7103 South Peek Road
Unit E500
Richmond
Texas 77407

Phone: 346-620-6850
Fax: 1877-569-1910

NEW PATIENT INFORMATION

Patient Name: Patient Name:	Gender: M/F Date of Birth:____/____/____ Gender: M/F Date of Birth: ___/____/____
Address: Apartment #:	Mobile Phone #: Alternative Phone #:
City/State/Zip Code:	Email Address:
Referred By:	Pharmacy Name, Address and Phone Number:
Name of Mother or Legal Guardian: Date of Birth:	Name of Father or Legal Guardian: Date of Birth:
Driver's License #:	Driver's License #:
Occupation: Employer: Work #:	Occupation: Employer: Work #:
Insurance Co. Name: Policy/ID #: Group #:	Secondary Insurance Co. Name: Policy/ID #: Group #:

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

Person Responsible for Payment: Address and Contact #:

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

	☐ Yes	☐ No	☐		
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file to insurance as a COURTESY: however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans. **It is your responsibility to:**
   - **Bring your insurance card and photo ID to every visit.**
   - **Pay your co-pay and/or deductible at each visit.**
   - Pay in full for any medical care/services that are not covered by your insurance.
2. If your child has insurance that we do not accept, or your child does not have insurance, payment is due in full at the time of service provided. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP or PCM (Primary Care Provider or Primary Care Manager). You will need to select Dr. D. Deoskar as your child(s) PCP or PCM. If your insurance card lists another physician's name, we will see your child, but you will be notified to update the PCP or PCM.
4. *Secondary Insurance*: **It is your responsibility to update the COB with your primary and secondary insurance.**
5. **You are financially responsible for any amount not covered by your child's insurance**.
6. If you have questions about your insurance, you may contact our office. However, specific benefit(s) questions should be directed to your insurance provider. If the payment is denied, it is the parent(s) responsibility to contact the insurance provider.
7. **If you fail to make a payment in full for services that are rendered, your outstanding balance will be sent to a third-party collection agency.** Accounts are considered past due after 90 days. You will be responsible for any fees associated with your collection of outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
8. To protect your child's records, we ask you to provide our office with a valid driver's license or other photo ID. Annually, or as changes occur, we will ask to sign our financial policy and update your registration information. We will check these documents prior to release your child(s) records.
9. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child(s) account.

Late Arrival/No-Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back into the schedule at a later time. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you do not show up to three times, we reserve the right to discharge your child from the practice. Appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time there will be a No-Show fee of $25.00.

ADVANCED BENEFICARY NOTICE: These services may NOT be covered by your insurance provider. The purpose of this list is to help you make an informed choice about whether you choose for your child to receive certain services. The face that your insurance provider does not cover a service does not mean that you should not receive that service, it means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance provider, you will be financially responsible for the balance on your account.

We will not provide medical care to children whose parents/guarantors refuse to sign and comply with our financial policy. Signature of Understanding: I have read and understand the above stated financial policy.

Child's Name	Date of Birth	Child's Name	Date of Birth

Patient or Parent/Guardian if Patient is under 18 years of age Date

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CONSENT TO TREAT

I, _____ the parent and legal guardian of

_____hereby give my consent for and authorize the administration and performance of all medical care, treatment and diagnostic procedures which in the judgement of the licensed physicians, nurses and health care professionals of Legacy Pediatrics are believed to be medically necessary. I understand that all services will be provided according to generally accepted standards of pediatric medical care and in accordance with applicable state law.

Included among the medical care services provided will be the administration of immunizations as required by law and generally recommended by the American Academy of Pediatrics and Center for Disease Control (CDC).

I acknowledge that I may revoke or change this Consent in writing addressed to Legacy Pediatrics.

PRIVACY PRACTICE AND OFFICE PROTOCOL ACKNOWLEDGEMENT

1. I hereby acknowledge that I have been presented with a copy of Legacy Pediatrics Notice of Privacy Practices.

2. I hereby acknowledge that I have been presented with a copy of Legacy Pediatrics Office Policies and understand my responsibilities.

Name: _____

Parent/Legal Guardian Signature: _____

Date Signed: _____

24 Hour Cancellation & "NO SHOW" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Legacy Pediatrics reserves the right to charge a fee of $25 for all missed appointment (no shows) and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice.

No show fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs for all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel authorization any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Security Code : _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature **Date**

RELEASE OF MEDICAL RECORDS TO LEGACY PEDIATRICS

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

_____ Persons or class of persons authorized to make the use or disclosure:

Legacy Pediatrics Above information released **FROM**

(Name of Clinic/Doctor, Hospital, Insurance Company, Self, etc.)

Address: _____

Phone Number: _____ **Fax Number:** _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient, which is call "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the follow purposes:

__ Changing Physicians __ Insurance Application __ Billing __ Other: _____

Specific information to be used or disclosed: Date(s) of service:
__ All Medical Records (Including VACCINE RECORDS & GROWTH CHARTS)
__ Vaccine Records __ Growth Charts __ Lab Reports __ Radiology Reports __ Specialist(s) Notes
__ Other _____

_____ _____

Print Name of Patient's Representative **Signature of Patient or Guardian**

_____ _____

Relation to Patient **Date**

Office Representative Initials _____ *Faxed Date* _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR 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)

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