



Pediatric Partners

El Paso

E-Mail: _____

Today's Date: _____

PATIENT INFORMATION

(Please use full legal name, no nicknames please)

Last Name: _____ First Name: _____ M _____
Date of Birth: _____ Age: _____ Sex: Female [] Male []
Address: _____ S.S # _____
City: _____ State: _____ Zip: _____
Home Phone# _____ Cell Phone# _____
Emergency Contact Name: _____ Emerg. Phone # _____

PARENT /LEGAL GUARDIAN INFORMATION

**Person responsible for bill: _____ Mother _____ Father _____ Other: _____

Mom's First & Last Name: _____
Maiden Name: _____ Date of Birth: _____ S.S# _____
Mom's Work # _____ Mom's Cell# _____
Dad's First and Last Name: _____ Date of Birth: _____
S.S# _____ Dad's Cell # _____ Dad's Work# _____
Married [] Divorced [] Single []
Address (if different than above) _____
Please provide name of patient's siblings: _____

INSURANCE INFORMATION

(Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance: _____ Policy Holder's name: _____
Relationship to the patient: _____
Policy Holder's S.S.# _____ Policy Holder's Date of Birth: _____
Policy/ID# _____ GRP# _____
Eff Date: _____ Claims Address: _____
Insurance Phone #: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **Date of Birth:** _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and **NOT** the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____ **Date:** _____
(please sign here – Patient or Responsible Party)

Responsible Party Name: _____
(please print name of Responsibility Party if different from Patient)



Pediatric Partners

El Paso

In order for us to provide you with the best quality care, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. Missed appointments affect us, you and to

the other patients who were denied services due to no availability.

Effective April 1, 2014 if you miss or fail to cancel an appointment within 24 hours three times within a calendar year (January-December), you will be discharged from the practice. We do realize that on rare occasions emergencies may arise and we will address these situations with you at that time.

We thank you for working with us to ensure you receive the excellent service you deserve.

Con el propósito de brindarles un mejor servicio, le pedimos que traten de asistir y ser puntuales a sus citas. Las citas perdidas le afectan a usted, a nuestra práctica y a aquellos pacientes a quienes se les niega servicio por falta de cupo.

Efectivo 1ro de abril, de 2014, si usted falta o no cancela su cita con 24 horas de anticipación tres veces en un año (enero diciembre), usted será dado de baja de nuestra práctica. Estamos conscientes que pueden surgir emergencias y trataremos éstas en su momento con la seriedad y el respeto que ameritan.

Agradecemos su cooperación para poder proveerle el servicio de excelencia que merece.

I have been notified of the No Show Policy

Se me ha informado acerca de las Reglas de Ausencias y Tardanzas.

Patient's Name (Nombre del Paciente): _____

Date of Birth (Fecha de Nacimiento): _____

Parent or Legal Guardian's name (Nombre del padre o tutor legal): _____

Parent or Legal Guardian's signature (Firma del padre o tutor legal): _____

Date: _____

Privacy Directive for Minors

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your child's **appointment(s)** with a co-worker, receptionist or secretary that regularly answers your calls? Yes No N/A

May we leave **messages** regarding your child on a voice mail at work? Yes No N/A

May we discuss your children's **appointments/treatment** with a designated care giver?
Yes No N/A

If yes please provide name of those we can disclose information to:

You must inform us, **in writing**, of any changes in your directives. This record takes effect (date)_____, and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Minor's name: _____ DOB: _____

Signature of Parent/Guardian: _____ Date _____

Physician Office Representative _____

**AUTHORIZATION FOR NON-PARENT TO ACCOMPANY MINOR
PATIENT(S)**

I, _____, give the person(s) listed below permission to bring my child/children to Pediatric Partners El Paso for medical care. I do understand that this consent **DOES NOT APPLY TO IMMUNIZATIONS, WELL CHILD CHECK OR ADHD MEDICATION.**

Child's Name: _____ D.O.B: _____

Child's Name: _____ D.O.B: _____

Child's Name: _____ D.O.B: _____

Child's Name: _____ D.O.B: _____

Name of person (first and last) allowed to bring child/children: _____

Relationship to patient: _____

Name of person (first and last) allowed to bring child/children: _____

Relationship to patient: _____

Name of person (first and last) allowed to bring child/children: _____

Relationship to patient: _____

Signature of Parent or Legal Guardian

Date



Authorization for text message communication

Patient's name: _____

Patient's date of birth: _____

Pediatric Partners now has the ability to provide our patients with appointment reminders via text message. If you wish to have the opportunity to receive information of this type, please complete the form below.

Pediatric Partners strongly believes in protecting the privacy of our patients, which is why no personal or confidential information (such as test results, etc.) will be sent via text messages. Pediatric Partners does not share private information of our patients to any other company, patient or non-authorized person.

Please fill the form in a legible form.

_____ **YES**, I authorize Pediatric Partners to communicate with me via text message.

Cellphone number: (_____) _____

_____ **NO**, I do not authorize Pediatric Partners to send me text messages.

Relationship to patient

Date

Signature

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Pediatric Partners El Paso. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research

Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices*' form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- ◆ The right to request restrictions on the use and disclosure of your protected health information;
- ◆ The right to request restrictions on disclosure to a health plan if you paid out of pocket, in full, for items or services;
- ◆ The right to receive confidential communications concerning your medical condition and treatment;
- ◆ The right to inspect and copy your protected health information;
- ◆ The right to amend or submit corrections to your protected health information;
- ◆ The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- ◆ The right to receive a printed copy of this notice.

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this “Notice of Privacy Practices”.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. You have the right to access your protected health information in electronic format where it is available. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, please contact our office and speak to the office manager

You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.



Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the “Notice of Privacy Practices”

Name of Patient (print) Date of Birth: _____

Signature of Patient Representative

Relationship to the patient

Date



**Pediatric
Partners**

El Paso

AGREEMENT AS TO FORUM SELECTION: I (we) and my health care providers, including my doctor, physician assistant, nurse practitioner, nurse or other employee of Pediatric Partners El Paso. P.A., agree that in the event of a dispute, any lawsuit, action, or cause of which in any way relates to the health care provided to the patient shall only be brought in a District Court in El Paso County, Texas, the county/district where all or substantially all of the health care was provided or rendered. The forum selection provisions of this paragraph are mandatory and are not permissive.

I certify and acknowledge that I have read this form or had it read to me, that I understand the forum selection provisions, and that I had ample time to ask questions and consider my decision.

Patient's Name

Patient's Date of Birth

X _____
Patient's Signature/Other Legally Responsible Person

Relationship to Patient

Date:

Time:

X _____
Witness Signature

Title

Date:

Time:



ACUERDO SOBRE LA SELECCION DEL FORO: Yo (nosotros) y mis proveedores de atención médica, incluso mi médico, asistente médico, enfermera especializada, enfermera u otro empleado de El Paso Pediatric Partners, P.A., acordamos que, en caso de cualquier disputa, demanda, acción, o causa que de alguna manera se relacione con la atención medica brindada al paciente, solo se presentara en un Tribunal (una Corte) del Distrito en el condado del El Paso, Texas, el condado/distrito donde se brindo o se presto toda o sustancialmente toda la atención médica. Esta selección de foro es obligatoria y no permisiva.

Certifico y reconozco que he leído esta selección de foro o me lo han leído, que entiendo las disposiciones de selección del foro, y que tuve tiempo suficiente para hace preguntas y considerar mi decisión.

Nombre de Paciente

Fecha de Nacimiento

X _____
Firma del paciente o del representante del paciente

Relación con el paciente

Fecha

Tiempo

X _____
Testigo Firma

Titulo

Fecha

Tiempo

MEDICAL RECORD RELEASE FORM

1390 George Dieter Ste 100

El Paso, Tx 79936

Telephone: 915-591-7704

Preferred Method: Fax: 915-591-7734



**Pediatric
Partners**
El Paso

Patient Name and date of birth

Date

Address

Phone#

I hereby authorize the below listed entity to release medical information to Pediatric Partners El Paso.

Name: _____

Telephone#: _____

Address: _____

Fax#: _____

Medical Information Requested:

- ☐ All Records
- ☐ Specific Records from _____ to _____
- ☐ Immunizations & Physical Examinations
- ☐ Radiology Reports (X-ray, Ultrasound, CT, MRI, etc)

If you wish for certain information NOT be included please list below:

Signature of Patient or Legal Guardian

Date

Relationship to the patient

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time and that it must be done in writing unless the facility, which is to make the disclosure of information, has already done so in reliance on the statement.



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VACCINATION POLICY

We firmly believe in vaccinations. Our philosophy has been that it is our role to provide reasoned, scientific

information that can help alleviate concerns and ultimately encourage all parents to comply with the recommendations of the medical community. Unfortunately, there is a small group of parents that insist that they will not vaccinate their children.

Recent events have caused us to re-evaluate our policy regarding unvaccinated children using our practice for health care. Around the country, the actions of relatively few parents have put many of the most vulnerable at risk. Whooping cough and measles are now in full resurgence. These diseases are life threatening, especially to our youngest patients. Infants and those undergoing chemotherapy may be unprotected against these diseases. Additionally, children exposed to diseases such as measles require weeks of quarantine creating a tremendous burden to working parents. In the face of recent outbreaks, we will not allow children who have not vaccinated to remain in our practice. Many of our vaccine-compliant patients have voiced concern about possible exposure in our health care facilities. It is our duty to provide the safest environment possible to receive health care.

At Pediatric Partners El Paso:

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children should receive all of the recommended vaccines according to the schedule published by the [Advisory Committee on Immunization Practices \(ACIP\)](#) of the U.S. Centers for Disease Control and Prevention (CDC) and the [American Academy of Pediatrics \(AAP\)](#).
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- All of our own children are vaccinated.

All of our providers believe that vaccinating your children may be the *single most important* health-promoting and life-saving intervention that you can perform as parents.

Effective immediately we will not provide care for families that do not vaccinate their children.

Our policy states:

1. All children must receive all vaccines recommended by the AAP that are mandated for school entry by the State of Texas.
2. Parents or caregivers who don't agree with the Pediatric Partners El Paso vaccine policy will be given a 1 month grace period to find another healthcare facility. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, even death.

[CDC guidelines](#) provide a window for when a specific vaccine should be given. This allows sufficient flexibility in getting your child properly vaccinated. We prefer to remain your child's Pediatrician and will not dismiss any family who is actively working to properly vaccinate their children. Our staff of doctors and nurses is here to help. Please contact us if you have any questions or concerns.

NAME:	
DOB:	
AGE:	GENDER: ☐ MALE ☐ FEMALE

MEDICAID ID:
INFORMANT/RELATIONSHIP:
MEDICAL HOME:

IF CHILD OVER 5 YEARS: uncomplicated pregnancy, labor, delivery and nursery course: Y ☐ N ☐

*If yes, proceed with "Family Medical History and Personal Medical History"

IF < 5 YEARS OLD

PREGNANCY

G ☐ P ☐ AB ☐

Total number of living children: _____ Weight gain/loss: _____

Mother's age at birth: _____

Number of years between previous pregnancy and this child: _____

Trimester Prenatal Care Began: 1 ☐ 2 ☐ 3 ☐

Prenatal Care Provider: _____

Vitamins: Y ☐ N ☐ Iron: Y ☐ N ☐

MATERNAL COMPLICATIONS

- | | |
|---|---|
| ☐ Vaginal bleeding | ☐ Flu-like illness or high temp. |
| ☐ Anemia | ☐ Kidney or bladder infection |
| ☐ Hypertension | ☐ STIs |
| ☐ Rh negative | ☐ Hepatitis (A, B, or C) |
| ☐ Diabetes | ☐ Exposure to TB or had TB |
| ☐ Premature labor | ☐ Exposure to lead/chemicals |
| ☐ Dental disease | ☐ Injury/hospitalization/surgery |

MATERNAL SUBSTANCE USE

- ☐ OTC meds: _____
- ☐ Prescription meds: _____
- ☐ Tobacco: _____
- ☐ Alcohol: _____
- ☐ Street drugs: _____
- ☐ Caffeine: _____

