# Sun City Kidz Clinic

## New Patient Registration

PRIMARY LANGUAGE SPOKEN_____ DOCTOR YOU ARE HERE TO SEE? _____

## PATIENT INFORMATION

NAME _____ DOB _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

SEX : MALE FEMALE WAS PATIENT PREMATURE? YES NO IF YES, HOW MANY WEEKS? _____

RACE (CIRCLE ONE): AFRICAN AMERICAN ASIAN NATIVE AMERICAN OR ALASKA NATIVE
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE DECLINE TO STATE

ETHNICITY (CIRCLE ONE): HISPANIC/LATINO NON-HISPANIC/NON-LATINO DECLINE TO STATE

## PARENTS(S) OR GUARDIAN(S) INFORMATION

PARENTS MARITAL STATUS? ☐ MARRIED ☐ UNMARRIED ☐ WIDOWED ☐ OTHER _____

WHO DOES PATIENT LIVE WITH? ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER _____

FIRST CONTACT'S RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER _____

NAME _____ DOB _____ SS # _____
(LAST) (FIRST)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

CHECK PREFERRED NUMBER: □HOME PHONE: (_____)_____ □CELL PHONE: (____)_____

PLACE OF EMPLOYMENT: _____ WORK PHONE: (____)_____

SECOND CONTACT'S RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ OTHER _____

NAME _____ DOB _____ SS # _____
(LAST) (FIRST)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

CHECK PREFERRED NUMBER: □HOME PHONE: (_____)_____ □CELL PHONE: (____)_____

PLACE OF EMPLOYMENT: _____ WORK PHONE: (____)_____

## INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS)

PRIMARY INSURANCE _____ POLICY HOLDER _____
POLICY HOLDER RELATIONSHIP TO PATIENT _____ DOB _____

SECONDARY INSURANCE _____ POLICY HOLDER _____
POLICY HOLDER RELATIONSHIP TO PATIENT _____ DOB _____

## EMERGENCY CONTACT

NAME #1 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

PHONE (____)_____ HOME/MOBILE/WORK PHONE (____)_____ HOME/MOBILE/WORK

NAME #2 _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____

PHONE (____)_____ HOME/MOBILE/WORK PHONE (____)_____ HOME/MOBILE/WORK

## PHARMACY INFORMATION (THIS IS WHERE ELECTRONIC SCRIPTS WILL BE SENT)

NAME OF PHARMACY _____

CROSS STREETS (EXAMPLE: MESA & BALTIMORE) _____

## SIBLING NAMES (ONLY IF REGISTERING AS PATIENTS)

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

## PARENTAL CONSENT FOR TREATMENT

I grant the physicians at Sun City Kidz Clinic permission to medically treat all children listed on this form as they deem necessary.

_____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

_____ _____

PRINT NAME DATE

## CONSENT FOR OTHERS TO BRING CHILD(REN) TO CLINIC

In accordance with Texas Law, Sun City Kidz Clinic 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 of age, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for all of the children on this form in my absence.

NAME #1 _____ RELATIONSHIP TO PATIENT _____
PHONE NUMBER (____)_____
MAY THIS INDIVIDUAL APPROVE/SIGN FOR VACCINE ADMINISTRATION? (INITIAL ONE) _____ YES _____NO

NAME #2 _____ RELATIONSHIP TO PATIENT _____
PHONE NUMBER (____)_____
MAY THIS INDIVIDUAL APPROVE/SIGN FOR VACCINE ADMINISTRATION? (INITIAL ONE) _____ YES _____NO

_____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

_____ _____

PRINT NAME DATE

# General Office Policies

- We see patients from Birth to 18 years of age.

- We will gladly see your children in the following hospitals: Providence Memorial Hospital and Las Palmas Hospital.

- **Please arrive 15 minutes before your appointment time** to allow for insurance verification and appropriate paper work.

- If you are more than 15 minutes late for your appointment, you might be asked to reschedule or be seen as a walk-in appointment. The first available appointment may or may-not be on the day the appointment was missed.

- As a courtesy please provide a 24 hour notice for cancelled appointment. **After failing to appear for three appointments without calling to cancel, we will no longer be able to see your child in this clinic.**

- Please bring your child's insurance card and shot record to every visit. If your insurance requires a co-pay it will be due at the time of service.

- To make for shorter wait times, please call to make an appointment before bringing your child to the clinic. Same day appointments for illnesses and injuries are usually available.

- Walk-in patients are offered the first available appointment.

