Please check your preferred provider: ☐ **Dr. Katie Leonard** ☐ **Karli Butler, PNP**

PATIENT INFORMATION
(please print clearly)

Patient Full Name: _____

Date of Birth: _____/_____/_____ Sex: ☐M ☐F

Race/Ethnicity: _____

Home Phone: (_____) _____-_____

Hispanic/Latino ☐ Not Hispanic/Latino ☐

Primary Address:_____City:_____State:_____Zip:_____

Mother's Name: _____	Father's Name:_____
Mother's Cell: (_____) _____-_____	Father's Cell: (_____) _____-_____
Address:_____	Address:_____
DOB:_____	DOB:_____
Email:_____	Email:_____
Employer:_____	Employer:_____
Wright Pediatrics may contact me via: ☐Cell ☐Home ☐Text ☐Email	Wright Pediatrics may contact me via: ☐Cell ☐Home ☐Text ☐Email

Patient primarily resides with: ☐Both parents ☐Mother ☐Father ☐Legal Guardian ☐Other

Children's parents are: ☐Married ☐Divorced ☐Separated ☐Never Married ☐Widow(er) ☐Other

If parents are divorced, separated, or unmarried, please fill out this section:

Which parent has primary custody?_____

Are there any legal restrictions that would prevent the non-custodial parent's ability to consent to medical treatment of the child or from obtaining information about the child's medical treatment? Yes ☐ No ☐

If yes, please explain and provide a copy of any legal paperwork that supports any restrictions: _____

_____

**How did you hear about Wright Pediatrics? _____

EMERGENCY CONTACT INFORMATION
(other than persons listed above)

Name: _____ Phone: (_____) _____-_____ Relationship to patient: _____

PREFERRED PHARMACY INFORMATION
(This information will be kept on file and set your child's default location for electronic prescriptions)

Pharmacy Name: _____ Phone: (_____) _____-_____

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

INSURANCE INFORMATION
Insurance information is a necessary part of your child's medical record. We will do our best to direct your child's care and need for any specialist consults, lab work, and other medically necessary testing according to your managed care guidelines. However, ***it is the ultimate responsibility of the parent/policy holder to verify that all facilities and specialists that our providers refer you to are within your health plan network.***

PRIMARY INSURANCE

Policy Holder: _____

Date of Birth: _____/_____/_____

Insurance Company: _____

ID# _____

Group# _____

*****Please make our front office aware if your child has a secondary insurance policy*****

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

Parent/Legal Guardian Printed Name: _____ Relationship to Patient: _____

Signature of Parent/Legal Guardian: _____

If there are any changes regarding custody of the patient or medical restrictions, please update us within 30 days of the change being made

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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

Medication and/or Food Allergies:

_____

_____

Current Medications:

_____

_____

_____

Surgeries: *(list with month & year of procedure)*

_____

_____

_____

Hospitalizatons: *(list with month, year & diagnosis)*

_____

_____

_____

Childhood Illnesses *(check all that apply)*

- ☐ Environmental allergies
- ☐ ADHD
- ☐ Asthma
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart murmur
- ☐ Seizures/Epilepsy
- ☐ Autism
- ☐ Covid (age:___)
- ☐ Chicken Pox (age:___)
- ☐ Concussion (age:___)
- ☐ Developmental Delay (Details:_____)
- ☐ Learning disabilities (diagnosis:_____)
- ☐ Cancer (Type & age:_____)
- ☐ Other (Details:_____)

