not give** them permission to hang the picture in the office.

I fully understand and accept the terms of this consent. **Signature**: X_____

Printed Name:_____ **Relationship to patient**: ☐ ***Father*** ☐ ***Mother*** ☐ ***Guardian***

Date:_____ **Name of Patient**:_____ **Patient d.o.b.**:_____

Hometown Pediatrics
PEDIATRIC HISTORY

Patient's Name _____ **Date of Birth** _____ **Allergies to Meds** _____

Pregnancy Complications

(check Yes or No)	Yes	No
Pregnancy less than 9 months	☐	☐
High blood pressure	☐	☐
Gestational diabetes	☐	☐
Medications *(if yes, list)*	☐	☐

_____

_____

(check Yes or No)	Yes	No
Bleeding *(if yes, which month)*	☐	☐
Serious illnesses	☐	☐
Serious infections	☐	☐
Previous miscarriages	☐	☐
C-section *(if yes, why?)*	☐	☐

_____

Birth History

Place of birth: _____

Birth weight: _____ **Length:** _____

Length of labor: _____

Adopted: No ☐ Yes ☐

Birth Problems

(check Yes or No)	Yes	No
Jaundice	☐	☐
Breathing problems	☐	☐
Antibiotics	☐	☐

Other problems *(explain)* _____

_____

Breastfed: _____ **Formula fed** _____

Developmental History

At what AGE did your child…

	Yes	No
School Problems?	☐	☐

Smile: _____ **Roll over:** _____ **Sit alone:** _____

Walk alone: _____ **1st word with meaning:** _____ **Use 3 word sentence:** _____

Bladder trained: _____ **Bowel trained:** _____ **Ride tricycle:** _____ **Tie shoes:** _____

Medications Child Takes Routinely:

_____

_____

_____

Hospitalizations & Operations:

1 _____ **Date** _____

2 _____ **Date** _____

3 _____ **Date** _____

Childhood Illnesses

(check Yes or No)	Yes	No	Date
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Bed wetting	☐	☐	_____
Chickenpox	☐	☐	_____
Convulsions/epilepsy	☐	☐	_____
Diabetes	☐	☐	_____
Kidney disease	☐	☐	_____
Measles	☐	☐	_____
Meningitis	☐	☐	_____
Mumps	☐	☐	_____
Pneumonia	☐	☐	_____
Rheumatic fever	☐	☐	_____
Scarlet fever	☐	☐	_____
Sickle cell trait or disease	☐	☐	_____
Whooping cough	☐	☐	_____

Other Serious Illnesses	Date(s)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Hometown Pediatrics
PEDIATRIC HISTORY (Continued)

Patient's Name _____ **Date of Birth** _____ **Today's Date** _____

Child's Family

	full name	Age	Present Health or cause of death
Mother:			
Father:			

	full name		DOB	
Sib #1:		☐ *M* ☐ *F*		
Sib #2:		☐ *M* ☐ *F*		
Sib #3:		☐ *M* ☐ *F*		
Sib #4:		☐ *M* ☐ *F*		
Sib #5:		☐ *M* ☐ *F*		
Sib #6:		☐ *M* ☐ *F*		
Sib #7:		☐ *M* ☐ *F*		

Social History

(Check "No" or "Yes")	No	Yes	No./day
This teen patient smokes?	☐	☐	____
This teen patient drinks?	☐	☐	____
Household with smokers?	☐	☐	____
Pets? *(If "Yes", please list…)*	☐	☐	

_____

Family History

*(Check **if disease is present**)*	Mother's Side	Father's Side
Diabetes	☐	☐
Heart trouble	☐	☐
Heart attack	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐
Arthritis	☐	☐
Obesity	☐	☐
Suicide	☐	☐
Mental Illness	☐	☐
Thyroid problems	☐	☐
Sickle cell	☐	☐
Seizures/epilepsy	☐	☐
Bedwetting	☐	☐
Allergies	☐	☐
Hay fever	☐	☐
Asthma	☐	☐
Other: _____	☐	☐
Other: _____	☐	☐

Notes:

_____

_____

_____

_____

_____

_____

_____

Hometown Pediatrics

1595 Lake Front Circle

(281) 292-8980 (Office) **The Woodlands, TX 77380** **(281) 292-8070 (Fax)**

Kristie R. Chandler, MD, FAAP **Amanda E. Hathaway, MD, FAAP** **Tony John, MD, FAAP**

Sarah E. Moore, MD, FAAP **Mona Smith, MD, FAAP**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

Child's First & Last Name: _____ Date of Birth: _____

I do hereby authorize my child's medical records <u>from</u>:

Name of Medical Practice, Physician, Clinic or Hospital

Address _____

City, State, Zip _____

Phone Number _____ Fax _____

…to be released <u>to</u>:

Hometown Pediatrics, P.A.
1595 Lake Front Circle
The Woodlands, TX 77380-3604

281-292-8980 (Office) 281-292-8070 (Fax)

…for the purpose of: ☐ ***continuing or transfer of medical care*** ☐ ***proof of immunization***
☐ ***insurance review or underwriting*** ☐ ***legal matters***

Release information concerning the ***following dates***: from _____ to _____, and to include:

☐ ***complete medical records*** in your possession to include illness(es) and/or treatments

<u>or</u> ☐ medical records ***limited to the following specific types of information***:

_____

<u>Also,</u> I ☐**DO** or ☐**DO NOT** (*check one & initial* _____) consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing

I, the parent/guardian, agree that ***a photocopy or facsimile (fax) of this authorization may be considered valid***, this authorization shall be ***valid for 120 days from the date of signature***, and that ***this authorization can be revoked in writing at any time prior to the expiration date***.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless Hometown Pediatrics, PA from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Printed Name _____ **Signature:** X _____

Relationship to Patient*:* ☐***self*** ☐***mother*** ☐***father*** ☐***guardian*** **Date:** _____

Rev 06/18

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

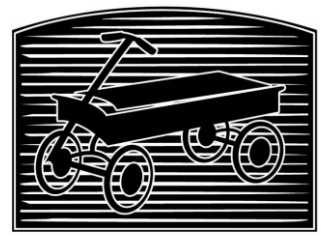
Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is 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.**



Hometown
PEDIATRICS

Permission to Treat

Date _____

I, _____, the parent of…

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

…do hereby give permission to the following listed person(s) to obtain medical treatment for the above referenced child(ren) with a provider of Hometown Pediatrics, P.A. This person(s) has my permission for medical decision-making included but not limited to administration of medications or vaccines, diagnostic or therapeutic procedures, and/or admission to the hospital, etc.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

This consent shall remain effective until revoked in writing and received by Hometown Pediatrics, P.A.

or until _____

In case of emergency, the parents may be reached at: _____

_____	_____
Parent's Name (Printed)	Parent's Signature