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

Hometown Pediatrics

NEWBORN 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 2/13

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 A. Smith, MD, FAAP**

Newborns

It is your responsibility to notify the subscriber's employer and insurance company of the birth of your child. This must be done before the patient is 30 days old. Failure to add your child to the policy could result in denied claims, which would then become your responsibility to pay. To find out how to add your child to your policy, call the member services number located on your insurance card.

Please note: Law requires 48 or 96 hour coverage on the mother's policy applicable only to the newborn's hospital stay. If you do not add the child before the patient is 30 days old, the initial hospital coverage is the only thing mandated by law. Some plans offer little to no newborn coverage under the mother's plan if the child isn't added to the policy.

If your plan is a Health Maintenance Organization (HMO), you likely will also be required to assign a "primary care physician" (PCP) to your child.

Newborn's Name (please print)	Newborn's Date of Birth	Newborn's Place of Birth

Parent or Guardian Printed Name	Relationship to Newborn

X_____ _____

Signature Date

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

ImmTrac2 Immunization Registry
NEWBORN REGISTRATION FORM

(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth *Newborns only.

Child's Gender: ☐ Male ☐ Female

Mother's First Name

Mother's Maiden Name

Mother's Street Address

Apartment #

Telephone

City

State

Zip Code

County

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 (younger than 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 important vaccines are not missed.

The Texas Department of State Health Services (DSHS) 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.

Please mark the appropriate box with a ☑ to indicate your choice.

☐ I **GRANT** consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

☐ I **DENY** consent for registration. I wish to EXCLUDE my child's information from 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) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

BIRTH REGISTRARS

Please enter newborn client information in the Texas Electronic Registrar and **affirm** that consent has been granted.
DO NOT fax to DSHS. Retain this form in the client's birth record.

Stock No. F11-11936 Revised 03/2017

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

ImmTrac2 Immunization Registry
(RECIÉN NACIDO) FORMULARIODE REGISTRO

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

Fecha de Nacimiento del Niño(a) *Solo recién nacidos.

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

Nombre de la Madre

Apellido de Soltera de la Madre

Dirección de la Madre, Calle

Apartamento #

Teléfono

Ciudad

Estado **Código Postal**

Condado

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) (menores de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac2. 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 de Texas (DSHS) le anima a que participe 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, autorizo 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 ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, 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 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 ImmTrac2 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.

Favor de marcar la caja ☑ indicando la selección de su preferencia.

☐ YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño(a) en el registro de inmunización de Texas.

☐ YO **NIEGO** el consentimiento para registrarlo. Deseo **EXCLUIR** la información de mi niño(a) del 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.texas.gov* para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac2 del DSHS o a un proveedor de salud inscrito.

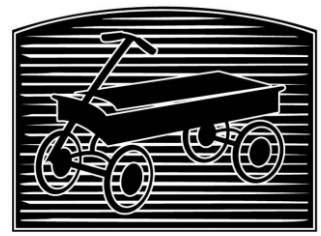
¿Tiene preguntas? (800) 348-9158 • (512) 776-7284 • www.ImmTrac.com • ImmTrac2 NB-2

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

BIRTH REGISTRARS

Please enter newborn client information in the Texas Electronic Registrar and **affirm** that consent has been granted.
DO NOT fax to DSHS. Retain this form in the client's birth record.

Stock No. F11-11936 Revised 03/2017



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