EL PASO KIDS KLINIC

HUMA Y LODHI MD

MELISSA HOLGUIN PA-C

Today's Date: _____

PATIENT INFORMATION

(Please use full legal name, no nicknames please)

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

PARENT/ LEGAL GUARDIAN INFORMATION

** Person responsible for bill: Mother [ ] Father[ ] Other[ ]

Mom's First & Last Name: _____
Maiden Name: _____DOB: _____SS#_____
Mom's Work #_____ Mom's Cell #_____
Dad's First and Last Name: _____ DOB: _____
SS#_____ 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 SS# _____Policy holder's DOB _____
Policy ID #_____Group#_____
Effective Date: _____Claims Address: _____
Insurance phone # _____

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

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. 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 a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

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

Individual (or individual's legally authorized representative): _____ 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)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac 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.**

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Patient Privacy Directive

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 **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes, No N/A

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

May we discuss your **appointments/treatment** with your spouse? Yes, No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes, No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes, No N/A

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

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

EL PASO KIDS KLINIC

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

PLEASE REVIEW IT CAREFULLY.

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 this practice. 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 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. 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.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. 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 and 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"

Patient Name (Print): _____ DOB: _____

Signature of Patient Representative: _____

Relationship to Patient: _____

Date: _____

Acuerdo de Recibo de la Noticia de Practicas de Privacidad HIPPA

Este consultorio se reserva el derecho de modificar las practicas de privacidad mencionadas

Yo he recibido una copia de "Noticia de Practicas de Privacidad"

Nombre del Paciente (letra de molde): _____Fecha de Nacimiento: _____

Firma del Paciente o Representante _____

Relacion con el Paciente _____

Fecha: _____

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NO SHOW POLICY / POLIZA DE CITAS SIN PRESENTACION

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. Cancellations must be done within a 24-hour period. Missed appointments result in a cost to us, you, and to other patients who were denied service due to no availability. We do realize that on rare occasions emergencies may arise and we will address these situations with you at that time. In rare cases when there is excessive abuse of missed appointments, we may choose to discharge patients from our practice. We thank you for working with us to ensure services are provided to you in the best possible way.

Para poder proveer el mejor cuidado possible, les pedimos que hagan el mayor esfuerzo para mantener y ser puntuales a sus citas. Las citas perdidas representan un costo para nosotros, para ustedes, y para los pacientes que podrian haber sido consultados. Las cancelaciones deberan hacerse con 24 horas de anticipacion. Estamos consientes de que en ciertas ocasiones ocurren emergencias y en ese caso abordaremos estas situaciones con usted en ese momento. En casos extremos, cuando hay abuso excesivo de citas peridas, podemos elegir despedir a los pacientes de nuestro consultorio. Le agradecemos su cooperacion para asegurar que reciban el mayor cuidado possible.

I have been notified of the No Show Policy

Se me ha notificado acerca de la poliza de las citas sin presentacion.

Patient name/ Nombre del Paciente: _____

Date of Birth/ Fecha de Nacimiento: _____

Parent or Legal guardian Signature / Firma de Padre o Tutor_____

Date / Fecha: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **DOB:** _____

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 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 Responsible party if different from Patient)