Please Continue to the other side:

TRINITY PEDIATRICS / GALAXY PEDIATRICS

Guardian Last Name: _____ First Name:_____M.I.____ Date of Birth: _____ Gender (M/F)_____
Address: _____City: _____
State: _____ Zip Code: _____
Phone:_____
Driver License /ID #:_____ Employment:_____
Occupation:_____ Work Ph: _____

I _____(guardian signature) authorize the following person/s to bring _____ (Child's name) to Trinity Pediatrics / Galaxy Pediatrics for patient care.

Full Name: _____ Relation to Pt.:_____

Full Name: _____ Relation to Pt.:_____

Full Name: _____ Relation to Pt.:_____

(Authorized person must present photo identification at check in)

Emergency Contact:

Name: _____Ph: _____ Relation _____

TRINITY PEDIATRICS / GALAXY PEDIATRICS

6105 Windcom Court , Suite #100
Plano , Texas 75093
Ph: 972-473-9063 Fax: 972-473-9059

556 Bluebird Lane
Red Oak , Texas 75154
Ph: 972-617-6660 Fax: 469-218-0070

*Date:*_____ ***Referred by:*** _____

Patient Last Name: _____ *First Name:*_____*M.I.*____
Date of Birth: _____ *Gender (M/F)*_____
Address: _____*City:* _____
State: _____ *Zip Code:* _____ *Phone:*_____

Mother Last Name: _____ *First Name:*_____*M.I.*____
Date of Birth: _____ *Gender (M/F)*_____
Address: _____*City:* _____
State: _____ *Zip Code:* _____ *Phone:*_____
*Driver License /ID #:*_____ *Employer:*_____
*Occupation:*_____ *Work Ph:* _____

Father Last Name: _____ *First Name:*_____*M.I.*_____
Date of Birth: _____ *Gender (M/F)*_____
Address: _____*City:* _____
State: _____ *Zip Code:* _____ *Phone:*_____
*Driver License /ID #:*_____ *Employment:*_____
*Occupation:*_____ *Work Ph:* _____

Are both parents Legal Guardians? _____ *If not , Name of Legal Guardian*

_____

(If Legal Guardian of Child is someone other than parent ,please provide a court ordered legal document)

TRIN ITY PEDIATRICS, P.A.
6105 WINDCOM COURT, # 100 PLANO, TX 75093 PHONE: 972-473-9063 FAX: 972-473-9059

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA,) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may ne involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

******

AVISO DE RECONOCIMIENTO DE LAS PRÁCTICAS DE PRIVACIDAD

Entiendo que según la ley de portabilidad y rendición de cuentas de seguro médico de 1996 (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi protegida información médica. Entiendo que esta información puede y será usado para:

- Planificar y dirigir el tratamiento y seguimiento entre todos los proveedores médicos y/o organizaciones dde salud que puedan estar envueltos en el tratamiento médico, directa o indirectamente.
-Obtener el pago por servicios médicos prestados.
-Realizar las operaciones normales de la salud tales como evaluaciones de calidad y certificaciones para los médicos y esta organización.

He recibido, leído y entiendo su aviso de privacidad que contiene una descripción más completa de los usos y revelaciones de mi información de salud. Entiendo que esta organización tiene el derecho de cambiar este aviso de prácticas de privacidad de vez en cuando y que puedo contactar esta organización en cualquier momento a la dirección anterior para obtener una copia actualizada del aviso de prácticas de privacidad. Entiendo que puedo pedir por escrito que se restrinja el cómo mi información privada es usada o divulgada para llevar a cabo operaciones de tratamiento, pago o cuidado de la salud. También entiendo no es requisto que esta organizacion acepte dichas restricciones, pero en caso de aceptarlas, está obligada a regirse por ellas.

Patient's Name (Nombre del Paciente) _____

Name of Parent or Guardian (Nombre Padre, madre o encargado) _____

Signature Parent or Guardian (Firma padre, madre o encargado) _____

Date (fecha) _____

TRINITY PEDIATRICS, P.A./ GALAXY PEDIATRICS
6105 Windcom Court # 100 Plano, TX 75093 / 556 Bluebird Lane. Redoak, Tx 75154
Phone: 972-473-9063 Fax: 972-473-9059 Phone: 972-617-6660 Fax 469-218-0070

FINANCIAL POLICY

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relation ship. Everyone is treated equally and fairly.

INSURANCE: Payment for services are due at the same time services are rendered, except as outlined below. "Payment" means deductibles, co-insurance and co-pays for participating insurance companies. We accept cash, checks, Master Card, Visa, Discover and American Express. Outstanding balances are due within 30 days, unless prior arrangements have been made with our billing department. **All personal balances over 90 days will be sent to a collection agency.** Even though we verify coverage, insurance plan vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to know your insurance policy benefits. NOT EMERGENT APPOINTMENTS, i.e. physicals, well child checks, etc. will have to be rescheduled if there are outstanding balances or co-pay is not paid at the same time of service. If you are experiencing financial difficulty, please let us know.

BILLING: We can provide you with an itemized statement each time your child receives services. A $ 10.00 rebilling fee will be charged to you if payment is not made at the time services or if you do not furnish us with correct insurance information.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of you account. Charges remaining unpaid ninety (90) days after the date of service are considered delinquent and will be sent to a collection agency.

IF WE DO PARTICIPATE WITH YOU INSURANCE COMPANY, all services performed in our office and at the hospital will be submitted to your insurance. Do not file your own claim, by contract, we have to do it. All co-pays are due at time of service. Deductibles and co-insurance are your responsibility and will be billed to you by our office as instructed by your insurance's explanation of benefits. Therefore, any balances

not covered by insurance and allowed by contract become the responsibility of the patient. Again, payment for services is due at the time of services.

MISSED APPOINTMENTS / LATE CANCELATIONS: Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a $35.00 fee for late, cancelled or missed appointments. Cancellations are requested 24 hours prior to the appointment.

FORMS AND FEES: There is a $ 30.00 fee for the review and completion of school/day care forms.. Please, complete all demographics and medical history portion before giving the form to our staff.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTANS THE FINANCIAL POLICY SET FORTH BY TRINITY PEDIATRICS, P.A. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTIONS IN ADDITION TH THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO ME.

Signature of Parent and/or Responsible Person: _____

Date: _____ Witness: _____

TRINITY PEDIATRICS

Family & Patient's Past History

Patient's Name _____ Date of Birth _____

Health problems of Patient's parents: _____

_____

Health Problems of Patient's siblings: _____

_____

Use this list below to identify any illnesses that run in the family or that are in the past history of the patient. Feel free to add any other illnesses not included in the list.

Condition	**No**	If yes for ***FAMILIY MEMBER,*** identify relationship.	If yes for **PATIENT**, indicate age when diagnosed or appearance of first symptoms.
Allergies			
Anemia			
Asthma, Emphysema			
Birth Defects			
Blood Disease			
Bone / Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Chicken Pox Disease			
Diabetes ( ) Adult / ( ) Juvenile			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Hearth Disease			
High Blood Pressure			
Hyperactivity			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Never Disorder (Epilepsy, C.P.)			
Obesity			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			

Complete and explain when applicable FOR THE PATIENT ONLY

Hospitalizations or surgeries?_____

Any adverse reaction to medications?_____

Any adverse reaction to immunizations?_____

Does your child hear/see well?_____

Does your child seem to be developing normally?_____

Is your child's speech understandable most of the time?

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

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.
☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ Signature _____ Date _____

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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2.** **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

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