Patient Information

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:_______________________________________ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

How did you find out about Pediatric Associates of Wylie, P.A.? ____

Primary Guarantor Information & Insurance

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:_______________________________________ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: _________________________________

Employment Status:____________________ Employer: ____

Phone: _______________________ Work: _________________________ Mobile: _________________________________

Email: ____

Insurance Company:____

Insurance Company Address:____________________________________ City: _____________ State: _____ Zip: ________

Subscribers I.D. #: ____ Group #: _______________________________

Insurance Company Phone Number: ___________________________________

(Please provide your ID card with this information)

Parent / Guardian Information

Parent / Guardian #1: (If different than Guarantor Information)

Relationship to Patient: _________________________________

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:_______________________________________ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: _________________________________

Employment Status:____________________ Employer: ____

Phone: _______________________ Work: _________________________ Mobile: _________________________________

Email: ____

Parent / Guardian #2: (If different than Guarantor Information)

Relationship to Patient: _________________________________

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:_______________________________________ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: _________________________________

Employment Status:____________________ Employer: ____

Phone: _______________________ Work: _________________________ Mobile: _________________________________

Email: ____

Emergency Contact

Name: _________________________Middle:_________________Last:_____________________________Suffix:__________

Address:____ City:_________________ State:__________ Zip:______________

Is above Emergency contact a Parent / Guardian? Yes / No Sex: M / F

Phone: _______________________ Work: _________________________ Mobile: _________________________________

Email: ____

Assignment and Release

I hereby authorize payment directly to Dr. Nicole L. Lanman, Pediatric Associates of Wylie, P.A. of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: ____ Date: _____________________

Date: ___________

Initial Patient History

Patient name: ______________________________ Patient D.O.B. ___________
Male ______ Female _______
Parents/Guardians name: ____
With whom does the patient live? ____

Name of Sibling	**Age**

Birth History

Pregnancy complications, if any: ____
Did mother smoke, use drugs, or alcohol? Yes No
Birth Weight __________ Length at Birth ___________ Term Preterm ________
Vaginal delivery C-section Delivery Complications, if any: __________________
Problems with baby after birth, if any: ____
____

Family History

Allergies/Asthma		Ear infections/tubes	
Eczema		Seizure disorder	
High Cholesterol		Learning/attention problems	
High Blood Pressure		Depression/Anxiety	
Heart disease/ Stroke		Drug/Alcohol abuse	
Cancer		Mental Retardation	
Anemia/ Bleeding disorder		Hearing loss/ deafness	
Diabetes		Vision loss	
Thyroid problems		Kidney disorder	
Gastrointestinal disorder		HIV/Hepatitis/ Tuberculosis	

(See Reverse Side)

Past Medical History

Drug allergies? No Yes (medication & reaction)_____________________________

Surgery/Reason for Hospitalization	Date

Has your child ever had chickenpox? Approximate date: _______________

Current medication	Dosage	Prescribed By

Review of Systems

Does the patient have or has ever had any of the following:

Allergies, Asthma or Respiratory Problems	
Eye, Ear, Nose or Throat Problems	
Heart Murmur or Heart Problems	
Anemia or Bleeding problems	
Abdominal Pain, Constipation, Vomiting or Diarrhea	
Bladder or Kidney Problems	
Skin Rashes or Problems (acne, eczema, etc.)	
Headaches, Seizures, ADHD	
Diabetes or Thyroid Problems	
Fever, Decreased Activity, Poor Appetite	
Behavior or Attention Problems	
Other Problems	

Pediatric Associates of Wylie P.A.

Lovejoy Pediatrics

Consent for Use and Disclosure of Protected Health Information

Our practice reserves the right to modify the privacy practices outlined in the notice:

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices (NPP). I understand and agree to the following:

Pediatric Associates of Wylie, P.A. may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations as described in our Notice of Privacy Practices (NPP).

Pediatric Associates of Wylie, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

Pediatric Associates of Wylie, P.A. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards, and patient statements.

Pediatric Associates of Wylie, P.A. may email any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

I have the right to restrict how my child's PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that Pediatric Associates of Wylie, P.A. reserves the right to refuse requested restrictions.

