Texas Children's® Pediatrics

Date Completed
Primary Care Provider

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	Preferred Name
Other Children in family:			
Child's Street Address (City, State, Zip Code)	Telephone#where child lives	Parent's Work # ☐Mom ☐Dad	Parent's Email Address: ☐ Mom ☐ Dad

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian and other Pacific Islander ☐ White

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Patient's Primary Language: English ____ Spanish ____ Other _____

Parent's/Legal Guardian's Primary Language: English ____ Spanish ____ Other _____

Does the parent/legal guardian require an interpreter? Yes ☐ No

If there is insurance for child/children, please present the insurance card to the check-in staff.

Emergency Contacts

Mother's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Father's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			

Who may we thank for referring you to our practice?	**Birth Hospital**

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #

Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer

Patient Name:_____
DOB:_____
Date:_____

Texas Children's Pediatrics

Allergies: (Include name of medication or food, reaction, and age of onset)

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight:_____ Birth Head Circumference:_____
Discharge Weight: _____ Gestational Age at Birth (weeks):_____ Delivery Method: Vaginal C-section
If C-section, why? _____

APGAR scores: 1 min ____ 5 min _____ 10 min _____ Infant Feeding: Breast Bottle Both
Formula name: _____

Hearing Screening: Pass Fail Re-testing Heart disease screening: Pass Fail

Medical History: (Check any that have been diagnosed and comment below)

____Hospitalizations?
____Asthma
____Allergic Rhinitis
____Eczema
____Wheezing
____Food Allergies
____Murmur
____Congenital Heart Disease
____Prematurity
____GE Reflux
____Constipation
____Anemia
____Recurrent Ear infections
____Recurrent Strep
____Urinary Tract Infection (UTI)
____Vesicoureteral Reflux (VUR)
____Diabetes
____Vision problems
____Developmental Delay
____Seizures
____ADD/ADHD
____Mental Illness
____Substance Abuse

Other Medical History: _____
_____

Surgical History: _____**No Surgeries**

(Check any past surgeries and complete age/date and surgeon if known)

	Procedure	Date or Age	Surgeon
	Adenoidectomy		
	Appendectomy		
	Ear Tubes		
	Fundoplication		
	Gastrostomy Tube Placement		
	Heart Surgery		
	Hernia Repair		
	Orthopedic Surgery		
	Tonsillectomy		
	Urological Surgery		
	VP Shunt		

Other Surgical History: _____
_____

Patient Name:_____
DOB:_____
Date:_____

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Family History: (Check any known problems in the family – please complete *at least* for parents and siblings)

Relationship to CHILD		Name	Alive?	No Known Problems		ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	MentalIllness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		Y N																				
	Father		Y N																				
Siblings	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
	Bro Sis		Y N																				
Grandparents	MGM		Y N																				
	MGF		Y N																				
	PGM		Y N																				
	PGF		Y N																				

Comments (including *Other* responses): _____
_____

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather
For example: MGM = Maternal Grandmother

Additional Family History (if needed)

Relationship to CHILD	Name	Alive?	No Known Problems		ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	MentalIllness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
		Y N																				
		Y N																				
		Y N																				
		Y N																				
		Y N																				
		Y N																				

Home Environment:
Number of People at Home: _____
Lives with biological parents: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others:_____
Daycare (hours/day): _____
Time at Relatives (hours/day): _____
Pets: Yes No

Parent's Status: Married Divorced Single Other_____
Mother's Occupation: _____ Father's Occupation: _____

Texas Children's Pediatrics

General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education.

I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means: _____ (name of patient).

Electronic Medical Record

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical record system, they may have access to your medical record. If you do not want medical records shared with other providers please request and complete a Health Information Exchange Opt-out form.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

Testing in Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to the patient's blood or bodily fluids, or AIDS, pursuant to Texas law, I will be required to have blood tested to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing a small amount of blood and using substances to test the blood.

I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). I understand that if any test is positive, I will receive counseling about the meaning of these tests as it relates to the herein-named patient's healthcare.

I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain patient and physician anonymity.

I acknowledge that I have received a Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact the Privacy Office at (832) 824-2091.

Advance Directive

The patient has an Advance Directive: Yes No

If yes, check all that apply: Directive to Physicians:☐ Medical Power of Attorney: ☐ Out of Hospital DNR: ☐

Please communicate the existence of any advance directive to your health care provider and provide copies for the medical record.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Patient's Name: _____

Patient's Date of birth (MM/DD/YYYY): _____

Name of Patient's Representative, if patient under 18 (Printed):

_____

Relationship of Patient's Representative if patient under 18:

_____

Signature of Patient or Patient's Representative: _____

Date: _____

Signature of Witness/Translator: _____

Scan to: Gen Consent TCP v2016

Texas Children's MyChart

MyChart and MyChart Bedside Proxy/Release of Information Form

Completing this form allows access to portion of a patient's health record (other than yourself) via the MyChart and MyChart Bedside.

