EL PASO KID'S KLINIC

HUMA Y LODHI M.D. MELISSA HOLGUIN PA-C

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)

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
FIRST RESPONDER/FAMILY MEMBER REQUEST FORM

ImmTrac Texas Immunization Registry

(Please print clearly)

Client's Last Name

For Clinic/Office Use

Client's First Name

Client's Middle Name

Client's Date of Birth

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Telephone

City

State

Zip Code

County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your immunization records. State law permits the inclusion of immunization records for First Responders and their immediate family members (over 18 years of age) in the Registry. With your consent, your immunization information will be included in ImmTrac and health care providers can access your immunization history. 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 less than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac child" by completing the *Immunization Registry (ImmTrac) Consent Form (#C-7).*

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

Request for Inclusion of First Responder or First Responder Family Member Immunization Information and Release of Immunization Records to Authorized Entities

I understand that, by requesting inclusion below, I am authorizing release of my 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, my immunization information may by law be accessed by a physician or other health care provider legally authorized to administer vaccines, for treating me as a patient.

I understand that I may withdraw this request to include my immunization information in the ImmTrac Registry and my request 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.

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 (over 18 years of age)** of a First Responder

Client: _____
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)

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

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.*

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE INMUNIZACIÓN (IMMTRAC) FORMULARIO DE CONSENTIMIENTO DE RETENCIÓN DE INFORMACIÓN SOBRE EL DESASTRE

ImmTrac Texas Immunization Registry

(Favor de escribir claramente con letra de molde)

Apellido del Cliente

For Clinic/Office Use

Nombre del Cliente

Segundo Nombre del Cliente

Fecha de Nacimiento del Cliente / /

Género: ☐ **Masculino** ☐ **Femenino**

Dirección del Cliente

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Municipio

ImmTrac, el registro de inmunización de Texas, es un servicio gratuito del Departamento Estatal de Servicios de Salud de Texas. El registro de inmunización es un servicio seguro y confidencial que consolida y almacena su expediente de inmunización. La ley estatal permite la inclusión de los expedientes de inmunización del personal de primera respuesta y sus familiares inmediatos (mayores de 18 años de edad) en el registro. Con su consentimiento, su información de inmunización se incluirá en ImmTrac y los profesionales de la salud pueden acceder a su historial de vacunas. Al "personal de primera respuesta" se le define como empleados o voluntarios de seguridad pública entre cuyos deberes está responder rápidamente a una emergencia. Un "familiar inmediato" se define como uno de los padres, el cónyuge, el hijo o hija o hermano(a) que vive en la misma casa que el personal de primera respuesta. Para un familiar menor de 18 años de edad, uno de los padres, el tutor legal o el custodio administrador puede dar el consentimiento de participación como "ImmTrac child," llenando el Registro de Inmunización (ImmTrac) Formulario de Consentimiento (#C-7).

El Departamento Estatal de Servicios de Salud de Texas (DSHS) le anima a que participe voluntariamente en el registro de inmunización de Texas.

Solicitud de inclusión de información de inmunización sobre personal de primera respuesta o un familiar del personal de primera respuesta y consentimiento para dar a conocer el expediente de inmunización a las entidades autorizadas

Entiendo que, con mi solicitud a continuación, autorizó que se de a conocer mi información de inmunización al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac"). Una vez que mi información de inmunización esté en ImmTrac, puede ésta por ley ser accedida por médicos o otros profesionales de la salud legalmente autorizados para administrar vacunas, para tratarme como paciente.

Entiendo que puedo retirar esta solicitud para incluir mi información de inmunización en el registro de ImmTrac y mi consentimiento para dar a conocer mi información del registro, en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

Marque la casilla correspondiente para indicar si es usted personal de primera respuesta o un familiar inmediato.

Soy **PERSONAL DE PRIMERA RESPUESTA**

☐ Soy **FAMILIAR INMEDIATO (mayor de 18 años de edad)** de un empleado de primera respuesta

Con mi firma a continuación, SOLICITO la inclusión de mi información de inmunización en el registro de inmunización de Texas.

Cliente: _____
Nombre en letra de molde

Fecha _____ **Firma** _____

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 552.023, 559.003 y 559.004)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac del DSHS o a un proveedor de salud inscrito.

¿Tiene preguntas? (800) 252-9152 • (512) 776-7284 • Fax: 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

ImmTrac FR/FM Stock No. EF11-12955
Revised 05/18/2012

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.

