

Abilene Children's Medical Association, LLP

2150 Cedar St. Abilene, Texas 79601 | 414 Lone Star Dr Ste A, Abilene, Texas 79602

Patient Information

Name (Last) _____ (First) _____ (MI) _____
Date of Birth _____ Age _____ Sex M F
Address (Street) _____
(City,State,ZIP) _____
Relationship to Guarantor _____
Phone # _____ Guardian Email Address _____
At which hospital was this child born? _____
Mothers Full Name _____ Mothers Social Security # _____
Mothers Date of Birth _____ Mothers Maiden Name _____
Fathers Full Name _____ Fathers Date of Birth _____ Fathers Social Security # _____
Other children seen at this office _____
Which is your preferred pharmacy? _____

Responsible Party/Guardian Information

Name (Last) _____ (First) _____ (MI) _____
Address(Street) _____ (City,State,ZIP) _____
Employed? Y / N Place of Employment _____
Home Phone# _____ Cell Phone # _____ Work Phone # _____
Date of Birth _____ Social Security # _____ Marital Status _____

Emergency Contact / Person(s) authorized to bring child to appointments

Name	Relationship to Patient	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

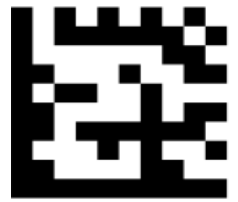
Insurance/Medicaid Information

Policy Holder _____
Relationship to Patient _____
Social Security# _____
Date of Birth _____
Insurance Name _____
Policy# _____
Group # _____

Policy Holder _____
Relationship to Patient _____
Social Security# _____
Date of Birth _____
Insurance Name _____
Policy# _____
Group # _____

I have reviewed and understand the office policies of Abilene Children's Medical Association.
I hereby assign, transfer, and set over to Abilene Children's Medical Association, LLP all of my rights, title and interest to my medical reimbursement benefits under my Private Insurance or Medicaid policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by Private Insurance or Medicaid.

Responsible Party Signature _____ Date _____



(Please print clearly)

Child's Last Name

Child's Last Name

Child's First Name

Child's First Name

Child's Middle Name

Child's Middle Name

Child's Date of Birth

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: Male Female

Child's Address

Child's Address

Apartment #

Apartment #

Telephone

Telephone

City

City

State

State

Zip Code

Zip Code

County

County

Mother's First Name

Mother's First Name

Mother's Maiden 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.

Abilene Children's Medical Association

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this offices' 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.

Signature of Patient Representative	Relationship	Date
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Name of Patient(s)

By my initials, I authorize ACMA to contact me by the designated means noted below and to leave messages regarding appointments, medical results and billing issues:

_____ Home Phone	_____ Cell Phone and Voice Mail
_____ Home Answering Machine/Voice Mail	_____ Office/Work Place Phone and Voicemail

Signature: _____ Date: _____ Effective until: _____
If not indicated, one year from date signed

I authorize ACMA to disclose private health information to the following schools/daycare programs for the purpose of continuity of care:

Childs Name	DOB	School/Day Care	Authorization Effective until (date) <small>If no date is specified, authorization valid for one year</small>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: _____ Date: _____

Authorization for Use/Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

I voluntarily consent to and authorize my healthcare provider to use or disclose my health information during the term of this authorization to the recipient(s) that I have identified below.

To / From
Doctor/Clinic Name: _____

To / From
Abilene Children's Medical Association

Address: _____

2150 Cedar St, Abilene, Texas 79601

Phone: _____ fax: _____

325-677-6067 fax: 325-677-6233

I authorize the release of my health information for the following specific purpose: _____

(Note: "at the request of the patient" is sufficient if the patient is authorizing this authorization)

I authorize the release of the following health information (check the applicable box below)

- All of my health information that the provider has in their possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- Only the following records or types of health information: _____

I understand this authorization will remain in effect:

- From the date of this authorization until the _____ day of _____, 20__
- Until the provider fulfills this request
- Until the following event occurs: _____

I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at ACMA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to ACMA at the address listed above. The revocation will be effective immediately upon my healthcare providers' receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it received my written notice of revocation.

