Neighborhood Pediatrics
RACHEL McCONNELL MD SHARON LUCAS MD
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P 832.813.5743 | F 832.813.8127
NEIGHBORHOODPEDIATRICS.COM

PATIENT INFORMATION INFORMATION

Patient Name: ______________________ Date of Birth: ____________ Sex: *(circle)* Male Female

Ethnicity: (circle) Hispanic Non-Hispanic Race: __________ Language Spoken at Hom ______________

Social Security #: ______________________ Address: ______________________

City: ______________ State: ________ Zip: __________ Home Phone: ______________

Father's Cell Phone #: ______________________ Mother's Cell Phone #: ______________________

Father's Name: ______________________ Email: ______________________

Employer: ______________________ Work #: ______________________

Mother's Name: ______________________ Email: ______________________

Employer: ______________________ Work #: ______________________

Emergency Contact
(Other Than Listed Above)

Name: ______________ Relationship to patient: ______________ Best Contact #______________

Pharmacy to Electronically Send Prescriptions

Pharmacy Name: ______________________Phone #: ______________________

Address: ______________________ City:__________ State:________ Zip:________

Insurance Information

Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults, lab work and other tests according to your managed care guidelines. However, our office deals with many different plans and ***it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.*** *Please verify their participation* ***BEFORE*** *services are rendered to receive network benefits from your insurance company.*

Primary Insurance	Secondary Insurance
Policy Holder: ______________	**Policy Holder:** ______________
DOB: __________**SS#:** __________	**DOB:** __________**SS#:** __________
Relationship to Patient: __________	Relationship to Patient: __________
Insurance Company: __________	_ Insurance Company: __________
Address: __________	_ Address: __________
Phone #: ________ Effective Date: ________	Phone #: ________ Effective Date: ________
ID #: ________ Group #: ________	ID #: ________ Group #: ________

****How did you hear about Neighborhood Pediatrics? ______________________**

By signing below, I hereby authorize Neighborhood Pediatrics to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your child's care. I have read and understand the Neighborhood Pediatrics Financial Policy.

Parent/Guardian Printed Name: ______________________ **Signature:** X______________

Relationship to Patient: ______________________ **Date:** ______________

FINANCIAL POLICY

Welcome and thank you for choosing Neighborhood Pediatrics for the medical needs of your child. We are dedicated to providing the best possible care for your child, and we want you to completely understand our financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible.

Appointments: Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

Self-pay Accounts: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

Co-pays: The patient is expected to present an insurance card at each visit. All co-payments and past-due balances are due and payable at the time of service.

Insurance: If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is basically a contract between you and your insurance company. Not all insurance plans cover all services.

In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges.

Payment is due upon receipt of a statement from our office within 30 days.

Referrals: It is the responsibility of the patient to know their insurance plan's procedures for referrals. If your plan requires a referral, it will be necessary for you to inform us of that prior to you scheduling an appointment with a specialist. We kindly ask that you notify our office 5 (five) business days prior to non-urgent referral visits.

Late Arrival: As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are ***more than 15 minutes late***, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

No-Shows or Missed Appointments: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. ***If an appointment is missed without 24-hours prior notice, you may be charged a $25.00 fee.*** This includes appointments made on the same day or on the day prior. This fee is not payable by your insurance company and will be your responsibility.

Child Custody/Divorce Cases: This office will not bill a divorced spouse for the patient's service. It will be the responsibility of the parent or guardian that brings the child in for all co-pays, deductibles or balances. It is the parents' obligation to work out agreement themselves or through the court system.

Late Fee Charge: The office reserves the right to charge a 1.5% late fee on all unpaid balances that are 60+ days overdue. This will accumulate on balances only until paid in full.

I have read, understand and agree to the above Neighborhood Pediatrics Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.

Parent/Guardian Printed Name: _________ ____________________ **Signature:** X____________________________

Date: __________________ **Name of Patient:** ________________________________ **Patient d.o.b.:** ______________

rev 6/11

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, ___________________________________, understand that as part of my child's healthcare, Neighborhood Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. I understand that this information serves as:

- ☐ A basis for planning my child's care and treatment
- ☐ A means of communication among the many health professionals who contribute to their care
- ☐ A source of information for applying my diagnosis and/or surgical information to my bill
- ☐ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Neighborhood Pediatrics' *Notice of Information Practices* which is available for review upon request. I understand that I have the following rights and privileges:

- ☐ The right to review the notice prior to signing this consent
- ☐ The right to object to the use of my health information for directory purposes
- ☐ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Neighborhood Pediatrics, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Neighborhood Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Neighborhood Pediatrics change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent. **Signature:** X______ _______________________

Printed Name: ___________________________________**Relationship to patient:** *(circle one)* ***Father Mother Guardian***

Date: ________________ **Name of Patient:** __________________________________**Patient d.o.b.:** ________________

PEDIATRIC HISTORY

Patient's Name ____________________________ **Date of Birth** _________________ **Allergies to Meds** ________________

Pregnancy Complications

(check Yes or No)	Yes	No
Pregnancy less than 9 months	____	____
High blood pressure	____	____
Gestational diabetes	____	____
Medications *(if yes, list)*	____	____

