McKinney Pediatrics

1872 N. Lake Forest Dr., McKinney, Texas 75071, T: 972.548.0758, F: 972.548.0425

PATIENT INFORMATION

Patient's Name: _____ Male ☐ Female ☐

First *Middle* *Last*

Date of Birth: ____ ____ ____ Preferred Phone: _____

Month *Day* *Year* *(to be used for appointment reminders, etc.)*

Patient's Address: _____

Number *Street* *Apartment#*

_____

City *State* *Zip Code*

Name of Siblings: _____

Billing Address: _____ Billing Name: _____

(If bills should be sent to an address different from the patient's)

RESPONSIBLE PARTY CONTACT INFORMATION:

Mother: Patient lives with mother: _____

Name: _____ Date of Birth: _____

E-mail address: _____

Cell Phone: _____ Work Phone: _____

Father: Patient lives with father: _____

Name: _____ Date of Birth: _____

E-mail address: _____

Cell Phone: _____ Work Phone: _____

How did you find us? Friend _____ Driving by _____ Insurance _____ Advertisement _____ Other _____

Signature below indicates financial responsibility for all charges incurred on this account for any portion of your account not paid in full. This is a legally binding agreement for financial responsibility for collection fees, late charges, and any legal fees for nonpayment of the account. This is also a legally binding agreement for McKinney Pediatrics, P.A. to treat and care for your child, unless otherwise noted. Please note that payment is due at time of service unless prior arrangements have been made and agreed to.

THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR THE BILL.

Responsible Party Signature: _____

Responsible Party Printed: _____ Date: _____

INSURANCE INFORMATION

McKinney Pediatrics

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

POLICY EFFECTIVE DATE: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? YES ☐ NO ☐

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT:_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

POLICY EFFECTIVE DATE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT:_____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

McKinney Pediatrics

Date: _____

NEWBORN Health History

Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle it and we will be happy to discuss it with you. All information is confidential.

Child's Name: _____ Date of Birth: _____ Male ____ Female _____

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Place of birth: _____

Birth Weight: _____ Length: _____

Delivery (Please circle all that apply):

On Time Premature Late Normal Induced Prolonged Breech C-section

Please describe any other complications (if any): _____

Did your child have: Breathing problems Jaundice Transfusion

During pregnancy did the mother experience any of the following: (Please check all that apply)

	Alcohol Use		Anemia		Diabetes
	Edema/Swelling		High blood pressure		Hepatitis
	German Measles		Protein in urine		Venereal disease
	Fever		Urinary tract infection		Exposure to chemicals/radiation
	Tobacco use		Non-prescription drug use		Prescription drug use
	Controlled substance drug use		Other:		

Please circle any condition that any of the child's blood relatives have had and indicate the relationship to child:

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Alcoholism		HIV/AIDS	
Anemia		Kidney Disease	
Asthma/Allergies		Lung Disease	
Autism		Mental Disease/disorder	
Birth Defects		Muscular disorder	
Bone/Joint disorders		Rheumatic fever	
Cancer		Seizures/Convulsions	
Diabetes		Sickle cell disease	
Epilepsy		Skin disease	
Genetic Defects		Stroke	
Heart Disease		Thyroid disorder	
Hemophilia			
High Blood Pressure		Other:	

Signature: _____ Relationship to patient: _____

McKinney Pediatrics

1872 N. Lake Forest Drive, McKinney, Texas 75071 T: 972.548.0758 F: 972.548.0425

HIPAA Acknowledgement

I hereby authorize the release or use of my/my child's individually identifiable health information (protected health information or PHI) and medical information by McKinney Pediatrics in order to carry out treatment, payment, or health care operations.

I understand that I have the right to review the practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and I recognize that I have the right to review such Notice prior to signing this Consent Form.

I further understand that the Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. I understand that if they do make changes to the terms of their Notice of Privacy Practices, I may obtain a copy of the revised notice in writing or requesting a copy from the front desk staff.

I retain the right to request that the Practice further restrict how my/my child's protected health information is released or used to carry out treatment, payment, or heath care operations. I understand the Practice is not required to agree to such requested restrictions; however, if the Practice does agree to my requested restriction(s), I'm aware that such restrictions are then binding on the Practice.

