Carrollton Pediatrics

Patient Information / Forma De Registracion

Patient Last Name (Appellido): ______________ **First (Primer Nombre):** ______________
Address (Direccion): ____ Apt# ________
City (Cuidad): __________________ State (Estado): ________ Zip (Codigo Postal): ________
Cell number (Telefono cell.): __________________________ Age (Edad): ____________
Date of Birth (Fecha de Nacimiento): ________________________ Sex (Sexo): Male / Female
SS#:_____-_____-_____ Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and other Pacific Islander ☐ White
Ethnic group: ☐ Hispanic ☐ Non-Hispanic

Mother's / Guardian Name (Nombre de la Madre): ________________________________
Address (Direccion): ____
City (Cuidad): __________________ State (Estado): ________ Zip (Codigo Postal): ________
Date of Birth (Fecha de Nacimiento): ____________ SS# (Numero de Seguro): ____________
Cell (Cellular):(   )______________ Email: ______________________@________.com
Work(Trabajo):(   )_________ Occupation:___________ Employer(Empleador):___________
Emergency Contact (Contacto de emergencia): _______________ Phone (Telefono):__________
Primary Language(Idioma Primario):________________

Father's Name (Padre): _________________ Date of Birth (Fecha de Nacimiento):________
Address (Direccion): ____
City (Cuidad): __________________ State (Estado): ________ Zip (Codigo Postal): ________
SS# (Numero de Seguro): ______________ Home Phone (Telefono / Casa): ______________
Work (Trabajo): _____________________ Cell (Cellular): ___________________________
Occupation:__________________ Employer(Empleador):______________________________

Primary Insurance (Nombre de Aseguranza): ____________________________________
Address (Direccion): ____
Phone (Telefono): _______________________ Effective Date (Fecha de efecto): __________
Policy Number (Numero de Poliza):_____________________ Group (Grupo):______________
Name of Policy Holder (Nombre): _______________ DOB (Fecha de Nacimiento)__________

Secondary Insurance (Nombre de Aseguranza): __________________________________
Phone Number (Telefono): ______________ Name (Nombre): ______________________
DOB (Fecha de Nacimiento): ________________ SSN (Numero de Seguro) ______________
Policy # (# de Poliza)________________

Referred By:*Referrio Por:* Website Money Mailer Friend Hospital Yellow Pages Other:_____

Signature: ________________________________ Date: __________

Carrollton Pediatrics

Welcome! Please read & initial the following office policies and let us know if you have any questions.

1. ______*Payment is required at the time services are rendered* unless other arrangements have been made in advance. This includes applicable deductible amounts, co-insurance and co-payments for participating insurance companies. ***Co-payments for children are due at time of service regardless of who brings the child in.*** Please make arrangements to send payment with the person bringing your child in. You are required to pay your co-payment before your visit. We accept Visa/MC/Cash

2. ______Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, Carrollton Pediatrics will begin various collection activities including but not limited by submitting the past account to collections.

3. ______**Self Payment (Private, Cash Payment):** if you have no insurance coverage **We do not retro bill for self pay visit even though you get insurance with retroactive dates.** However, we will gladly provide you with a copy of super bills and your receipt.

4. ______ Please have your driver's license, shot record and insurance card ready at check-in. If you do not have a valid insurance card, we will hold you responsible for the full amount of the visit. We ask that you please contact our office with any address, telephone, or insurance changes.

5. ______ **Missed Appointments:** Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 10 minutes late.

6. ______**Automobile accident patients**: We **DO NOT** treat automobile accident patients. Therefore, require payment at the time of service. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

7. ______**Children of divorced parents**: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Carrollton Pediatrics.

8. ______Your insurance company may require additional information to process your claim such as accident details, coordination of benefits or student status. Your insurance company will request this information in writing. It is very important that you provide your insurance company with the information to process your claims. You are allowed 10 days to get this information to your insurance company. If, after 10 days, your insurance company has not received this information from you, the balance will become your responsibility and you will receive a statement from us for payment in full.

9. ______**Secondary Insurance**: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify provider in the future immediately of any additions, changes or deletions in primary or secondary insurance coverage.
   Initial/ complete as applicable.

   ______ **My child has NO secondary insurance coverage.**
   ______**My child has secondary insurance coverage as described on the attached demographic form.**

10. ______We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance it is your responsibility to contact our billing office at (972)428-7252 within 30 days of receipt of the initial statement.

Carrollton Pediatrics

11. ______Patients who have not made a payment on their account in the past 30 days will be required to pay before they are seen in the office again, except in the case of an emergency. We realize that people experience financial difficulty from time to time. Please contact our office if you are unable to pay your payment, and we will make every effort to extend reasonable arrangements to you until the account is resolved.

12. ______After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. We will send you a statement. The balance is due upon receipt of statement.

13. ______If your insurance company mistakenly sends you our payment, please forward the check immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.

14. ______**Prescription refill**: Please contact your pharmacy to put in a refill request. Please allow 3 business days for all prescription refills to be completed. If you lose a prescription or shot record there will be a $5.00 fee for a new one. Please have your Pharmacy name, number and location to send your prescription to the correct pharmacy. It is your responsibility to UPDATE us with any pharmacy changes.

15. ______There is a $5.00 charge for head start forms & $25 for FMLA forms that need to be filled out we require 48-72 business hours for completion.

16. ______ Please confirm with your primary health insurance to confirm that we are in network. In case we do not accept your insurance or we are not the PCP, the patient will be responsible for the bill. Payment will be due at the time of visit.