Social History: *(check all that apply)*

Attends Daycare *(if so, where?)*_____

Exposed to second hand smoke Yes ☐ No ☐

Pets at home *(if so, what type?)* _____

Prenatal History: *(check all that apply)*

Pregnancy < 9 months ☐ Serious Illness ☐

High Blood Pressure ☐ Serious Infection ☐

Gestational Diabetes ☐ Covid ☐

Growth Concerns ☐

Birth History: Adopted ☐

Place of birth: _____ Birth Weight:_____

Length at birth: _____ Gestational age in weeks:_____

Circumcised ☐ Breech ☐ C-section ☐

Jaundice ☐ Antibiotics ☐

NICU ☐ Breathing Problem ☐

Other Complications: *(explain briefly)*

_____

_____

Family History *(check all that apply)*

	Mom	Dad	Sibling	Grandparent (Specify maternal/paternal)
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐
Sudden cardiac death (>50)	☐	☐	☐	☐
Allergies_____	☐	☐	☐	☐
Heart condition_____	☐	☐	☐	☐
Mental Illness_____	☐	☐	☐	☐
Cancer_____	☐	☐	☐	☐
Other_____	☐	☐	☐	☐

Child's Family

	Name	DOB	Present Health
Mom:	_____	_____	_____
Dad:	_____	_____	_____
Sib#1:	_____	_____	_____
Sib#2:	_____	_____	_____
Sib#3:	_____	_____	_____
Sib#4:	_____	_____	_____
Sib#5:	_____	_____	_____

# of Brothers:_____ # of Sisters:_____

WRIGHT PEDIATRICS PRESCRIPTION HISTORY
& IMMTRAC IMMUNIZATON REPORTING CONSENT

Patient Name: _____ **DOB: _____/_____/_____**

I, as the parent/guardian of the above mentioned patient, grant permission, without limitation or exclusion, for Wright Pediatrics, P.A. providers and affiliates to view my child's external prescription history via eClinical Works for purposes of my child's care and treatment. I understand that my child's medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

_____ **I certify that I have read and understand the scope of my consent and that I authorize the above practice.**

_____ I do not grant permission for my child's prescription history to be viewed.

I, as the parent/guardian of the above mentioned patient, authorize Wright Pediatrics, P.A. providers and affiliates to release my child's immunization information to DSHS via eClinical Works interface and I further understand that DSHS will include this information in the state of Texas' 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.

_____**I certify that I have read and understand the scope of my consent and that I authorize the above practice.**

_____ I do not authorize Wright Pediatrics to report my child's immunizations to the ImmTrac Registry.

_____

Print Parent/Guardian Name

_____ _____

Signature of Parent/Guardian *Date*

PRIVACY INFORMATION

Wright Pediatrics' personnel must have permission from the parent/legal guardian to relay a patient's medical information over the phone. Please let us know how you, (the parent/legal guardian), would like to be contacted, list the names of who we may relay information to in the event that you are unavailable , and confirm or deny permission for us to leave laboratory/diagnostic testing results on your voicemail. If you do not give specific permission for us to speak to family members, we will assume that you do not want any information relayed to anyone else in your household.

☐ **HOME PHONE** ☐ **MOM CELL PHONE** ☐ **DAD CELL PHONE** ☐ **WORK PHONE**

Please list the name of each individual with whom we are authorized to discuss your child's medical care or test results:

_____

_____

May we leave lab results on home voicemail? ☐ **YES** **NO** ☐

May we leave lab results on cell voicemail? ☐ **YES** **NO** ☐

May we email regarding lab results? ☐ **YES** **NO** ☐

If yes, which email address should be used?

_____

Would you like to be added to our patient portal? ☐ **Yes** **No** ☐

_____ _____

Signature of Parent/Guardian *Date*

WRIGHT PEDIATRICS, P.A.
OFFICE AND FINANCIAL POLICY

Welcome and thank you for choosing Wright 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 office and 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. Please review and initial the following statements:

___**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.

___**Vaccine Policy:** We **ONLY** follow the vaccine schedule required by the CDC. The Flu, Covid and HPV vaccines are recommended but are not required. We do not currently carry the Covid vaccine. Please initial that you have read and agree to the terms of our Vaccine Policy Statement. This is made available for your review at your child's first visit to our office, at the front desk upon your request, as well as online at www.wrightpediatrics.com.

___**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.

It is the parent/guardian's responsibility to contact the insurance company and confirm that the child's doctor is "In Network" with their specific insurance plan. If our doctors are "Out of Network", the parent will be responsible for any charges not covered by their "Out of Network" benefits.

___**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 ***15 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 2-hour notice of cancellation by you. ***If an appointment is missed without at least 2-hours prior notice, you will be charged a $30.00 fee or $50.00 fee for Behavioral Health/ADHD appointments.*** 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 an agreement themselves or through the court system.

___**After Hours Calls:** Our physicians are available to answer your calls after regular office hours. **There is a $25 fee per call for this service.** However, the fee will be waived if you are advised to go to the ER, follow up in the office the next business day or your child is 3 months or younger.

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 Wright 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: _____** **Date: ____/____/____**

Name of Patient: _____ **Patient D.O.B.: ____/____/____**

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

I, _____, understand that as a part of my child's healthcare, Wright Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnosis, 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 within Wright Pediatrics' HIPAA Notice of Privacy Practices which is available for review upon my 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 Wright Pediatrics 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 Wright 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 Wright 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 a 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.

I fully understand and accept the terms of this consent.

_____ _____
Patient Name *Patient DOB*

_____ _____
Parent/Guardian Printed Name *Relationship to Patient*

_____ _____
Signature of Parent/Guardian *Date*

Katie E. Leonard, MD
Karli Butler, PNP
18924 Freeport Dr. Ste B
Montgomery, TX 77356
936-582-7337

CONSENT TO SEEK MEDICAL TREATMENT OF MINOR

In the event you are unable to bring your child in we must have this form on file for any person(s) over the age of 18 seeking medical care for your child.

I, _____, give my permission for the following person(s) to bring my children in for medical attention at Wright Pediatrics:

_____ (Print first and last name)

_____ (Print first and last name)

_____ (Print first and last name)

_____ (Print first and last name)

Please allow the person(s) listed above to bring my child(ren), listed below, in to receive treatment by the Wright Pediatrics doctors and affiliates.

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

I can be reached at: (_____)_____-_____ with any questions or concerns.

_____
Signature of Parent/Guardian

HIPAA RELEASE OF INFORMATION MEDIA RELEASE AUTHORIZATION FORM

I,_____, hereby authorize Wright Pediatrics, it's duly authorized employees or agents, to publish:

- ☐ **Photographs of my child**
- ☐ **First name of my child**
- ☐ **Occasion:_____**

that may be used in print media, on our website, blog, and/or on the social media platforms such as Facebook, Instagram, Twitter, Pinterest, Tik Tok and YouTube.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to this practice. However, this authorization may not be revoked if Wright Pediatrics, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or for coverage of services.

Name of patient:_____ Date of Birth:_____

Signature of Parent/Guardian:_____ Date:_____

Name of Parent/Guardian:_____

Katie E. Leonard, MD
Karli Butler, PNP
18924 Freeport Dr. Ste B
Montgomery, TX 77356
936-582-7337

Authorization for Disclosure of Confidential Information

Patient Full Name: _____ DOB: _____/_____/_____
Patient Full Name: _____ DOB: _____/_____/_____
Patient Full Name: _____ DOB: _____/_____/_____

I hereby authorize my child/children's medical records to be released from:

Name of Medical Practice, Physician, Clinic, or Hospital

Address: _____
City, State, Zip: _____
Ph: _____ Fax: _____

To be released to:

☐ **Wright Pediatrics, P.A.**
18924 Freeport Dr. Ste B
Montgomery, TX 77356
Phone: 936.582.7337
Fax: 936.582.7338

☐ **Name:**_____
Address: _____
City, State, Zip: _____
Phone: _____ **Fax:** _____

For the purpose of:

☐ Continuing or transfer of medical care
☐ Legal Matters
☐ Proof of Immunization
☐ Insurance Review or Underwriting

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

☐ Complete Medical Record
☐ Lab Reports Only
☐ Other: _____
☐ Immunizations Only
☐ Progress Notes Only

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

I, the parent/legal 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 the above named medical practices, physician, or facility from all liability and damage resulting from the lawful release of my protected health information.

_____ _____
Signature of Parent/Legal Guardian *Date*