CH.37 Child Health History (2 Pages)

Child Health History

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: _____
DOB: ____/____/____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Pregnancy and Birth

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
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: ___ Y ___N*
**If yes, proceed with "Child's Medical History.*

Birth/Delivery

Place of birth _____
Birth attendant _____
Hours of labor _____

___Term
___Premature (Weeks)_____
___More than 2 weeks overdue

Type of delivery:
___Vaginal
___C-Section
___Forceps

Complications:
___Breech
___Multiple birth
___Other

Explanation/Other:

Maternal Complications

___Vaginal bleeding
___Anemia
___Hypertension
___Rh negative
___Diabetes
___Premature labor
___Injury/hospitalization/surgery
___Flu-like illness or high temp.
___Kidney or bladder infection
___STDs
___Hepatitis (A, B, or C)
___Exposure to TB
___Exposure to lead/chemicals
___Dental disease

Nursery Course

Birth Weight _____ Birth Length _____ FOC _____

___Difficulty with initial breathing
___Heart murmur
___Infection
___Transfusion
___Jaundice req. treatment
___Seizures

Age at discharge: _____ICN _____ days
Newborn blood screening (date/location):
1. _____
2. _____
Newborn hearing test (in hospital): ___ Normal ___Abnormal
Type of test: ___ABR ___OAE ___Unknown
Referral made: ___Y ___N
Comments:

Maternal Substance Use

___OTC meds _____
___Prescription meds _____
___Tobacco _____
___Alcohol _____
___Street drugs _____
___Caffeine _____

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
___ Heart disease before age 50
___ Cholesterol req. treatment
___ Hypertension/stroke
___ Asthma/allergy
___ Cancer
___ Diabetes
___ Epilepsy/seizures
___ Kidney problems
___ Muscle/bone disease
___ Genetic disease or major birth defects
___ Childhood hearing impairment
___ Tuberculosis

Y N HIV + Individual in household *(do not identify)*
___ Other immunosuppression
___ Dental decay
___ Alcohol/drug abuse
___ Tobacco use
___ Learning disorder
___ Mental retardation
___ Psychiatric disorder
___ Physical/sexual/emotional abuse
___ Domestic violence
___ Other

Explanation of positive history:

Child's Medical History

Immunizations current: ___Y ___N ___ Record unavailable
Dental care/sealants current: ___Y ___N

___Trauma/injuries
___Hospitalizations
___Surgery
___Medications
___Anemia
___Early childhood caries
___Hepatitis
___Strep throat
___Ear infections
___Bladder/kidney infections
___Pneumonia
___Developmental delays
___Vision problems
___Hearing problems
___Seizures
___Environmental toxin exposure (lead, etc.)
___Allergies
___Asthma
___Eczema
___Substance use (alcohol, drug, tobacco)
___Other

Explanation:

Date: _____ Signature/Title: _____ Signature/Title _____

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to El Paso Kids Klinic or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that El Paso Kids Klinic is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/COMMERCIAL INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of me or my dependent's authorized benefits be made directly to El Paso Kids Klinic or the physician on my behalf

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the El Paso Kids Klinic Patient Information Privacy Policy. I hereby authorize El Paso Kids Klinic or the physician individually to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail I hereby authorize an El Paso Kids Klinic representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying El Paso Kids Klinic to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my El Paso Kids Klinic physician or his or her designee.

Patient Name: _____ Date of Birth: _____

Guarantor Name (Please Print): _____ Date: _____

Guarantor Signature: _____ Date: _____

El Paso Kids Klinic

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 January 1, 2015, 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

Huma Lodhi M.D. & Melissa Holguin PA-C

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 posible, les pedimos que hagan el mayor esfuerzo para mantener y ser puntuales a sus citas. Citas perdidas representan un costo para nosotros, para ustedes, y para los pacientes que podrían haber sido consultados. Cancelaciones tendrían que ser con 24 horas de anticipación. Estamos consientes 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 perdidas, podemos elegir despedir a los pacientes de nuestro consultorio. Le agradecemos su cooperación para asegurar que reciban el mejor cuidado posible

I have been notified of the No Show Policy—Se me ha informado acerca de la Póliza de las citas sin presentación

Patient Name (Nombre del Paciente):_____

Date of Birth (Fecha de Naciemente):_____

Parent Signature(Firma del Padre):_____

Date (Fecha):_____

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"

_____ Date of Birth:_____
Name of Patient (print)

_____
Signature of Patient Representative

_____
Relationship to the patient

_____
Date