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_____

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.**

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

_____

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) If no date is specified, authorization valid for one year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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	To / From
Doctor/Clinic Name: _____	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)

- o 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.
- o Only the following records or types of health information: _____

I understand this authorization will remain in effect:

- o From the date of this authorization until the _____ day of _____, 20___
- o Until the provider fulfills this request
- o 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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2150 Cedar St.
Abilene, TX 79601
(325) 677-6067

414-A Lone Star Dr.
Abilene, TX 79602
(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