Patient Name: _____ Date of Birth: _____
(Please Print Name)

Signed: _____ Date: _____
(Parent/Legal Guardian)

McKinney Pediatrics

1872 N. Lake Forest Dr., McKinney, Texas 75071 *T: 972.548.0758 * F: 972.548.0425

Advance Practice Nurse Consent for Treatment

McKinney Pediatrics, P.A. has on staff an Advance Practice Nurse to assist in the delivery of Pediatric care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my child's health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Patient's Name:_____Date of Birth:_____

Parent's Signature:_____Date: _____

McKinney Pediatrics

1872 N. Lake Forest Dr. McKinney, Texas 75071 T: 972.548.0758 F: 972.548.0425

Permission for Medical Care & Release of Information

I, _____hereby authorize the physicians and staff of McKinney Pediatrics, PA to give the following people information about my child's health and well-being. Also, in my absence, any persons listed below can accompany my child to the office for medical care.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

The following information may be given:

	People listed above	**Voicemail**
Appointment Time	Yes or No	Yes or No
Test/Lab Results	Yes or No	Yes or No
Medications	Yes or No	Yes or No
Procedures	Yes or No	Yes or No
Any info. not listed above regarding my child's health	Yes or No	Yes or No

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure. Until written notification is given, this request will remain valid.

Patient's Name: _____ Date of Birth: _____

Signed: _____ Date: _____

(Parent/Legal Guardian)

McKinney Pediatrics

1872 N. Lake Forest Dr * McKinney, Texas 75071 * T: (972) 548-0758 * F: (972) 548-0425

No-Show Policy

McKinney Pediatrics policy regarding "No-Show" is as follows:

- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment – calling us will help with our time management. Our reminder call system allows for an indication for your need to reschedule, McKinney Pediatrics will accept this notification in lieu of a phone call, if it is after business hours.

- **Late arrivals (more than 15 minutes after scheduled appointment) will be offered the next available appointment.** While we will do all that is possible to accommodate requests, the first-available appointment *may or may not* be on the same day the appointment was missed.

- **A "No-Show" will be documented in your child's record and is used to track missed appointments.** Three "No-Show" appointments within a six (6) month rolling time period (without calling at least 3 business hours prior to the appointment time) will result in dismissal from McKinney Pediatrics and notification to your insurance carrier. McKinney Pediatrics will NOT send out reminders of no-shows, the courtesy of a phone call is all we ask.

- **Remember: appointments canceled more than 3 business hours prior to when they were scheduled will *not* incur a "No-Show".**

By signing below you acknowledge notification and understanding of McKinney Pediatrics policy on No-Show appointments.

Signature_____ Date_____

ImmTrac
Texas Immunization Registry

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth ***Children under 18 years only.**

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

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 (under 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 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 ("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.

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.state.tx.us 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 ImmTrac 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 • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

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

McKinney Pediatrics

1872 N. Lake Forest Drive, McKinney, Texas 75071 T: 972.548.0758 F: 972.548.0425

Patient Portal and Use of Electronic Communications

To better serve our patients, our office has established a Patient Portal for some forms of communication. The Patient Portal is a simple way to access your child's health information online. In addition, the Patient Portal allows you to:

- View and request appointments
- View and print immunization records for school and day care
- Request prescription refills
- Retrieve test/lab results
- View and update your child's demographic information
- View billing statements and balance
- Make secure credit card payments
- Communicate with our office by sending and receiving secure messages

For routine matters that do not require immediate response, please feel free to contact us through the Patient Portal. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is approximately one business day. **Should you require urgent or immediate attention, please contact our office directly.**

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your child's medical record information confidential. Despite our best efforts, due to the nature of electronic communications, third parties may have access to messages. When communicating from work, you should be aware that some companies consider electronic communications corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your electronic communications is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to your child's provider, the staff and/or other providers would have access to this information.

Dear Patients,

Our practice is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs, but it will also improve the quality of your care and our ability to communicate with you, our patients.

As part of this program, the government requires us to record the following demographic information about you:

▶ Preferred language ▶ Race ▶ Ethnicity ▶ Date of birth ▶ Gender

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

McKinney Pediatrics

Please identify your Race from the following CDC-defined options:

- ☐ African
- ☐ African American
- ☐ Alaska Native
- ☐ American Indian
- ☐ American Indian or Alaska Native
- ☐ Arab
- ☐ Asian
- ☐ Asian Indian
- ☐ Bahamian
- ☐ Bangladeshi
- ☐ Barbadian
- ☐ Bhutanese
- ☐ Black
- ☐ Black or African American
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Dominica Islander
- ☐ Dominican
- ☐ European
- ☐ Fillipino
- ☐ Haitian
- ☐ Hmong
- ☐ Indonesian
- ☐ Iwo Jiman
- ☐ Jamaican
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Madagascar
- ☐ Malaysian
- ☐ Maldivian
- ☐ Melanesian
- ☐ Micronesian
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Nepalese
- ☐ Okinawan
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Pakistani
- ☐ Polynesian
- ☐ Singaporean
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Tobagoan
- ☐ Trinidadian
- ☐ Vietnamese
- ☐ West Indian
- ☐ White

Please identify your Ethnicity from the following CDC-defined options:

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino/Spanish
- ☐ Latin American/Latin, Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard