Premier Pediatrics

Ismaela Gomez DNP, APRN, CPNP, PMHS; Amy Long DNP, CPNP; Shaylon Rettig, MD

Patient Information

Full Name: _____ DOB: _____ Age: _____ Sex: M ___F ___

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

Mother/Guardian: _____DOB: _____

Home Tele. #: _____Cell #: _____ Email: _____

Father/Guardian: _____DOB: _____

Home Tele. #: _____ Cell #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Tele. # _____

Insurance:

Insurance: _____ Name of Insured: _____ DOB: _____

Employer: _____

Policy #:_____Group #: _____ Social Security #: _____

Secondary Insurance: _____ Name of Insured: _____ DOB: _____

Employer: _____

Policy #: _____Group #: _____ Social Security #: _____

Medicaid: _____ Medicaid #: _____Self Pay: _____

Assignment and Release:

I, the undersigned certify that (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to Premier Plus Pediatrics. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the providers to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Parents/Guardian Signature Date

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Perinatal History

Date History Obtained _____

Patient Name_____DOB_____

Maternal Complications_____

Term_____ Pre-Term_____ (wks) Post –dates_____ (wks)

Weight_____ Delivery: vaginal _____ C-Section (reason) _____

Infant Complications: Breathing Problems _____ Jaundice_____ Infection_____

Seizures_____ Other_____

Development: Sat_____ (mos) Crawled_____ (mos) Walked_____ (mos)

First words (other than ma-ma, da-da) _____ (mos)

School History_____

Family History

Heart Disease _____ Diabetes _____ Bleeding Disorders _____ Hypertension_____

Seizures_____ Allergies/Asthma_____ Strokes _____ Birth Defects _____

Cystic Fibrosis _____ Elevated Cholesterol _____ Anemia/Sickle Cell Disease_____

Learning Disabilities _____ Mental/Emotional Illness_____ Other (Substance abuse, etc.)

Siblings Full Name

_____

_____

Social History

Parents: Married____ Divorced____ Separated____ Single____ Widow ____

Who lives in household? _____

Daycare: _____

Patient History

Allergies: _____

Illnesses: _____

History of Chicken Pox: _____

Hospitalization/Surgeries/Serious Injuries: _____

Current Medications: _____

Premier Plus Pediatrics, PLLC | 932 S. State Highway 123 Bypass, Seguin, TX 78155
Tel: 830-491-5019 | **Fax:** 830-491-5109 | **Email:** Info@PremierPlusPediatrics.com

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Consent form

Due to any circumstances in the absence of the parent(s) I, (parent name) _____

_____give my permission for the following person(s) to authorize medical,

attention/decisions for my child/children (child name) _____.

1. Name_____Relationship_____Phone#_____
2. Name _____Relationship_____Phone#_____
3. Name _____Relationship_____Phone#_____
4. Name _____Relationship_____Phone#_____

Patient/Guardian Signature: _____ Date: _____

My signature below signifies that Premier Plus Pediatrics Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of the Premier Plus Pediatrics. The Notice of Privacy Practices for Premier Plus Pediatrics is also provided at the front desk. This Notice of Privacy Practices also describes my rights and Premier Plus Pediatrics duties with respect to my protected health information.

I consent to use Telehealth when appropriate ___ yes ___ No

Patient/Guardian Signature: _____ Date: _____

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Patient Orientation and Financial Policy

Patient Name: _____ **DOB:** _____

Appointments:

- Appointments will be made according to the type of appointment needed.
- If you are more than 15 minutes late for your appointment, you may be asked to see another provider or reschedule.
- If you are unable to keep your appointment, we ask that you kindly call the office 24 hours in advance to cancel.
- Any scheduled appointment that results in a missed appointment will incur a $25.00 missed appointment fee. A missed appointment is any appointment that is missed or not cancelled within 24 hours.
- We cannot see a minor patent without a parent or other responsible adult present.
- When your child turns 18 years of age, they are considered an adult and as such we cannot release any information without their written consent.

Insurance/Fees:

- Co-pays at the time of visit, deductible amounts can be set up as payment plans, and any balances from previous visits are due at the time of service.
- Please verify preventive care benefits with your insurance company including limitation, exclusions, and vaccine coverage.
- During your wellness visit if another problem or diagnosis is discovered, discussed, and treated there may be an additional charge.
- Uninsured patients please see the Self-Pay section below.
- Present your card at each visit and update your personal information (address, phone number, etc.) as soon as there is a change.

E-Prescribing:

- I authorize Premier Plus Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as this child is a patient at this office.

Emergencies/Urgent:

- You will be seen in our office by a provider that is available or clinical staff member.
- You will be seen within 24-48 hours of calling with conditions such as high fever, animal bite, severe pain, etc.
- The provider feels the hospital ER is more appropriate, i.e., severe trauma, severe bleeding, seizures, chest pains, shortness of breath etc.

After-Hours:

- We have a provider on call, 24 hours a day, to provide emergency and urgent medical needs. Please call office at 830-491-5019 and follow instructions given.

Self-pay Patients

Estimated charges for your visit with one of our providers will be determined at the time of checkout. You will be offered a self-pay discount if paid in full at check out. If there are any additional charges based on your type of visit you will be sent a statement for additional payment. If you have any questions, please call our office, and ask to speak with the billing department.

Parent/Guardian Signature: _____ **Date:** _____

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Authorization for Release of Records

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

I authorize the release of medical information as indicated below:

FROM:

Name_____

Address_____

_____

Phone_____

TO:

Name Premier Plus Pediatrics

Address 932 S State Hwy 123, bypass

Seguin, TX 78155

Phone 830-491-5019/ Fax: 830-491-5109

___I would like to pick up my records ___I would like my records mailed to address above

What to release: Please choose the records you would like to release-

__All Medical Records __Immunization Records __Laboratory Reports

__Other-Specify_____

The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDs, including HIV test __ Yes __No/NA

The diagnosis or treatment of drug and/or alcohol abuse __Yes __ No/NA

The treatment and/or consultation for mental health __ Yes __ No/NA

Purpose of release: Please check the reason for this release

__Continue patient care __ Moving __Switching doctor's __Personal use

__Use in law suit __ Follow-up related to an injury __Other-specify _____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

__Please change the expiration date to last for _____ days

I understand this authorization can be revoked at any time to Premier Plus Pediatrics privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of the release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Premier Plus Pediatric and may potentially be re-disclosed by the party who received these records. Premier Plus Pediatrics, its employees and officers, and attending physicians are released for legal responsibility or liability for the above information to extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use of the protected health information under the above stated terms.

Signature of parent/legal guardian_____**Date**_____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

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

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone _____ - _____ - _____

Child's Address _____ Apartment # _____ Email address _____

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 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 ImmTrac2. 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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and affirm that consent has been granted.
DO NOT fax to ImmTrac2. Retain this form in your client's record.

Stock No. C-7

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