Healing Hands PEDIATRICS

be healthy. be positive. be well.

Annie Baker, MD
Tracie Calloway, DO

PATIENT

First	Middle	Last	Nickname (if any)	Present Age	Date of Birth

Mailing Address	Social Security #	☐ Male ☐ Female	Primary Phone Number

Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined

City / State /Zip

Preferred Language: English Spanish Other

PARENT/GUARDIAN

Mother's Name	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License#	Alternate Phone	Home Work Cell
	Employer		Email Address	

Father's Name	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License #	Alternate Phone	Home Work Cell
	Employer		Email Address	

Responsible Party (if parent under 18 years of age/Foster parent/Guardian)	Relationship	Date of Birth	Primary Phone	Home Work Cell

Address (if different)	Social Security #	Driver's License #	Alternate Phone	Home Work Cell
	Employer		Email Address	

INSURANCE

Patient's Primary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone

Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient

Patient's Secondary Insurance Company	Name of Insured Party	Insured Date of Birth	Insured Phone

Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient

EMERGENCY CONTACTS

Name	Phone

SIBLINGS

Name	Date of Birth

Signature of Responsible Party Date

Update Signature Date

Update Signature Date

Update Signature Date

Update Signature Date

4503 Texas Blvd. Texarkana, Texas 75503 903-792-4003 FAX 903-794-6743

MEDICAL HISTORY

Patient's Name: _____

Primary Pharmacy: _____ City/State: _____

Medication Allergies (list medication and kinds of reactions):

_____

_____

Birth History

Birth Weight: _____ Delivered Where: _____

Any Problems: _____

Name / Ages of Siblings:

_____

_____

_____

_____

_____

A. Childhood Dieases (check all that apply)

_____ German Measles (3-day) _____ Croup

_____ Mumps _____ Ear Infections

_____ Red Measles _____ Hay Fever

_____ Roseola _____ Asthma

_____ Eczema _____ Other _____

B. Serious Illness: _____

C. Serious Injuries: _____

D. Operations (when, type): _____

E. Hospitalizations: _____

F. Tobacco (any form): _____ NO _____ YES

G. Alcohol: _____ NO _____ YES

Immunization Up to Date? _____ Some insurance companies require that we have an up to date record of all immunizations. Please provide us with a copy of the most recent record.

Patient Signature (Parent if minor): _____

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GETTING TO KNOW YOUR CHILD

Child's Name: _____ Date: _____

Child Lives with: _____

What school do they attend: _____

What grade are they currently in: _____

How is their school performance: _____ Excellent _____ Good/Average _____ Poor

What are their Extra-cirrcluar Activities: _____

_____

How much TV exposure do they get: _____ >1 hr. _____ 2-3 hrs. ____ <3 hrs.

Are there any pets in the home: _____ Yes or No List them: _____

_____ _____ Inside or Outside Pets

Does your child attend daycare: _____ ____ Facility ____Individual

FAMILY HISTORY: Please list immediate family members only.

Family Member	Status: Alive, deceased, unknown	DOB/Age	Illness: Cancer, Heart disease, asthma, etc.
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Granfather			
Siblings			

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Printed Name of Patient

_____

Patient's Date of Birth

_____

Printed Name of Parent or Guardian

_____

Signature of Patient, Parent or Guardian

_____

Relationship to Patient

_____

Date

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PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, Healing Hands Pediatrics will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a "minor" if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

_____ _____

Patient/Child Patient/Child Date of Birth

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____ _____

Name/Relationship Phone #

_____

Parent/Legal Guardian Date

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PATIENT AUTHORIZATION

Patient/Child Name _____Date of Birth_____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A".

Initials

MEDICAID ASSIGNMENT OF BENEFITS

☐ I certify that the information I gave in applying for payment of Medicaid benefit is correct. I assign Medicaid benefits payable for Healing Hands Pediatrics, PLLC services to Healing Hands Pediatrics, PLLC.