- Appointments for additional children should be made by phone prior to coming to the office.

- For prescription refills, call during office hours. Allow at least 48 hours for any prescription refill.

- Please turn off cell phones in exam rooms. No food allowed in exam rooms.

- If you are sending your child with a grandparent or other family member please be sure you have filled out a consent form. If you have signed an advance consent to treat form, we may see your child in the event of an illness or injury when you are unable to accompany them to the office.

- Only a legal guardian may sign for immunizations, unless specific, written authorization if given to another individual to sign these consents.

- **Due to a need to protect our patients and staff, we do not accept NEW patients who choose not to be vaccinated or wish to follow an alternate vaccine schedule. _____ Initial here**

Parent Signature _____ Date _____

# Sun City Kidz Clinic, P.A. Payment Policy

## Fees for services

We would like you to know about your charges in advance. Fees for medical services are based on the cost of procedures required, the amount of professional skill involved, and the amount of time spent. Fees for professional services are determined in essentially the same manner as those of individual practicing physicians throughout Texas.

The office manager will be glad to talk with you about our fees. We will be happy to estimate your charges, although due to the nature of diagnosing medical problems, it will be difficult to be precise concerning total charges. If at any time you have questions about your charges, please let us know.

## Payment at time of service

Payment is requested on the day of your visit. If you have medical insurance, we will estimate what your personal balance for the service will be after applying your deductible and co-insurance and ask that you pay that amount. For patients without health insurance we require a minimum payment of 100% at the time of service.

## Options for payment

We accept cash, personal checks, Visa and MasterCard. However, there will be a $35.00 service fee for all returned checks.

## What if the account is not paid?

We want to be understanding and cooperative with everyone in paying their medical bill. The staff will work with you in setting up payment arrangements. Hwever, for those patients that do not fulfill their obligations after 90 days, it will be considered in everyone's best interest for those accounts to be referred to a collection agency. Once an unpaid balance is placed with a collection agency, the account must be settled through the collection agency office, not with *Sun City Kidz Clinic, P.A.* In addition, if patients have been referred to collections, all future visits will be provided on a cash only basis.

## Physician and Hospital Charges

Charges for medical care provided by our physicians while you are in the hospital are billed by *Sun City Kidz Clinic, P. A.* These charges should not be confused with charges billed by the hospital.

## A word about insurance

As a service to you, we will file insurance claims for each of your insurance policies. You will need to furnish the clinic with all the necessary information. Please bring your insurance card to every visit.

It should be understood that your insurance policy is an agreement between you and the insurance company to pay certain amounts for medical care. Your physician's bill is an agreement between you and your physician. You are responsible for full payment of your account, regardless of the status of your insurance claim.

## Acceptance of responsibility

I understand that I am financially responsible for all charges whether or not paid by said insurance company. I know that it is my responsibility to notify *Sun City Kidz Clinic, P.A.* of all changes to my account, this includes changes in insurance address, telephone numbers, emergency contacts, etc.

_____ _____

**Signature** **Date**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## Sun City Kidz Clinic, P.A.

Your signature below acknowledges that you have received a copy of the Privacy Policies and Practices Notice from the office of Sun City Kidz Clinic, P.A. This document provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Your signature also acknowledges receipt of our Payment Policy Notice as well as our General Office Policies.

Signature of Patient/Patient Representative _____ Date _____

Name of Patient/Patient Representative (Please Print) _____ Relationship to Patient _____

**OFFICE USE ONLY:**

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

□ Patient representative refused to sign

□ Emergency Situation Prevented Signature

□ Other (Please Specify) _____

Provider Representative Signature _____ Date _____

# SUN CITY KIDZ CLINIC, PA

## Your Information. Your Rights. Our Responsibilities.

### (Notice of Privacy Policies)
Effective March 2014

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.**

### Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us at the following address: Attn: HIPPA Officer 3917 N Mesa, El Paso, TX 79930 or by calling (915)544-5439.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

### Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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

# *IMMUNIZATION REGISTRY (ImmTrac2)*
# ADULT CONSENT FORM

(Please print clearly)

**Last Name**

**First Name** **Middle Name**

**Date of Birth** **Gender:** ☐ **Male** ☐ **Female**

**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 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). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

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

## 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 state's central immunization registry, ImmTrac2. 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.**

**By my signature below, I <u>GRANT</u> consent for registration. I wish to <u>INCLUDE</u> 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**

**<u>PROVIDERS REGISTERED WITH ImmTrac2</u>**: 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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