THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

Patient Information Today's date: _____

Patient's name: _____ Date of birth: _____

Patient's Social Security Number: _____

Child's address: _____

City: _____ State: _____ Zip: _____

Home telephone number: (___) _____ Sex of child: ☐ MALE ☐ FEMALE

Mother's Information

Mother's Name: _____ Mother's Maiden Name: _____

Social Security Number: _____ Mother's Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home telephone number: ( ) _____ Cell #: _____

Email address: _____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Name of husband if Married: _____

Is mother responsible for account? Yes ☐ No ☐ Is mother employed Y ☐ N ☐

Employer's name if Employed: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Work telephone number: ( ) _____

Email address _____

Father's Information

Father's Name: _____

Social Security Number: _____ Father's Date of birth: _____

Address: _____ City: _____ State: _____ Zip _____

Home telephone number: _____ Cell #: _____ _____

Email address: _____

Marital status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Name of wife if married: _____

Is father responsible for account? Yes ☐ No ☐ Is father employed Y ☐ N ☐

Employer's name if employed: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Work telephone number: ( ) _____

Email address _____

Insurance Information

Name of primary insurance company: _____

Address: _____ City: _____ State: _____ Zip: _____

Group name: _____ Group #: _____ ID# _____

Card holder's name: _____

Signature of Parent: _____

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

FAMILY INFORMATION

PATIENT'S NAME: dddd DATE COMPLETED: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

CHILD'S BROTHERS' AND SISTERS' NAMES:		M	F	STEP SIBL.
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N
_____	DATE OF BIRTH: _____	■	☐	■ Y ☐ N

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

MEDICAL INFORMATION

PATIENT'S NAME:_____ TODAY'S DATE : _____

PREGNANCY INFORMATION(THIS CHILD)

AGE OF MOTHER AT TIME OF CHILD'S BIRTH:_____ MOTHER'S BLOOD TYPE:_____

TOTAL # OF PREGNANCIES:_____ THIS PREGNANCY WAS #: _____

OF MISCARRIAGES/STILLBIRTHS/ABORTIONS:_____ # OF LIVING CHILDREN: _____

WAS THE PREGNANCY COMPLICATED BY: ANEMIA_____ BLEEDING_____ HIGH BLOOD PRESSURE _____

INFECTION_____ OTHER: _____

BIRTH INFORMATION(THIS CHILD)

CHILD'S PLACE OF BIRTH:_____ CITY: _____

WHICH MEDICATIONS WERE NEEDED? _____

TYPE OF DELIVERY: ◉ NORMAL ○ C-SECTION ○ FORCEPS ○ BREECH

BIRTH WEIGHT:_____ LENGTH:_____ BLOOD TYPE: _____

LIST ANY COMPLICATIONS AT BIRTH:_____

MEDICAL HISTORY(THIS CHILD)

LIST ANY DRUG ALLERGIES AND REACTIONS: _____

_____

PREVIOUS PHYSICIAN:_____ CITY: _____

LIST MAJOR ILLNESSES OR DIAGNOSES: _____

OF HOSPITALIZATIONS:_____ REASONS: _____

OF SURGERIES:_____ REASONS: _____

FAMILY MEDICAL HISTORY

MOTHER'S AGE:_____ STATE OF HEALTH: _____

LIST MAJOR ILLNESSES/MEDICATIONS: _____

FATHER'S AGE:_____ STATE OF HEALTH: _____

LIST MAJOR ILLNESSES/MEDICATIONS: _____

OTHER SIGNIFICANT MEDICAL PROBLEMS IN RELATIVES:_____

EMERGENCY NFORMATION(PERSON TO CONTACT IN CASE OF EMERGENCY OTHER THAN PARENTS)

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____

HOME TELEPHONE #:_____ CELL NUMBER:_____ WORK NUMBER: _____

RELATIONSHIP TO PATIENT:_____

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin • Woodville • Jasper • Rusk

POLICY REGARDING WHO MAY SEEK TREATMENT AND RECEIVE INFORMATION

Because we have had problems in the past with legal issues involving divorce, separation, stepparent or grandparent rights, we have had to implement stricter policies regarding who is authorized to receive medical information or seek treatment for children.

A legal guardian who brings in a new patient will be required to submit a photo ID, a copy of which will be placed in the chart. This person will also be asked to fill out a third party consent form listing the people who have authority to seek treatment for the child. Only people so authorized by the legal guardian will be allowed to seek treatment for the child. If a person claiming to be the one listed on the third party consent form brings in the child for treatment, he or she must present a photo ID that matches the name on the said form. If the person seeking treatment is not authorized, The Children's Clinic reserves the right to refuse treatment.

The legal guardian will also be asked to fill out an information release form listing the people to whom certain medical information can be released. Only the people listed on this form will have access to this information.

In cases of divorced or separated parents, The Children's Clinic will treat children brought in by anyone listed on the third party consent form. If one parent decides he or she would like to prevent the other from seeking treatment for the child, he or she must present legal documents stating who is authorized by the court to seek treatment.

