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 # ☐ Parent #1 ☐ Parent #2	Parent's Email Address: ☐ Parent #1 ☐ Parent #2

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

Parent #1's highest level of education : ☐ Some high school ☐ High school diploma or GED ☐ Some college ☐ Bachelor's degree ☐ Graduate degree or higher ☐ Prefer not to answer

Parent #2's highest level of education : ☐ Some high school ☐ High school diploma or GED ☐ Some college ☐ Bachelor's degree ☐ Graduate degree or higher ☐ Prefer not to answer

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

Emergency Contacts

Parent #1's Name (Last, First, Middle)	Home #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Parent #2'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

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 Pediatrics

2025

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, autodialed calls and text messages regarding financial obligations; healthcare related notifications, including but not limited to, messages related to scheduling, appointment reminders, immunization reminders, lab results, directions for location appointments, and links for required paperwork; debt collection; surveys; and marketing to the phone number I provide to TCP. 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. If my visit and/or appointment is before 8:00 AM or after 9:00 PM, I understand that I may receive visit and/or appointment arrival-related text messages outside of normal business hours/before 8:00 AM and/or after 9:00 PM.
- 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 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 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®

Patient Name:
DOB:
Date:

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: _____

_____

Texas Children's Pediatrics®

Patient Name:
DOB:
Date:

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	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Biological Mother			Y N																			
Biological Father			Y N																			
Siblings	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		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	Mental Illness	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 primary guardians: 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 _____

Parent #1 Occupation: _____ Parent #2 Occupation: _____

Texas Children's Pediatrics

VOLUNTARY AUTHORIZATION OF NON-PARENT/NON-LEGAL GUARDIAN TO ACCOMPANY PATIENT

By law, any child under eighteen (18) years of age cannot be seen by a doctor without consent from their parent or legal guardian. If the minor arrives at Texas Children's Pediatrics accompanied by someone other than their parent or legal guardian, our practice requires written permission from you that this adult has been appointed to accompany your child.

Minor Patient's Name: _____DOB:_____

Below, please list those individual(s) who may accompany your child in your absence:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

AUTHORIZATION:

I am the parent or legal guardian of the above named minor patient. I have medical consenting rights for my child. If the patient comes into the clinic with one of the individual(s) named above, I give advance authorization and consent for the patient to receive routine or emergency medical, dental or other healthcare treatment. I understand information about my child's diagnosis, treatment, and care may be shared with the individual(s) listed above on the day of the visit.

This form is valid for one (1) year after signature or until revoked by written notice to Texas Children's Pediatrics.

PLEASE PRINT:

_____	_____
Parent or Legal Guardian's Name	Phone Number Where I Can Be Reached
_____	_____
Parent or Legal Guardian's Signature	Date

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

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

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

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

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
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ Signature _____ Date _____

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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

Stock No. C-7
Revised 02/2024

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*