Patient Registration

Patient Name:_____ **MALE/ FEMALE** **DOB:**_____

Patient Name:_____ **MALE/ FEMALE** **DOB:**_____

Patient Name:_____ **MALE/ FEMALE** **DOB:**_____

Permanent Address:_____

Mother's Name: _____

Address : _____

City:_____ ST:_____ Zip:_____ APT:_____

Home Phone #/:_____ Cell #:_____

Birth Date:_____ DL #:_____

EMAIL ADDRESS:_____

Father's Name/Nombre del Padre:_____

Address : _____

City:_____ ST:_____ Zip:_____ APT:_____

Home Phone #/:_____ Cell #:_____

Birth Date:_____ DL #:_____

Responsible Party **(Who will pay for the bill if the insurance doesn't.)**_____

Transfer of Consent to another Party/Emergency Contacts:

I hereby authorize the following person(s) to bring my child to medical attention and consent of treatment in my absence.

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Assignment of Benefits: I hereby assign all medical benefits and/or surgical benefits to the attending physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information necessary to secure payment.

Signed:_____ Date:_____

OFFICE POLICIES

Tots2Teens & staff appreciate the confidence you have shown in choosing us to provide for your medical needs. Our office strives to provide quality and timely healthcare for your child as well as thousands of other children in the area. Our staff works very hard to provide flexibility in the scheduling of appointments so that they maintain availability of our healthcare providers to see your child as promptly as possible. Our office see's pediatric patients ranging from Newborn until the age of 18, once patient turns 18 they must choose a different clinic to continue the care of the patient. Your new physician can request medical records from us and we will gladly fax medical records to any physician. Please read our policies below.

Appointments & Walk-Ins:

We accept walk-ins during our business hours but please note that we will give priority to our patients that have scheduled appointments, it is the office policy to verify your insurance eligibility and benefits each time you come in. This process is time consuming and out of our control. We apologize for any inconvenience this may cause. For this reason we recommend you to have an appointment schedule with is so that we may verify your insurance the day before. We have appointments for the same day but it is recommended you call in the morning. Once again we do accept walk-ins during our regular business hours but there will be a waiting time.

Medical Records/ Paperwork to be filled out:

Please note that because of our busy schedule we may not be able to fill out paper work or print your medical records immediately. Dr. Willis Starnes office will make they're best efforts to have them ready within 15 business days after your request has been received. Please note that there is a fee for any lost immunization card of $25 and for Medical Records is subjected to a fee of $25.00 for the first 25 pages, and $0.50 for each page thereafter, along with the reasonable fee for the actual cost of mailing, shipping, or delivery. Other separate additional fees may be applied for different paper work, if additional information is needed please see our medical records policy.

Please keep in mind that order such as Title 19, personal care services, and/or any forms that are required to be filled out or need physician signature, will not be signed unless the patient has been seen in our office in the last 3 months and the patient must be up-to-date with their Texas Health Steps Physical.

I have reviewed and understand the office policy provided to me Tots2Teens

Parent Signature:_____ **Date:**_____

Physician Assistant/Nurse Practitioners Consent for Treatment

The facility has on staff a Physician Assistant/ Nurse Practitioner to assist in the delivery of medical care. A Physician Assistant/ Nurse Practitioner is not a doctor. A Physician Assistant/ Nurse Practitioners is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a Physician Assistant/ Nurse Practitioners can diagnose, treat, and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does not require the constant physician presence of the supervising physician, but rather overseeing the activities of accepting responsibility of the medical service provided.

A Physician Assistant/ Nurse Practitioners may provide such medical services that are within her education, training, and experience. These may include:

- Obtaining histories and performing physician's exams.
- Ordering and/or performing diagnostic and therapeutic procedures.
- Formulating a working diagnosis.
- Developing and implementing a treatment plan.
- Monitoring the effectiveness of therapeutic interventions.
- Offering counseling and education.
- Supplying sample medications and writing prescriptions (where allowed by law).
- Making appropriate Referrals.

By signing below you indicate that you have read above and give consent to the services of a Physician Assistant/ Nurse Practitioner for your health care needs. That you understand that at any time you can refuse to see the Physician Assistant/ Nurse Practitioners and request to see a physician. And that you agree to all the condition and terms within all the 5 previous consent forms listed above.