This agreement will remain in effect without expiration unless I revoke my consent. I may revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent Pediatric Associates of Wylie, P.A. will continue to provide treatment to my child.

Your Name (Last, First)	Your Relationship to the Patient
	/ /
Patient Name (Last, First)	Patient Date of Birth (MM/DD/YYYY)

Signature of Patient

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

/ /

Today's Date (MM/DD/YYYY)

For Clinic Use Only:	
Date attempt was made to obtain signature (MM/DD/YYYY)	Reason signature was not obtained
Patient Name (Last, First)	Printed name of employee making attempt
Employee signature	Today's Date (MM/DD/YYYY)

Authorization for Release of Medical Information

____
Physician/Facility Name

___________________________________ ______________________ ________ ___________
Address City State Zip

_____________________________________ ____
Phone Number Fax Number

I hereby authorize the above stated physician/facility to release the following information:

- ☐ **Complete Medical Record**
- ☐ **Other, please specify:** ____
____

TO:

Pediatric Associates of Wylie, P.A.
501 Woodbridge Parkway
Wylie, TX 75098
972-442-2300 Fax: 972-442-2180

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS OR HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____________ Date:_____________

Release records regarding:

____ ________________________
Patient Name DOB: MM/DD/YYYY

___________________________________ ______________________ ____________ __________
Address City State Zip

____ ______________________________
Signature of parent / legal guardian Date

Acknowledgement of Understanding

This Authorization will expire 90 days after the date identified above. I understand that I may revoke this authorization at any time in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that the physician/facility you have requested records from has 15 days by law to send us the records.

Texas Department of State Health Services
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

Departamento Estatal de Servicios de Salud
REGISTRO DE INMUNIZACIÓN (ImmTrac)
Formulario de CONSENTIMIENTO

(Please type or print clearly.)

(Sírvase escribir claramente a maquina o con letra de molde.)

Child's Last Name / Apellido del niño(a)

Child's First Name / Nombre del niño(a)

Child's Middle Name / Segundo nombre del niño(a)

Child's Date of Birth / Fecha de nacimiento del niño(a)
***Children under 18 years only** / Solamente niños menores de 18 años*

Child's Gender / Género: ☐ **Male** / Masculino ☐ **Female** / Femenino

Mother's First name / Nombre de la madre

Mother's Maiden Name / Nombre de soltera de la madre

Child's Address / Dirección del niño(a)

Apartment # / Apartamento #

Telephone / Teléfono

City / Ciudad

State / Estado

Zip Code / Código postal

County / Municipio

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. 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.

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud. El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the 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, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

Consentimiento Para Registrar al Niño(a) y Para Poder Dar a Conocer a Entidades Autorizadas el Récord de Inmunizaciones del Niño(a)

Entiendo y acepto que al autorizar mi consentimiento en la parte inferior, registro a mi niño(a) en el registro de inmunización del Departamento Estatal de Servicios de Salud de Texas y autorizo al registro para que incluya la información de mi niño(a) en el registro y que el récord de inmunizaciones de mi niño(a) del pasado, presente y futuro sea dado a conocer a alguno de los padres del niño(a), y a cualquiera de los siguientes:

- distrito de salud pública o departamento de salud local;
- médico o proveedor de atención de salud;
- compañía de seguros, organización para el mantenimiento de salud o pagador;
- escuela o centro de cuidado de niños, en el que el niño(a) está inscrito y/o
- agencia estatal que tenga custodia legal del niño.

Reconozco y acepto que en cualquier momento puedo retirar mi consentimiento de poder incluir la información de mi niño(a) en el Registro ImmTrac, y también retirar mi consentimiento para poder dar a conocer la información del registro, por medio de comunicación escrita dirigida al Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child´s information in the Texas immunization registry.
Al firmar abajo, YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:
Alguno de los padres, tutor legal o administrador de bienes:

Printed Name / Escriba con letra de molde

Date / Fecha

Signature / Firma

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)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta.
Diríjase a **http://www.dshs.state.tx.us** para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Questions? / ¿Tiene preguntas? (800) 252-9152 · (512) 458-7284 · www.ImmTrac.com
Texas Department of State Health Services · ImmTrac Group - MC 1946 · 1100 West 49th St. · Austin, TX 78756