Step-parents will not be permitted to seek treatment for the child unless there are legal documents giving permission or the stepparent is listed on the third party consent form. Medical information will not be released to stepparents under any circumstances unless, The Children's Clinic has expressed written permission from the child's legal guardian. These rules apply even if the stepparent is the legal guardian of another child who is a patient at The Children's Clinic.

Grandparents will not be permitted to seek treatment for the child unless the grandparents are listed on the third party consent form. Medical information will not be released to the grandparents under any circumstances unless The Children's Clinic has expressed written permission from the child's legal guardian.

I have read, understood, and will agree to abide by the policy detailed above.

Signed_____ Date_____

Guardian's Name_____ Child's Name _____

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

MEDICAL INFORMATION RELEASE FORM

I,_____, the legal guardian of_____, give The Children's Clinic permission to release lab results, x-ray results, or other pertinent information, not including medical records, to the parties listed below. I understand that The Children's Clinic will not release medical information, even verbally, to anyone not named on this form.

Signed_____Date_____

(Please check all that apply.)

- Anyone who answers the telephone at my home.
- My answering machine or voice mail.
- Any member of the child's family.
- Only the child's legal guardian.
- Other (please specify by name)

_____

_____

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

AUTHORIZATION FOR THIRD PARTY

(Consent for treatment of minor lacking capacity to consent)

I/We, _____, being the parent/legal guardian of
(Please Print Your Name)

_____, a minor, request that
(Print Child's Name)

_____be allowed, in the event of my
(Name of Person(s) acting on your behalf)

absence, to act as agent(s) for the undersigned consent to any x-ray examination, and anesthetic, medical, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care with a physician, meeting the requirements of this authorization, may in the exercise of his/her best judgement deem advisable.

I/We, hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to my/our above named agent(s) upon the completion of treatment.

_____ _____

Signature of Parent/Legal Guardian Date

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

NEW PATIENT AGREEMENT FORM

Our office is contracted with several insurance carriers. We will accept assignment if we are contracted with your insurance company and we can verify coverage at the time of service. Please check our website at www.childrensclinicluf kin.com or ask our receptionist for a list of contracted insurance companies. We will file your claim forms and assist you in every way we can. However, you are responsible for full payment, or payment according to your insurance policy at your initial visit and any other office visits. If we are not contracted with your insurance company, we will be happy to provide receipts for service to simplify your filing process.

Office policy regarding insurance assignment:

1. You must understand that the contract you have is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance company.**
2. By taking your insurance on assignment, we have agreed to wait for the majority of our payment. Therefore, your portion is **due at the time of each visit, this includes copays.**
3. Once your insurance remits payment, any balance will be due in full at that time. Arrangements must be made in advance for our office to agree to any other payment arrangements.
4. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy and what it covers. However, if for some reason your claim is denied, **you are responsible for the full amount of your bill.**
5. You are required to sign a statement authorizing payment to be made directly to our office. See attached.
6. Our office will not enter into a dispute with your insurance company over the claim. This is your responsibility and obligation.
7. Delinquent accounts will be turned over to a collection agency when deemed necessary.
8. If for some reason you are unable to keep a scheduled appointment, we request that you notify us in advance.
9. Per your insurance requirements, we must have the insured's date of birth on file for verification purposes. We ask that you provide this information and all other information asked in our patient information packet.
10. If the Children's Clinic is listed in your bankruptcy case, you could be dismissed from our practice.
11. We will not be involved in divorce/legal financial issues. The adult accompanying the patient to the clinic will be responsible for payment at the time of service.

By signing this statement, you are stating that you understand and agree to follow our office policy.

_____ _____

Signature Date

_____

Patient's Name

THE CHILDREN'S CLINIC

Healthy Children, Healthy Communities

Lufkin · Woodville · Jasper · Rusk

NOTICE CONCERNING COMPLAINTS

Complaints about physician, as well as other licensees and registrants of the Texas State Board of medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
1812 Centre Creek Drive, Suite 300
P.O. Box 149134
Austin, TX 78714-9134

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353

AVISO SOBRE QUEJAS

Se pueden presentar quejas acerca de medicos, asi tambien como de orras personas autorizadas y registradas por la Junta de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupunturistas, para su investigacion, en la siguiente direccion:

Texas State Board of Medical Examiners
Attention: Investigations
1812 Centre Creek Drive, Suite 300
P.O. Box 149134
Austin, TX 78714-9134

Se puede obtener ayuda para presentar una queja llamando al siguiente numero telefonico:
1-800-201-9353

TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ■ No

_____
Screener's Initials

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Provider's Name/Clinic's Name: _____ Phone Number: (_____) _____
Area Code + number

Please check the first category that applies; check only one.

(a) ■ Is enrolled in Medicaid, or

_____ _____
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

_____ _____
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(c) ☐ Is an American Indian, or

(d) ☐ Is an Alaskan Native, or

(e) ☐ Does not have health insurance (uninsured), or

(f) ☐ Is underinsured:

- ☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- ☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- ☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ■ Has private insurance that covers vaccines:

Name of Insurer: _____ Insurer Contact Number: (_____) _____
Area Code + number

Policy/Subscriber Number: _____ Group Number (if applicable): _____

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: _____ Date: _____
(mm/dd/yyyy)

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)

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.

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

Stock No. C-7
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.***

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Sign #12 and #13 only.

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)