- You may request proxy access if you are:
  - the parent or legal guardian of a minor child under the age of 18, or
  - a legally appointed guardian or healthcare decision maker for a patient over the age of 18
- MyChart Bedside Proxy allows access to portions of your minor child's medical record during an inpatient admission at Texas Children's.
- I understand that Texas Children's may loan me a tablet to use for MyChart Bedside to view patient health information during an inpatient stay.

In order to obtain proxy access to the MyChart account of a Texas Children's patient, please complete **all** information below.

Parent/legal guardian information for proxy access:

Parent/guardian name: _____ Parent/guardian DOB:_____

Previous name(s), if applicable: _____ Have you been seen or treated at any Texas Children's facility? ☐

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

Home Phone: _____ Work Phone: _____

E-mail:																																

Proper ID must be provided and validated, which will be filed with this application. Please fax this form and proper ID to Health Information Management (HIM) @ 832-825-0124.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

- I understand that by signing this authorization, I am providing Texas Children's with documentation of my authorization to provide access to this patient's protected health information through MyChart and MyChart Bedside.
- I am entitled to access the patient's protected health information as his/her parent or legally appointed guardian.
- I am ***not*** a Foster Parent of the patient
- My rights to access to this patient's protected health information have not been modified in any manner by any court of law.
- The documents I have provided in support of my right to access the patient's protected health information, if any, are true and correct copies and are the most recent documents related to this matter.
- I understand that Texas Children's reserves the sole right to determine whether proxy eligibility exists and to whom it will grant Proxy Access rights.
- I understand that this authorization must be filled out completely and signed and dated in order to be considered valid, and activation of the MyChart proxy access feature must occur within 60 days from the date of this authorization.

Signature of Patient/Authorized Person | **Authorized Person's Authority to Sign** (parent, guardian, power of attorney, etc.) | **Date**

Patient information: (Patient to which proxy access is requested)

Patient Name: _____ MRN: _____

Previous Name(s), if applicable: _____ DOB: _____

Relationship to patient:

_____ Parent _____ Foster Parent _____ Legal Guardian* _____ Other** : _____

**Legal documentation is required (Examples include drivers license, passport, court order, etc.)*
***Route to HIM for processing via fax: 832-825-0124*

http://www.texaschildrens.org
Texas Children's Privacy Office
832-824-2091
privacy@texaschildrens.org

Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND BILLING INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Joint Notice of Privacy Practices applies to the privacy practices of professional staff, employees, volunteers, and Medical Staff for Texas Children's Hospital, Texas Children's Health Plan, Texas Children's Health Plan – The Center for Children and Women, Texas Children's Pediatrics, Texas Children's Urgent Care, Texas Children's Physician Services Organization, and Texas Children's Women's Specialists.

Under the Health Insurance Portability and Accountability Act ("HIPAA"), each of the Texas Children's entities named above may use and disclose your Protected Health Information ("PHI") to facilitate their own treatment, payment and operational activities relating to your care. The entities also participate in an Organized Healthcare Arrangement ("OHCA") under HIPAA, which allows them to share your PHI with and among each other in order to perform joint activities, such as utilization review, quality assessment/improvement and certain payment activities. This Joint Notice of Privacy Practices serves as the Notice of Privacy Practices for the Texas Children's OHCA and each of the Texas Children's entities individually.

Your Health Information Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Forms are available on our website, http://www.texaschildrens.org, or by contacting Texas Children's Privacy Office at (832) 824-2091.

- **A copy of this Notice.** You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Paper copies of this notice may be obtained from any registration or admissions desk. You may obtain an electronic copy of this notice on our web site, http://www.texaschildrens.org.
- **Get an electronic or paper copy of your medical record or health and claims record.** You may ask to see or get an electronic or paper copy of your medical record or health and claims records and other health information we have about you. Texas Children's may charge you a reasonable, cost-based fee for copying your information. You must make this request in writing.
- **Ask us to correct your medical record or your health and claims records.** You may ask us to correct your health information or health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days. You must make your request in writing and you must provide a reason for the request.
- **Ask us to limit what we use or share.** You may ask us not to use or share certain health information for treatment, payment, or our operations. If you personally pay in full for an item or service or someone other than your health plan pays in full for the item or service on your behalf, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" if you have already paid in full for the item or service unless a law requires us to share that information. Otherwise, we are not required to agree to your request, and we may say "no" if it would affect your care.
- **Request confidential communications.** You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Texas Children's Health Plan will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. Except for Texas Children's Health Plan, we will say "yes" to all reasonable requests. You must make this request in writing and you must tell us how or where you wish to be contacted.
- **Get a list of those with whom we've shared information.** You may ask for a list (accounting) of the times we've shared your health information, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, or health care operations, or certain other disclosures (such as any you asked us to make). We will include each disclosure we made for the past six (6) years, unless you request a shorter time period. We will provide one accounting a year for free but will charge you a reasonable, cost-based fee if you ask for another one within 12 months.

- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may complain if you feel we have violated your rights by contacting the Texas Children's Family Advocacy Office at (832) 824-1919. You may also file a complaint with the United States Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. *You will not be penalized or retaliated against in any way for filing a complaint.* We will not require you to waive your right to file a complaint as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; or
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the case of fundraising: We may use certain portions of your PHI, including your name, address, phone number, email address, age, gender, date of birth, the dates you received treatment or services at Texas Children's, department(s) of service, treating physician(s), outcome information, and health insurance status to contact you for fundraising efforts to support hospital programs and operations. You can choose not to receive these communications. If you do not want Texas Children's to contact you about a contribution or fundraising program, please contact the Development Office at optout@texaschildrens.org.

In these cases we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes, which are kept separate from the rest of your medical record; and
- Marketing purposes.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**. We may use your health information and share it with other professionals who are treating you. We may share your health information with doctors, nurses, technicians, medical students, or other members of your health care team at Texas Children's to keep them informed about your care status or condition as necessary. For example, a doctor treating you for diabetes may need to tell a dietitian that you have diabetes so appropriate meals can be arranged. We also may share your health information with people outside Texas Children's who may be involved in your medical care, such as health care providers who will provide follow-up care after hospitalization, physical therapy organizations, medical equipment suppliers, laboratories, or pharmacies (verbal or electronic). We share medical records electronically with other health care providers. If you visit another provider who uses the same electronic medical record as Texas Children's, they may have access to your medical record.
- **Payment**. We may use and share your health information to bill and get payment from your insurance company or a third party. For example, we may need to provide your health plan with information about treatment you received for an ear infection so that your health plan will pay us or reimburse you for the treatment. Also, we may share your health information with your other health care providers to assist those providers in obtaining payment from your insurance company or a third party. Texas Children's Health Plan may use and share your health information as they pay for your services.
- **Run our organization**. We may use and share your health information to run our organization, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services or improve our services. We can also share your health information in a limited data set, which excludes

some identifying information. Texas Children's Health Plan is not allowed to use genetic information to decide whether to give you coverage or to decide the price of the coverage.

- **Business Associates**. We may share your health information with our business associates for any of the purposes listed above.
- **Electronic**. We may share your information electronically.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**. We may share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting births and deaths; reporting suspected abuse, neglect, or domestic violence; reporting reactions to medications or product problems; or preventing or reducing a serious threat to anyone's health or safety. We may share portions of your health information with local, state, and/or federal registry programs as required. We may share your health information for these activities in a limited data set, which excludes some identifying information.
- **Do research**. We may use or share your information for health research. We may share your health information for these activities in a limited data set, which excludes some identifying information.
- **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to ensure we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**. We may share health information about you with organ procurement organizations.
- **Work with a medical Examiner or funeral director**. We may share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**. We may use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official or correctional institution; with health oversight agencies for activities authorized by law; or for special government functions, such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**. We may share health information about you in response to a court or administrative order, or in response to a subpoena.
- **Schools (including Child-Care Facilities, Early Childhood Programs, Primary and Secondary Schools)**. We may share your immunization records with a school with a verbal authorization sometimes.

Texas Children's Responsibilities

We are required by law to maintain the privacy and security of your oral, written, and electronic PHI. Texas Children's maintains policies and procedures intended to protect PHI maintained by Texas Children's in any form. Workforce members with access to your PHI receive privacy training which covers the how PHI can be used and disclosed and actions they must take to safeguard your information. Our computer systems protect your electronic PHI at all times. We will let you know promptly if an incident occurs that may have compromised the privacy or security of your information. We will not sell your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. An Authorization form and Revocation of Authorization form are available on our website, http://www.texaschildrens.org, or by contacting the Texas Children's Privacy Office at (832) 824-2091.

Changes to This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website at http://www.texaschildrens.org. This notice is effective April 1, 2016.

