117 Dilworth Plaza
Poth, TX 78147
830-484-0320

Patient Demographics

Patient Name: _____ DOB: _____ Sex: Female/Male

Address: _____City/Zip: _____

Patient lives with: Both Parents / Mother / Father / Legal Guardian

Preferred Pharmacy: _____ City: _____

Parent/Guardian Demographics

Primary Contact:

Relation to patient: Mother / Father / Legal Guardian

Name: _____ DOB: _____

Address: _____

Phone: _____ Cell/Home/Work Preferred Contact? Yes/No

Employer: _____ Work Phone: _____

Secondary Contact:

Relation to patient: Mother / Father / Legal Guardian

Name: _____ DOB: _____

Address: _____

Phone: _____ Cell/Home/Work

Employer: _____ Work Phone: _____

Is it okay for Ryan Pediatrics to send appointment reminders/updates via text to the number(s) listed above? Yes/No

Preferred Contact? _____

Insurance Information

Primary Insurance Company: _____ Policy Number:_____

Subscriber/Policy Holder: _____ DOB: _____ SSN:_____

Secondary Insurance Company: _____ Policy Number:_____

Subscriber/Policy Holder: _____ DOB: _____ SSN:_____

Assignment of Benefits/Authorization/Notice of Collection Action: I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file**. I further understand that all co-payments are due at time of service, and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs).** I further understand that it is my responsibility to obtain any necessary referrals from primary care of other providers, as applicable.

Also, please be advised our office may contact you via an automated system through phone, email, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I provide written notice to Ryan Pediatrics, PLLC of my intention to revoke this authorization. I have fully read and understand the above statement of payment policy. I hereby assign to Ryan Pediatrics, PLLC any benefits paid on my behalf. I authorize Ryan Pediatrics, PLLC to release my health information to obtain reimbursement for the provision of health care services. I understand that Ryan Pediatrics, PLLC does not accept partial payments made by insurance carriers as full payment for the services rendered, and I will be responsible for any charges not covered by insurance.

E-Prescribing: I authorize Ryan Pediatrics, PLLC to allow E-Prescribing for patient's prescription. This allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medical dispense history if this child is a patient at this office.

HIPAA: I have been provided a copy of the HIPAA policy.

Immunization Policy: I acknowledge that I received, reviewed, and agree to comply with the Ryan Pediatrics Immunization Policy. I understand I do not have to immunize my child to be seen at this practice.

Please be advised that our office submits confidential data on children and adult vaccinations to the TDHS (Texas Dept of State Health Services) per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of a patient's immunization history.

Signature Required: The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ _____ _____

Parent/Guardian/Patient (if >18yrs) (PLEASE SIGN) Parent/ Guardian/Patient (if >18yrs) (PLEASE PRINT) Date

APPOINTMENT POLICY AND FEE SCHEDULE

APPOINTMENT ARRIVAL REQUIREMENTS

Please bring your insurance card to every visit. All insurance companies require that it be validated prior to each encounter. If this is not done, your insurance may deny your claim and your visit will be considered self-pay or we may reschedule. **If your insurance plan is an HMO or Medicaid policy, please make sure Mrs. Ryan is selected as your PCP for each child.** If Mrs. Ryan is not listed as PCP for these plans, we will have to reschedule.

SCHEDULING APPPOINTMENTS

Your child's yearly well visit should be scheduled at least a month in advance to accommodate your schedule. Please remember we do need to save appointment times for sick visits and cannot book the scheduled with well visits.

If your child(ren) are on ADHD medication they will need to be seen every 3 months to send in medication refills.

CALL AHEAD IF YOU ARE LATE OR UNABLE TO MAKE YOUR APPOINTMENT TIME

If you are more than 15 minutes late for your scheduled appointment it will be considered a no-show and a charge of $25 will apply. Please contact the office 24 hours in advance to cancel appointments not to incur a no-show appointment.

APPOINTMENTS FOR ADDITIONAL CHILDREN

It is not guaranteed added on siblings can be seen at same time. We will do all that we can to accommodate you. Regular co-pays do apply to added on siblings at time of service.

REFILL REQUESTS

Please call a week in advance to request a refill. If you reach our offices after hours, please do not leave a message for a refill. We want to ensure that the request is sent promptly so there is no interruption in medication. Please call during normal business hours for refill requests or have the pharmacy fax us a request.

NO-SHOW POLICY

A no-show appointment is considered an appointment that is missed without notification or cancelled less than 24 hours before the scheduled appointment time.

1st No-Show $25

2nd No-Show $50

3rd No-Show $75 and possible termination from Ryan Pediatrics, PLLC.

FORMS

Medical Records	$25.00
FMLA Paperwork	$25.00
School/Sports/Camp/Medication/Services Authorization Forms	$25.00

Immunzation Records

Please remember to bring your immunization card to your visit if vaccinations are being performed. We are not allowed to e-mail updated immunization records due to HIPPA. We can fax immunization records to your child(ren)'s school if provided with the fax number. You may pick up immunization records in office or have it mailed to you for $2.50

Voice Mails

For appointment requests and other non-urgent matters, you may leave a message or call the office during regular hours. If urgent, please call the after-hour number (provided on first visit or on business card).

Signature Required: The undersigned acknowledges that I have read and understand the above terms and conditions.

_____	_____	_____
Parent/Guardian/Patient (if >18yrs) (PLEASE SIGN)	Parent/ Guardian/Patient (if >18yrs) (PLEASE PRINT)	Date

Medical Consent for Minor

I am the parent/legal guardian of: _____ DOB: _____

I authorize the following persons listed to seek medical care for the above listed child (in the event I am unable to be present at an appointment):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

This authorization allows for the above-named person to consent to all medical care at Ryan Pediatrics, PLLC. This authorization will remain in force until revoked in writing. I hereby attest that I have legal authority to delegate consent of care and no legal agreement prevents me from delegating authority.

Signature Required: The undersigned acknowledges that I have read and understand the above terms and conditions.

_____	_____	_____
Parent/Guardian/Patient (if >18yrs) (PLEASE SIGN)	Parent/ Guardian/Patient (if >18yrs) (PLEASE PRINT)	Date

Immunization Administration Consent Form

I give consent administration of any required/recommended immunizations listed below by Ryan Pediatrics, PLLC. I know the benefits and risks associated with all vaccines. I release Ryan Pediatrics, PLLC, including the provider and any employees, from any liability that may occur from vaccines. I understand that at the time of immunization I will be given the vaccine information sheet (VIS). By signing this I agree to read over the VIS entirely. If I have any questions, I will ask Mrs. Ryan before administration of the vaccine is given.

Vaccinations provided at Ryan Pediatrics, PLLC:

Hepatitis A	DTap (Diphtheria, Tetanus, Pertussis)
Hepatitis B	Tdap (Tetanus, Diptheria, Pertussis)
HIB (Haemophilus Influenza Type B)	Td (Teatnus, Diptheria)
RV (Rotavirus)	MCV4 (Meningococcal Disease)
MMR (Measles, Mumps, Rubella)	Varicella (Chicken Pox)
IPV (Polio)	Influenza (Flu)
PCV (Pneumococcal Diseases)	HPV (Human Papillomavirus)

Child's Name: _____ **DOB:** _____

Signature Required: The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ _____ _____

Parent/Guardian/Patient (if >18yrs) (PLEASE SIGN) Parent/ Guardian/Patient (if >18yrs) (PLEASE PRINT) Date

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

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization 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, and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ Signature _____ Date _____

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)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

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