Patient Information

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:____ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

How did you find out about Pediatric Associates of Wylie, P.A.? ____

Primary Guarantor Information & Insurance

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:____ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: ________________________________

Employment Status:____________________ Employer: ____

Phone: ______________________ Work: ________________________ Mobile: _________________________________

Email: ____

Insurance Company:____

Insurance Company Address:___________________________________ City: ____________ State: _____ Zip: ________

Subscribers I.D. #: ____ Group #: ______________________________

Insurance Company Phone Number: __________________________________

(Please provide your ID card with this information)

Parent / Guardian Information

Parent / Guardian #1: (If different than Guarantor Information)

Relationship to Patient: ________________________________

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:____ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: ________________________________

Employment Status:____________________ Employer: ____

Phone: ______________________ Work: ________________________ Mobile: _________________________________

Email: ____

Parent / Guardian #2: (If different than Guarantor Information)

Relationship to Patient: ________________________________

Name: ________________________Middle:_________________Last:____________________________Suffix:__________

Address:____ City:_________________ State:__________ Zip:______________

SSN: ______-_____-_________ Sex: M / F DOB:_____/_____/_____

Marital Status: _____________________ Relationship to Patient: ________________________________

Employment Status:____________________ Employer: ____

Phone: ______________________ Work: ________________________ Mobile: _________________________________

Email: ____

Emergency Contact

Name: __________________________Middle:__________________Last:______________________________Suffix:___________

Address:____ City:__________________ State:___________ Zip:_______________

Is above Emergency contact a Parent / Guardian? Yes / No Sex: M / F

Phone: ________________________ Work: ___________________________ Mobile: ____________________________________

Email: ____

Assignment and Release

I hereby authorize payment directly to Dr. Nicole L. Lanman, Pediatric Associates of Wylie, P.A. of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: ____ Date: ______________________

Authorized Consent: Please list all persons authorized to bring your child to their appointments:

1st Authorized Agent: _________________________________ Relation: ______________________________

2nd Authorized Agent: _________________________________ Relation: ______________________________

3rd Authorized Agent: _________________________________ Relation: ______________________________

4th Authorized Agent: _________________________________ Relation: ______________________________

I authorize Pediatric Associates of Wylie, P.A. to perform the necessary medical services for my child.

Parent/Guardian: ____ Date: ____________________

Date: ___________

Initial Patient History

Patient name: _______________________________ Patient D.O.B. ___________
Male ______ Female _______
Parents/Guardians name: ____
With whom does the patient live? ____

Name of Sibling	**Age**

Birth History

Pregnancy complications, if any: ____
Did mother smoke, use drugs, or alcohol? ☐ Yes ☐ No
Birth Weight __________ Length at Birth ___________ ☐ Term ☐Preterm ________
☐ Vaginal delivery ☐ C-section Delivery Complications, if any: __________________
Problems with baby after birth, if any: ____
____

Family History

Allergies/Asthma		Ear infections/tubes	
Eczema		Seizure disorder	
High Cholesterol		Learning/attention problems	
High Blood Pressure		Depression/Anxiety	
Heart disease/ Stroke		Drug/Alcohol abuse	
Cancer		Mental Retardation	
Anemia/ Bleeding disorder		Hearing loss/ deafness	
Diabetes		Vision loss	
Thyroid problems		Kidney disorder	
Gastrointestinal disorder		HIV/Hepatitis/ Tuberculosis	

(See Reverse Side)

Past Medical History

Drug allergies? ☐ No ☐ Yes (medication & reaction)______________________________

Surgery/Reason for Hospitalization	Date

Has your child ever had chickenpox? Approximate date: ________________

Current medication	Dosage	Prescribed By

Review of Systems

Does the patient have or has ever had any of the following:

Allergies, Asthma or Respiratory Problems	
Eye, Ear, Nose or Throat Problems	
Heart Murmur or Heart Problems	
Anemia or Bleeding problems	
Abdominal Pain, Constipation, Vomiting or Diarrhea	
Bladder or Kidney Problems	
Skin Rashes or Problems (acne, eczema, etc.)	
Headaches, Seizures, ADHD	
Diabetes or Thyroid Problems	
Fever, Decreased Activity, Poor Appetite	
Behavior or Attention Problems	
Other Problems	

Pediatric Associates of Wylie P.A.

Lovejoy Pediatrics

Consent for Use and Disclosure of Protected Health Information

Our practice reserves the right to modify the privacy practices outlined in the notice:

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 your Notice of Privacy Practices (NPP). I understand and agree to the following:

Pediatric Associates of Wylie, P.A. may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations as described in our Notice of Privacy Practices (NPP).

Pediatric Associates of Wylie, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

Pediatric Associates of Wylie, P.A. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards, and patient statements.

Pediatric Associates of Wylie, P.A. may email any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

I have the right to restrict how my child's PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that Pediatric Associates of Wylie, P.A. reserves the right to refuse requested restrictions.

This agreement will remain in effect without expiration unless I revoke my consent. I may revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent Pediatric Associates of Wylie, P.A. will continue to provide treatment to my child.