Signature

Date

Signature of Witness

If individual is unable to sign this authorization, please complete the information below:

Name of Guardian/Representative

Legal Relationship

Date

Signature of Witness

NOTE: This authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act

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(325) 677-6067

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(325) 793-9973

Paige LeMasters, M.D., F.A.A.P.

Kelly Palmere, M.D., F.A.A.P.

Tushar M. Shah, M.D., F.A.A.P.

Rachel Anderson, M.D., F.A.A.P.

ACMA Vaccine Policy Statement

As professional healthcare providers specializing in pediatrics, we are committed to protecting the health and well-being of your children and our community. Providing routine childhood immunizations is essential in achieving that goal. Vaccines are one of the most helpful interventions in the history of modern medicine.

- Vaccines are safe and effective in preventing serious illness and saving lives. If this were not the case, we would not recommend vaccines for our patients, including our own children.
- All children and young adults should receive ALL of the recommended vaccines according to the schedule published by the Center for Disease Control (CDC) and the American Academy of Pediatrics. This schedule is the only scheduled that has been studied for safety and efficacy.
- Based upon all available literature, evidence and current studies, vaccines do NOT cause autism or other developmental disabilities.
- Vaccinating children and young adults may be the single most important intervention we use as healthcare providers, and that you can use as parents. The recommended vaccines and schedule are the results of years of scientific study and data gathering on millions of children by thousands of the world's leading scientists and physicians.
- We are aware that there has been controversy surrounding vaccination. We ask that you keep in mind that because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chicken pox. You quite possibly have never known a friend or family member whose child died of one of these diseases. That success can make us complacent or even question the need for vaccinating our children, but such an attitude may lead to tragic, preventable deaths, or devastating brain injury.
- We therefore emphasize the importance of vaccinating your child. We recognize that the choice may be emotional for you. We will do everything we can to show you that vaccinating is the right thing to do. Please feel free to discuss your concerns with your healthcare provider.
- **Lastly, if you choose to not vaccinate your children according to the CDC and AAP guidelines, we will ask you to find another healthcare provider who shares your views. Please be aware that by not vaccinating, you are putting your child and other children (such as those with compromised immune systems) at unnecessary risk for life-threatening illness, disability and death.**

I acknowledge receipt of the ACMA vaccine policy statement, and understand that I will be asked to find another healthcare provider for my child/children if I choose to not comply with this policy.

Date _____

Guarantor Name (please print) _____

Name(s) of Children _____

Guarantor Signature _____

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Understanding Your Visit and Insurance Billing

SICK VISIT This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (headaches, allergies, asthma, etc.).

WELL VISIT This is an office visit for a routine physical exam and to assess and monitor your child's overall health and development.

SICK/WELL VISIT This is a combination visit of a well visit exam where an acute or chronic issue is also addressed. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a combination visit and must be billed differently than just a well visit or just a sick visit.

WHY IT IS BILLED DIFFERENTLY It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals and/or prescription medications). It involves additional documentation as well. **Physicians are required to document any and all issues addressed and include that documentation when filing claims with your insurance company.**

HOW THIS AFFECTS ME Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay a copay for these visits, even if your insurance does not require a copay for well visits alone.

Well visits target preventive care and are billed as such. **Medication refills and/or other ailments, injuries, or illnesses addressed during a well visit are billed IN ADDITION to the annual physical.** These charges may be determined by your insurance to be the patient's responsibility. Also, some in office procedures may be applied to your deductible, according to your specific coverage. Please contact your insurance company to confirm your coverage for all types of doctor visits.

We realize this can be confusing, and if you have any questions or concerns after reviewing this material, please ask or contact our billing office at 670-5705.

Patient(s) Name and DOB

Responsible Party Name and Signature

Date

Please let us know if you would like a copy for your records