Parent Signature:_____ **Date:**_____

OFFICE POLICIES

HIPAA ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, Tots2Teens may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Willis L Starnes Notice of Privacy Practices for a more complete description of such uses and disclosure. The practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996. I have the right to review of the Notice of Privacy Practices prior to signing the consent. Wills L Starnes reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Willis L Starnes. With my consent, Willis L Starnes may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results and others. With my consent, Willis L Starnes may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointments reminder cards and patient statements. I may revoke my consent in writing except in the manner that the clinic has already given information before I have given information before I have revoked this consent. If I do not sign this consent, the clinic may deny treatment to my child (ren).

This consent is given freely with the understanding that:

1. All records, whether written, oral or in electronic format, are confidential and may not be disclosed for reasons other than treatment, payment or health care operations without my prior written authorization, except as provided by law. Contrary.
2. A photocopy or fax of this consent is as valid as this original.
3. Tots2Teens is authorized to release the patient's medical information to the insurance companies, to the physicians who refer to him to request the orders of the doctors, to the authorization for the service to obtain a reimbursement for the services. The information can be sent by first class mail or fax with established procedures to limit the possibility of unauthorized access. The date of dispatch will be documented by the staff of the responsible office.
4. I have the right to request that the use of my protected health information be restricted, used or disclosed for the purposes of treatment, payment or health care operations. I also understand that Tots2Teens and I must; and I agree to terminate any written restriction on the use and disclosure of my protected health information that was previously agreed upon.

Parent Signature:_____ **Date:**_____

OFFICE OF INSPECTOR GENERAL (OIG) NOTICE TO PATIENTS

If our office has a contract with your insurance company, we are required by law to collect all co-payments, deductibles, and coinsurance. Our office will NOT waive your copayment, deductible, and / or co-insurance as this will violate our contract with your insurance company. Our office will not reimburse you for any payment once you have been seen by our provider, unless your insurance specifies otherwise, for this reason it is important that you inform our receptionist in the main office to avoid any misunderstanding. All co-payments, deductibles, co-insurance and payments on your own account must be paid at the time of the visit before consulting the provider. Any remaining balance for patients paying on their own will be paid in the departure window. Keep in mind that our providers are NOT allowed to talk about your financial account. Please direct your questions to our billing department.

We accept the following payments: cash, debit cards, VISA, Master Card. Payment is expected in full at the time of the visit. In some cases, we may have a contract with your insurance company to regulate the way we handle your account. This contract may prevent us from offering a service time discount.

Insurance coverage is never a guarantee. If, at any given time, your insurance is canceled and / or insurance does not pay for the service provided, you will have to pay out of pocket for anything that is not covered by the insurance unless the service is covered by a contractual agreement between our provider, Tots2Teens, and your insurance company. Your insurance company determines the benefits once they receive our bills. Any statement made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company if your insurance does not cover you will be responsible for your account. It is the responsibility of the patient to determine if our clinic and our provider is in network with the patient's insurance.

An insurance benefit does not guarantee payment unless the law requires otherwise. All benefits are subject to the terms, conditions, limitations, and exclusions of the member's policy, included in the patient's actual status on the actual date of service.

Do not hesitate to ask the billing department about any financial questions you may have. Our intention is to provide you with the highest level of service and attention.

Parent Signature:_____ **Date:**_____

TVFC ELIGIBILITY

Patient Name: _____ **DOB:** _____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (circle 1st category that applies, check only ONE):

A. enrolled in Medicaid: Medicaid Number _____ Eligibility Date: _____
B. does not have health insurance.
C. is an American Indian.
D. is an Alaskan Native
E. is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).
   CHIP Number: _____Eligibility Date: _____
F. is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2)insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only) ; or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.
G. Has private insurance that covers vaccines: (Not VFC eligible)

**Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.*

Signature:_____ Date:_____

IMMTRAC

I understand that, by granting the consent, I am authorizing the release of the child's immunization information to ImmTrac Registry and my consent to release information from the Immtrac Registry at any time may be revoked by written communication to the Texas Department of State Health Services,

ImmTrac Group – MC 1946
P.O. Box 149347, Austin,
Texas 78714-9347.

Once in the registry, 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.

By signing this form, I GRANT consent for registration. I wish to INCLUDE my child's information in the above selected registry.

Signature:_____ Date:_____