Your Name (Last, First) | Your Relationship to the Patient

Patient Name (Last, First) | Patient Date of Birth (MM/DD/YYYY) / /

Signature of Patient

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

/ /
Today's Date (MM/DD/YYYY)

For Clinic Use Only:	
Date attempt was made to obtain signature (MM/DD/YYYY)	Reason signature was not obtained
Patient Name (Last, First)	Printed name of employee making attempt
Employee signature	Today's Date (MM/DD/YYYY)

501 Woodbridge Pkwy, Wylie, TX 75098 – 2730 Country Club, Suite B, Lucas, TX 75002
(972) 442-2300 – (972) 442-2180 Fax

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Authorization for Release of Medical Information

____
Physician/Facility Name

______________________ ______________ ______ _______
Address City State Zip

______________________ ______________________
Phone Number Fax Number

I hereby authorize the above stated physician/facility to release the following information:

- ☐ **Complete Medical Record**
- ☐ **Other, please specify:** ______________________________________

____

TO:

Pediatric Associates of Wylie, P.A.
501 Woodbridge Parkway
Wylie, TX 75098
972-442-2300 Fax: 972-442-2180

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS OR HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____________ **Date:**_____________

Release records regarding:

______________________________ ______________
Patient Name DOB: MM/DD/YYYY

______________________ ______________ ______ _______
Address City State Zip

______________________ ______________ ______ _______
Parent/Legal Guardian Relationship to Patient Cell Phone Work #

______________________________ ______________
Signature of Parent/Legal guardian Date

Acknowledgement of Understanding

This Authorization will expire 90 days after the date identified above. I understand that I may revoke this authorization at any time in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that the physician/facility you have requested records from has 15 days by law to send us the records.

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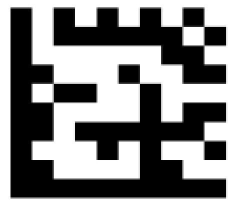
IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(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.**

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Office Policies

Welcome to Pediatric Associates of Wylie! Here are a few of our "rules" that we would like for you to be aware of to facilitate a good relationship between you and your pediatrician:

Office Hours: Our office hours are 8:30 a.m. to 5:00 p.m. Monday through Thursday and 8:30 a.m. to 4:00 p.m. on Fridays.

Appointments: Patients are seen **by appointment only**. Each child needing examination by the doctor should have an individual appointment.

In general, well examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. In addition, well examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the well examination, but can see your child for his/her illness during the scheduled appointment. This also applies to other conditions that require a significant amount of time for the physician to effectively manage the condition (i.e., asthma, ADHD).

We will attempt to contact you 1-2 business days prior to your appointment as a reminder. If we are unable to reach you, it is still your responsibility to keep the appointment.

Absences from school will only be excused by our office if your child has been seen in the office for the illness.

Walk Ins and Late Arrivals: Rescheduling will be necessary if you are more than 10 minutes late for your appointment. We will try to work you in if time allows. There will be a $25 fee for missed appointments. We will send one warning letter after the initial missed appointment before assessing any fees. In addition, any cancellation or reschedule for well visits made within 24 hours or less of the scheduled appointment will be charged a $25 fee. A warning letter will be sent prior to assessing any fee.

Fees, Insurance and Health Plans: A Parent/Guardian must notify the office of changes in address, telephone number or insurance. You must bring your insurance cards to every visit. The person who brings the child to the office will be expected to pay at the time of service.

You will be responsible for payment of charges from services rendered if we are unable to verify benefits with your insurance company. Insurance companies require collection of your co-pay or contracted percentage of services at **every** visit. If you have a deductible that has not yet been met, you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always question your insurance company regarding your benefits first if you have any questions about covered services or bills.

Balances are due at time of appointment. Financial arrangements will be required for balances greater than 60 days outstanding and prior to appointment.

We accept cash, checks, Visa, MasterCard, American Express and Discover.

There is a $25 fee for returned checks.

Medical Records: Medical records can be faxed to another physician's office free of charge upon release of the medical record. Patient copies of the medical record can be obtained for a fee. Copies of the medical record will be provided within 2 business days with a prepayment.

Medication Refills: Patients on medication for ADHD will be seen for medication check-ups every 3 months. Refills for ADHD medications will be provided only if these appointments are kept. Parents/Guardians may call the nurse to request a refill for ADHD medications. These prescriptions will be available for pick-up 48 hrs after the request has been made during our regular business hours. Controlled substance medications (ADHD medications) must be picked up by a parent/guardian and filled within 21days of the date the prescription was written. In the event, the prescription is not picked up and filled, a $15.00 charge will be applied for rewrites.

Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies), as long as the patient is established and has been seen for the condition within the past 6 months. Refills will not be provided after hours or on the weekends. Please allow 48 hrs for these refills to be completed.

Any prescription refills needed prior to our office policy of 48 hours, will be assessed a $15 fee.

Telephone Calls: Our nurses/medical assistants are always available during business hours to serve your needs. You can ask to leave a message with any questions that you may have. All messages received prior to 3:00 p.m. will be returned on that business day; however, depending on the daily schedule, these calls may not be returned until the end of the day, and they will be returned in order of urgency. Calls received after 3:00 p.m. will be returned the next business day. If you feel your child needs to be seen you should speak with someone in the front office to schedule an appointment, as the schedule fills quickly.

In general, antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen.

In case of an emergency, call 911 or take your child to the nearest hospital emergency room.

After Hours Services: After-hours contact with the nurse/physician is intended for urgent medical problems only. Questions about appointments, billing, referrals, refills, or other issues of a non-urgent nature should be placed during normal business hours. There is a $20 service fee for after-hour services.

Violation of office policies may result in dismissal from the practice.

By signing below you acknowledge that you have read and understand the office policies.
Signed: ____ Date: ___________________
Signature of Parent/Guardian

Revised 10/1/2021