BIRTH/DELIVERY

Place of birth: _____

Birth attendant: _____

Hours of labor: _____

- ☐ Term ☐ Premature (weeks): _____
- ☐ More than two weeks overdue

Type of delivery: _____

- ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Other/Explanation: _____

Complications: _____

- ☐ Breech ☐ Multiple birth ☐ Other: _____

NURSERY COURSE

Birth Weight: _____ Birth Length: _____ FOC: _____

- | | |
|--|---------------------------------------|
| ☐ Difficulty with initial breathing | ☐ Transfusion |
| ☐ Jaundice req. treatment | ☐ Heart murmur |
| ☐ Infection | ☐ Seizures |
| ☐ NICU: _____ days | Age at discharge: _____ |

Newborn blood screening (date/location):

1: _____

2: _____

Newborn hearing test (in hospital): ☐ Pass ☐ Fail

Type of test: ☐ ABR ☐ OAE ☐ Unknown

Referral made: Y ☐ N ☐

Critical congenital heart disease(in hospital): ☐ Pass ☐ Fail

Comments: _____

FAMILY MEDICAL HISTORY

Abbreviations for relatives listed below.

M-Mother	MGM-Maternal Grandmother	PGM-Paternal Grandmother
F-Father	MGF-Maternal Grandfather	PGF-Paternal Grandfather
S-Sibling	MA-Maternal Aunt	PA-Paternal Aunt
	MU-Maternal Uncle	PU-Paternal Uncle

- | | |
|---|--|
| ☐ Anemia/blood disorder | ☐ HIV + individual in household (do not identify) |
| ☐ Heart disease before age 50 | ☐ Other immunosuppression |
| ☐ Cholesterol req. treatment | ☐ Dental decay |
| ☐ Hypertension/stroke | ☐ Alcohol/drug abuse |
| ☐ Asthma/allergy | ☐ Tobacco use |
| ☐ Cancer | ☐ Learning disorder |
| ☐ Diabetes | ☐ Mental retardation |
| ☐ Epilepsy/seizures | ☐ Psychiatric disorder |
| ☐ Kidney problems | ☐ Physical/sexual/emotional abuse |
| ☐ Muscle/bone disease | ☐ Domestic violence |
| ☐ Genetic disease or major birth defects | ☐ Childhood hearing impairment |
| ☐ Tuberculosis | |
| ☐ Other/Explanation: _____ | |

PERSONAL MEDICAL HISTORY

Immunizations current: Y ☐ N ☐ Record unavailable ☐

Dental care current: Y ☐ N ☐ Sealants: Y ☐ N ☐

- | | |
|--|--|
| ☐ Trauma/injuries | ☐ Vision problems |
| ☐ Hospitalizations | ☐ Hearing problems |
| ☐ Surgery | ☐ Seizures |
| ☐ Medications | ☐ Environmental toxin exposure (lead, etc.) |
| ☐ Anemia | ☐ Allergies |
| ☐ Early childhood caries | ☐ Cancer |
| ☐ STIs | ☐ Asthma |
| ☐ Hepatitis | ☐ Eczema |
| ☐ Strep throat | ☐ Substance use (alcohol, drug, tobacco) |
| ☐ Ear infections | ☐ Developmental delays/learning disorder |
| ☐ Bladder/kidney infections | ☐ Immune suppression |
| ☐ Pneumonia | ☐ Psychiatric disorder |
| ☐ Physical/sexual/emotional abuse | |
| ☐ Muscle/bone disease | |
| ☐ Other/Explanation: _____ | |

Date: _____

Signature/title _____

Signature/title _____



TEXAS
Health and Human
Services

Texas Department of State
Health Services

IMMUNIZATION REGISTRY (ImmTrac2) Minor Consent Form



(Please print clearly)

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____
 Child's Date of Birth _____ *Children younger than 18 years old only. Child's Gender: ☐ Male ☐ Female Telephone _____

Child's Address _____ Apartment # _____ Email address _____
 City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Recipient Refused			Ethnicity (select only one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Recipient Refused
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The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

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

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name _____

Date _____

Signature _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

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

PROVIDERS REGISTERED WITH ImmTrac2

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