Stock No. C-7
Revised 05/25/05

***PROVIDERS REGISTERED WITH ImmTrac** – please fax this **signed** (by parent) Consent Form to ImmTrac **only if the child is not** currently registered with ImmTrac.*
*Fax to: **(512) 458-7290 (Austin)** or toll free **(866) 624-0180.***

Office Policies

Welcome to Pediatric Associates of Wylie! Here are a few of our "rules" that we would like for you to be aware of to facilitate a good relationship between you and your pediatrician:

Office Hours: Our office hours are 8:30 a.m. to 5:00 p.m. Monday through Thursday and 8:30 a.m. to 4:00 p.m. on Fridays.

Appointments: Patients are seen **by appointment only**. Each child needing examination by the doctor should have an individual appointment.

In general, well examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. In addition, well examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the well examination, but can see your child for his/her illness during the scheduled appointment. This also applies to other conditions that require a significant amount of time for the physician to effectively manage the condition (i.e., asthma, ADHD).

We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep the appointment.

Absences from school will only be excused by our office if your child has been seen in the office for the illness.

Walk Ins and Late Arrivals: Rescheduling will be necessary if you are more than 10 minutes late for your appointment. We will try to work you in if time allows. There will be a $25 fee for missed appointments. We will send one warning letter after the initial missed appointment before assessing any fees. In addition, any cancellation or reschedule for well visits made within 24 hours or less of the scheduled appointment will be charged a $25 fee. A warning letter will be sent prior to assessing any fee.

Fees, Insurance and Health Plans: A Parent/Guardian must notify the office of changes in address, telephone number or insurance. You must bring your insurance cards to every visit. The person who brings the child to the office will be expected to pay at the time of service.

You will be responsible for payment of charges from services rendered if we are unable to verify benefits with your insurance company. Insurance companies require collection of your co-pay or contracted percentage of services at **every** visit. If you have a deductible that has not yet been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always question your insurance company regarding your benefits first if you have any questions about covered services or bills.

Balances are due at time of appointment. Financial arrangements will be required for balances greater than 60 days outstanding and prior to appointment.

We accept cash, checks, Visa, MasterCard, American Express and Discover.

There is a $25 fee for returned checks.

Medical Records: Medical records can be faxed to another physician's office free of charge upon release of the medical record. Patient copies of the medical record can be obtained for a fee. Copies of the medical record will be provided within 2 business days with a prepayment.

Medication Refills: Patients on medication for ADHD will be seen for medication check-ups every 3 months. Refills for ADHD medications will be provided only if these appointments are kept. Parents/Guardians may call the nurse to request a refill for ADHD medications. These prescriptions will be available for pick-up 48 hrs after the request has been made during our regular business hours. Controlled substance medications (ADHD medications) must be picked up by a parent/guardian and filled within 21days of the date the prescription was written. In the event, the prescription is not picked up and filled, a $15.00 charge will be applied for rewrites.

Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies), as long as the patient is established and has been seen for the condition within the past 6 months. Refills will not be provided after hours or on the weekends. Please allow 48 hrs for these refills to be completed.

Any prescription refills needed prior to our office policy of 48 hours, will be assessed a $15 fee.

Telephone Calls: Our nurses/medical assistants are always available during business hours to serve your needs. You can ask to leave a message with any questions that you may have. All messages received prior to 3:00 p.m. will be returned on that business day; however, depending on the daily schedule, these calls may not be returned until the end of the day, and they will be returned in order of urgency. Calls received after 3:00 p.m. will be returned the next business day. If you feel your child needs to be seen you should speak with someone in the front office to schedule an appointment, as the schedule fills quickly.

In general, antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen.

In case of an emergency, call 911 or take your child to the nearest hospital emergency room.

After Hours Services: After-hours contact with the nurse/physician is intended for urgent medical problems only. Questions about appointments, billing, referrals, refills, or other issues of a non-urgent nature should be placed during normal business hours. There is a $10 service fee for after-hour services.

Violation of office policies may result in dismissal from the practice.

By signing below you acknowledge that you have read and understand the office policies.
Signed: ____ Date: __________________
Signature of Parent/Guardian

Revised 1/1/2011