17. ______Medical records transferred to patients and/or guardians will be charged a $25.00 charge fee for the first 20 pages then after that each page will be $0.50

18. ______We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

19. ______ ***After Hours*** In case of an emergency call 911. For non-urgent medical advice, contact your insurance company's nurse advice line. This number can be found on the back of your insurance card. If your insurance nurse line was not able to give you reassurance or unable to reach them, if still in need to page the on-call provider, please call Carrollton Pediatrics office for after- hours instructions. Please be aware there may be a fee.

I, ________________________________, do hereby affirm that I have read and understand the above policies. I hereby assign Carrollton Pediatrics all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Carrollton Pediatrics to release medical information that may be necessary to request reimbursement from insurance companies to whom they have submitted a claim. I give permission for Carrollton Pediatrics to treat and provide services needed to the patient. I understand that I am responsible for all medical fees during my treatment with Carrollton Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_________________________________ ______________

Patient Name/Nombre del Paciente | Patient Date of Birth

_________________________________ ______________

Signature of Parent or Guardian/Firma del Padre | Date/Fecha

CARROLLTON PEDIATRICS

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I have received a copy and/ or read the "Notice of Privacy Practices." which explains how my medical information will be used and disclosed. Copy is available upon request.
Yo he leido/ recibido una copia de la "Poliza de Privado" de esta oficina, en la que explica como mi informacion medica sera usada y obtenido. Copia esta disponible si gusta.

In effort to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your child's privacy according to your wishes when it comes to your family and friends.

I would like to be contacted via: Quisiera que se comuniquen conmigo a los numeros apuntados:

Home Phone Number/Numero de casa: ______________________________

Cell Number/Numero de cellular: __________________________________

****E-Mail address/Correo electronico:** ____

@__________.com

Please circle your response to the following:

May we leave messages concerning your child's appointments with family, friends, or secretary who regularly answers your calls? **Yes No N/A**
Podriamos dejar mensajes sobre citas que tiene su hijo/a con familares, amiga/o quien usualmente contestan sus llamadas? **Si No N/A**

May we send text or leave messages on a voicemail at home/ cell phone/ or work phone regarding an appointment, referral, or test results? **Yes No N/A**
Podriamos enviar o dejar mensajes en el correo de voz de casa/cellular/ o trabajo perteneciendo a citas y resultados de examines sobre su hijo/a? **Si No N/A**

May we share your child's pertinent medical information with specialists that they may be seeing?
Yes No N/A
Podriamos dar informacion sobre su hijo/a a especialistas que esten viendo?
Si No N/A

May we release forms, prescriptions, or samples to your spouse or family members if they need to pick them up for you? **Yes No N/A**
Podriamos dar informacion sobre recetas, formas, o muestras a su esposo/a o familiars si tienen que venir a recojer lo por usted? **Si No N/A**

This office now sends your child's **prescriptions** electronically to your pharmacy; please provide us with your pharmacy name and number:
Esta oficina ahora manda las **recetas** de su hijo/a electronicamente a su farmacia; por favor de darnos la informacion de su farmacia y numero de telefono:

Name: __________________________ Phone Number: ___________________ ZipCode:________

Nombre: _________________________ Numero:__________________________ Codigo:________

____

Name of Patient/Nombre del paciente Date/Fecha

____

Signature/Firma Relationship to patient/ Relacion al paciente

CARROLLTON PEDIATRICS

4300 N JOSEY LANE SUITE 110
CARROLLTON, TX 75010
TEL: (214)483-3292 FAX: (214)483-3286

Treatment Authorization for Minors

We recognize that parents may not always be able to be present during treatment of their young child or teen. This form addresses the situation when your child is accompanied by another adult.

Reconocemos que los padres no siempre pueden estar presentes durante el tratamiento de su hijo/a pequeno o adolescente. Esta forma se refiere a la situacion en la que su hijo/a va estar acompanado de otro adulto.

I, (parent/guardian):
Yo, (padre/custodio):____

Authorize my child:
Autorizo mi hijo/a: ____

Date of Birth:
Fecha de Nacimiento: ____/____/____

May be treated and discuss my child's medical needs with the following persons:
Puede ser tratado y hablar sobre el salud de mi nino con las personas indicadas abajo:

Name: **Nombre:**	**Relation to patient:** **Relacion al paciente:**
☐ ______________________________	______________________________ (must have Picture ID at visit)
☐ ______________________________	______________________________ (must have Picture ID at visit)
☐ ______________________________	______________________________ (must have Picture ID at visit)
☐ ______________________________	______________________________ (must have Picture ID at visit)

This authorization is valid for one year unless you notify us otherwise
Esta authorizacion is valido por un ano al menos que usted nos notifique lo contrario

______________________________ ____/____/____
Parent Signature Today's Date

CARROLLTON PEDIATRICS

4300 N JOSEY LANE SUITE 110
CARROLLTON, TX 75010
TEL: (214)483-3292 FAX: (214)483-3286

I understand that Dr. Mirza at times will have a Physician Assistant/ Nurse Practitioner seeing some of his patients to perform well child exams. I give my permission for my child to have an exam performed by a Physician Assistant/ Nurse Practitioner.

Entiendo que el Dr. Mirza a veces tendra un asistente medico ver a algunos de sus pacientes para llevar a cabo los examenes. Doy Permiso para que mi hijo/a tenga un examen realizado por un medico asistente.

Signature:
Firma: ______________________________ Date:
Fecha: ____________________

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

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.***