____

____

(check Yes or No)	Yes	No
Bleeding *(if yes, which month)*	____	____
Serious illnesses	____	____
Serious infections	____	____
Previous miscarriages	____	____
C-section *(if yes, why?)*	____	____

____

Birth History

Place of birth: ______________________

Birth weight: ____________ **Length** ________

Length of labor: ______________________

Adopted: No ___ Yes ___

Birth Problems

(check Yes or No)	Yes	No
Jaundice	____	____
Breathing problems	____	____
Antibiotics	____	____

Other problems *(explain)* ______________________

____

Breastfed: ____________ **Formula fed** ______________

Developmental History

At what AGE did your child…

School Problems? Yes ____ No ____

Smile: ____________________ **Roll over:** ____________________ **Sit alone:**

Walk alone: ________________ **1st word with meaning:** ________________ **Use 3 word sentence:**

Bladder trained: __________ **Bowel trained:** __________ **Ride tricycle:** __________ **Tie shoes:** __________

Medications Child Takes Routinely:

____

____

____

Hospitalizations & Operations:

1 ______________________________ Date __________

2 ______________________________ Date __________

3 ______________________________ Date __________

Childhood Illnesses

(check Yes or No)	Yes	No	Date
Allergies	____	____	____
Asthma	____	____	____
Bed wetting	____	____	____
Chickenpox	____	____	____
Convulsions/epilepsy	____	____	____
Diabetes	____	____	____
Kidney disease	____	____	____
Measles	____	____	____
Meningitis	____	____	____
Mumps	____	____	____
Pneumonia	____	____	____
Rheumatic fever	____	____	____
Scarlet fever	____	____	____
Sickle cell trait or disease	____	____	____
Whooping cough	____	____	____

Other Serious Illnesses	Date(s)
1.	
2.	
3.	
4.	
5.	

PEDIATRIC HISTORY (Continued)

Patient's Name ________________________ **Date of Birth** ____________________ **Today's Date** __________________

Child's Family

	full name	Age	Present Health or cause of death
Mother:			
Father:			

	full name	circle	DOB	
Sib #1:		*M F*		
Sib #2:		*M F*		
Sib #3:		*M F*		
Sib #4:		*M F*		
Sib #5:		*M F*		
Sib #6:		*M F*		
Sib #7:		*M F*		

Social History

(Check "No" or "Yes")	No	Yes	No./day
This teen patient smokes?			
This teen patient drinks?			
Household with smokers?			
Pets? *(If "Yes", please list…)*			

____

Family History

*(Check **if disease is present**)*	Mother's Side	Father's Side
Diabetes		
Heart trouble		
Heart attack		
Stroke		
Cancer		
Tuberculosis		
Ulcer		
Arthritis		
Obesity		
Suicide		
Mental Illness		
Thyroid problems		
Sickle cell		
Seizures/epilepsy		
Bedwetting		
Allergies		
Hay fever		
Asthma		
Other: ______________		
Other: ______________		

Notes:

____

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____

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____

Neighborhood Pediatrics
RACHEL McCONNELL MD SHARON LUCAS MD
19221 I-45 SOUTH, SUITE 430, SHENANDOAH, TEXAS 77385
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NEIGHBORHOODPEDIATRICS.COM

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: ____Date of Birth: ____________________

Child's First & Last Name: ____Date of Birth: ____________________

Child's First & Last Name: ____Date of Birth: ____________________

Child's First & Last Name: ____Date of Birth: ____________________

I do hereby authorize my child's medical records from:

Name of Medical Practice, Physician, Clinic or Hospital

Address ____

City, State, Zip

Phone Number __________________________ Fax ________________________

…to be released to:

Neighborhood Pediatrics, PLLC
19221 I-45S Suite 430
Shenandoah, Texas 77385

832-813-5743 (Office) 832-813-8127 (Fax)

…for the purpose of: ☐ ***continuing or transfer of medical care*** ☐ ***proof of immunization*** ☐ ***insurance review or underwriting*** ☐ ***legal matters***

Release information concerning the ***following dates***: from _________to _________, and to include:

☐ ***complete medical records*** in your possession to include illness(es) and/or treatments

or ☐ medical records ***limited to the following specific types of information***:

____

Also, I ☐**DO** or ☐**DO NOT** (*check one & initial* ________) consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing

I, the parent/guardian, agree that ***a photocopy or facsimile (fax) of this authorization may be considered valid***, this authorization shall be ***valid for 120 days from the date of signature***, and that ***this authorization can be revoked in writing at any time prior to the expiration date***.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless Neighborhood Pediatrics, PA from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Printed Name ___________________________**Signature:** X ___________________________

Relationship to Patient *(circle one)* **:** ***self mother father guardian*** **Date:** ____________________

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
***IMMUNIZATION REGISTRY (ImmTrac)* 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**

__ / __ / ____ ***Children under 18 years only.*** **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Date of Birth

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)

Questions? (800) 252-9152 (512) 458-7284 www.ImmTrac.com
Texas Department of State Health Services **ImmTrac Group – MC 1946** **P.O. Box 149347** **Austin, TX 78714-9347**

Stock No. C-7
Revised 07/22/08

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.