FINANCIAL RESPONSIBILITY

☐ I will honor the Healing Hands Pediatrics, PLLC 's payment policy by payment in full at the time services are rendered, unless prior arrangements have been made. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsiblef or payment for services rendered at Healing Hands Pediatrics,PLLC. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that I may be billed for out sourced services (i.e. lab, x-ray, etc.); and I may receive additional billing from another facility. I agree to pay all expenses related to collection, whether by collection agency or by an attorney.

INSURANCE RESPONSIBILITY

☐ I irrevocably assign and transfer to Healing Hands Pediatrics, PLLC all insurance benefits covering Healing Hands Pediatrics, PLLC. services for the payment of serviced rendered. I understand it is my responsibility for providing a current copy of my insurance card and to comply with all pre- certification requirements.

AUTHORIZATION FOR CARE

☐ I grant permission for Healing Hands Pediatrics, PLLC to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ I hereby authorize Healing Hands Pediatrics, PLLC to release necessary information for the following reasons: to other physicians for continuing professional care; to any insu rance company or their representatives; or otherwise as allowed by law. I release Healing Hands Pediatrics, PLLC. from any liability for the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

_____ _____

Signature of Parent/Legal Guardian Date

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PATIENT PORTAL

Purpose of this Form:

Healing Hands Pediatrics offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) the secure message must reach the **correct email address,** and
2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**
You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Immunization record. Requesting an appointment. Requesting Lab/x-ray results.

If there is information that you don't want transmitted via online communication, please indicate below.

_____

_____

☐ I do not wish to participate in the Patient Portal at this time.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____ _____

Patient Name DOB

_____

Printed Name of Parent/Guardian

_____ _____

Parent/Guardian Signature Date

_____

Email address

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Patient Name: _____

Patient Date of Birth: _____

INSURANCE INFORMATION

Insurance Plan: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: _____

******PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. The parent/guardian who is present for office visits is the Billing Guarantor, please see below.******

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Healing Hands Pediatrics, PLLC. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Healing Hands Pediatrics, PLLC.
A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Healing Hands Pediatrics, PLLC. may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

Healing Hands Pediatrics, PLLC. will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since HHP is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at HHP is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then HHP will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, HHP will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Healing Hands Pediatrics, PLLC has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child[ren], as well as any they receive in the future. HHP will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practice.**

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

_____ _____ **Sex:** ☐ **F** ☐ **M**

Billing Guarantor Name *(print)* **Date of Birth** *(mm/dd/yyyy)*

_____ (____) ____-____

Address / City / State / Zip **Primary Phone**

_____ _____ _____

Billing Guarantor Signature **Social Security #** **Todays Date** *(mm/dd/*

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self
☐ Other: _____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, 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 (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, ImmTrac2 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

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.**

Dr. Annie Baker

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Dr. Tracie Calloway

4503 Texas Blvd.

903-792-4003

Texarkana, TX 75503

903-794-6743 Fax

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Full Name: _____

Date of Birth: _____

Parents Name_____Phone #:_____Cell #_____

I authorize the release of protected health information (medical records) on my child or myself from the physician, facility or individual listed below:

Name: _____

Address: _____Phone #_____

City, State, Zip: _____

__ __ Progress Note

__ __ Lab ____ X-Ray

_____ Immunization Records

_____ Entire Medical Records

_____ Other _____

The information will be used/disclosed for the following purpose: ___Continuation of Care ___ Other

This information should be sent to: Healing Hands Pediatrics Fax #: 903-794-6743

Address: 4503 Texas Blvd

City, State, Zip: Texarkana, TX 75503

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

I understand that B Pediatrics will receive compensation for its use/disclosure of the information except when the information is requested by a parent or healthcare provider.

I understand that I may refuse to sign this authorization and that my refusal to sign will not reflect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. (Note: this item is not required if the disclosure is requested by the patient.)

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature of Patient or Representative/Relation to Patient Date

_____

Witness