Contact

If you have any questions about this Notice or your privacy rights, or wish to obtain a form to exercise your rights as described above, you may contact Texas Children's Privacy Office at (832) 824-2091.

Texas Children's® Pediatrics

Acknowledgement of Privacy Practices

Written Acknowledgement of Receipt of Texas Children's Hospital Integrated Delivery System Notice of Privacy Practices
By signing below, you acknowledge receiving the Texas Children's Hospital Integrated Delivery System (TCH IDS) Notice of Privacy Practices (Notice). The Notice explains how TCH IDS may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

TCH IDS reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout TCH IDS and on our website at texaschildrens.org. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register or are admitted to any TCH IDS entity for treatment or healthcare services as an inpatient or outpatient, TCH IDS will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.
If you have any questions about the Notice, please contact the TCH IDS Privacy Office. Contact information is located in the Notice.

Printed Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Date _____

Thank you for choosing Texas Children's Pediatrics

Texas Children's Pediatrics

2022

FINANCIAL POLICY

WE at Texas Children's Pediatrics (TCP) are committed to providing you with the highest quality of care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

You are personally responsible for payment at the time of service for all charges that result from care provided by TCP, including any amounts not covered by your health plan. To assist us in establishing your TCP financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and TCP with any additional information requested to complete the processing of claims filed on your behalf.

UNACCOMPANIED MINORS
Minors must have an authorization for medical treatment signed by their parent/guardian. The minor is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE
TCP does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING HEALTH PLANS AND INSURANCE
For each visit to TCP, it is your responsibility to make sure TCP is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan.

If we are not contracted with your health plan, we may require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your health plan. Should your health plan require a more detailed description of services, please have them request it in writing.

Financial Assistance is available. Please speak with a Practice Representative to see if you qualify.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to obtain a referral before being seen by a specialist. If a referral is not obtained in advance, you may be held responsible for payment in full to the specialist.

If you feel you have made an overpayment to our office or are awaiting a refund based on insurance reimbursement, please contact our Billing Office at 832-824-2999.

ASSIGNMENT OF BENEFITS
You attest to the following:

In consideration of the services rendered or to be rendered by TCP, I hereby irrevocably assign, transfer and set over to TCP all right, title and interest in all benefits payable for the health care rendered by TCP to the patient(s) named below, which benefits are provided in any and all insurance policies, employee benefit plans, re-insurance/stop loss contract and/or third party actions against any other person or entity, for whom my spouse, dependents or I are entitled to recover. I also hereby irrevocably assign, transfer and set over to TCP all right, title and interest in any and all claims, administrative appeals and causes of action against all insurance companies, employee benefit plans, re-insurance/stop loss carriers, third party administrators and/or other persons or entities responsible for the payment of health insurance benefits. I authorize my insurer, plan administrator, fiduciary and/or attorney to release to TCP any and all insurance policies, plan documents, summary plan descriptions, and/or settlement information upon written request of TCP or its attorneys in order to claim such medical benefits.

I authorize payment to be made directly to TCP or my treating physician.

I understand that there may be professional fees associated with the care provided by TCP billed separately by the person or organization who provided the services. In consideration of such services, I hereby irrevocably assign, transfer and set over to such persons or organizations all right, title and interest in all benefits payable for the health care rendered by TCP to the patient(s) named below, which benefits are provided in any and all insurance policies, employee benefit plans, re-insurance/stop loss contract and/or third party actions against any other person or entity, for whom my spouse, dependents or I are entitled to recovered.

RELEASE OF INFORMATION
You attest to the following:

I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. This consent to release and obtain information is valid until revoked and I may revoke this consent in writing at any time, except with regard to disclosures already made.

- As the patient or responsible party, I hereby consent to receive from TCP or any third party with whom TCP contracts for autodialed calls and text messages regarding financial obligations, healthcare related notifications, and potentially other texts containing surveys or other marketing or advertising to the phone number I provide to TCP. Such autodialed calls and text messages may include, but are not limited to, messages related to scheduling, appointment reminder, immunization reminders, lab results, directions for location appointments, and links for required paperwork, debt collection, surveys, and marketing. These messages are a free service from TCP but my carrier may apply message and data rates. Opt-in consent is not required to receive services from TCP. At any time you can text STOP to stop receiving text messages.
- I have read and understand that I am personally responsible for payment on this account.
- Medicaid: I do _____ or I do not _____ currently have Medicaid Insurance.
- I understand that this practice may have a no show appointment fee of $25 dollars. For these practices, I am responsible for paying the fee if I do not cancel the appointment.
- I acknowledge and, by signature on this form, agree that my provider may be participating in a shared savings program with my managed care plan. Information regarding any active program is available to me upon my request.

Guarantor Signature:_____ **Date:**_____

Print Name_____ Guarantor Date of Birth: _____

E-mail_____ Relationship to Patient: _____

Patient Name: _____ Date of Birth: _____

TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

_____
Screener's Initials

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Provider's Name/Clinic's Name: _____ Phone Number: (_____) _____
Area Code + number

Please check the first category that applies; check only one.

(a) ☐ Is enrolled in Medicaid, or

_____ _____
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

_____ _____
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(c) ☐ Is an American Indian, or

(d) ☐ Is an Alaskan Native, or

(e) ☐ Does not have health insurance (uninsured), or

(f) ☐ Is underinsured:

- ☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- ☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- ☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: _____ Insurer Contact Number: (_____) _____
Area Code + number

Policy/Subscriber Number: _____ Group Number (if applicable): _____

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: _____ Date: _____
(mm/dd/yyyy)

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)

PROGRAMA DE VACUNAS PARA NIÑOS DE TEXAS (o TVFC)

REGISTRO DE DETERMINACIÓN DEL DERECHO A LA PARTICIPACIÓN DEL PACIENTE

PARA USO DE LA CLÍNICA
CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

_____
Screener's Initials

Debe mantenerse el registro de todos los niños de 18 años de edad o menos que reciban inmunizaciones mediante el Programa de Vacunas para Niños de Texas en el consultorio del proveedor de salud. El registro lo puede rellenar el padre o madre, el tutor, el individuo que consta en el registro, o el proveedor de salud. La determinación del derecho a la participación del TVFC debe realizarse en cada consulta de inmunización para asegurarse de que el derecho a la participación del niño no ha cambiado. El mismo registro cumplirá con los requisitos de todas las vacunas posteriores, en tanto el derecho a la participación del niño no haya cambiado. Si cambia el derecho a la participación del paciente, debe rellenarse un nuevo formulario. Aunque la verificación de las respuestas no se requiere, es necesario quedarse con este registro, o uno similar, para cada niño que reciba vacunas bajo el Programa de TVFC.

Fecha de la determinación: _____
(mm/dd/aaaa)

Nombre del niño: _____
Apellido Primer nombre Inicial del 2.o nombre

Fecha de nacimiento del niño: _____ Edad: _____
(mm/dd/aaaa)

Padre o madre, tutor o individuo que consta en el registro: _____
Apellido Primer nombre Inicial del 2.o nombre

Nombre del proveedor o de la clínica: _____ Número telefónico: (_____) _____
Código de área + el número

Marque la primera categoría que corresponda; marque sólo una.

(a) ☐ Está inscrito en Medicaid, o

_____ _____
Número de Medicaid: Fecha del derecho a la participación (mm/dd/aaaa)

(b) ☐ Es paciente que recibe prestaciones del Plan de Seguro Médico Infantil (o CHIP), o bien

_____ _____
Número de CHIP: Fecha del derecho a la participación (mm/dd/aaaa)

(c) ☐ Es indio americano, o

(d) ☐ Es nativo de Alaska, o

(e) ☐ No tiene seguro médico (no asegurado), o

(f) ☐ Está subasegurado:

- ☐ 1) tiene seguro médico comercial (privado), pero la cobertura no incluye las vacunas; o
- ☐ 2) el seguro cubre sólo algunas vacunas (reúne los requisitos del TVFC sólo para las vacunas no cubiertas); o
- ☐ 3) el seguro limita la cobertura de las vacunas a cierta cantidad. Una vez alcanzada esa cantidad de cobertura, se categorizará al niño como subasegurado.

(g) ☐ Tiene seguro privado que cubre las vacunas:

Nombre del asegurador: _____ Número de contacto del asegurador: (_____) _____
Código de área + el número

Número de póliza/suscriptor: _____ Número del grupo (de ser aplicable): _____

NOTA: Falsificar información en este documento a sabiendas constituye un fraude. Al firmar este formulario, por este medio doy fe que la información es verdadera y correcta. Yo declaro que la persona nombrada arriba es una persona autorizada y reúne los requisitos para recibir vacunas del TVFC.

Firma: _____ Fecha: _____
(mm/dd/aaaa)

Con ciertas excepciones, tiene derecho a pedir y a ser informado sobre la información que el estado de Texas reúne sobre usted. Tiene derecho a recibir y examinar la información al pedirla. También tiene derecho a pedir a la agencia estatal que corrija cualquier información que se determine es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la notificación de privacidad. (Referencia: Código gubernamental, sección 552.021, 552.023, 559.003 y 559.004)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 03/2012

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**

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)

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.***