EDINBURG CHILDREN'S CLINIC

PATIENT INFORMATION FORM

TODAY'S DATE_____ APPOINTMENT TIME_____

PATIENT PROFILE

PATIENT NAME_____ DOB_____ LANGUAGE PREF: _____

SEX: __M __F PATIENT SS #_____ RACE: _____ETHNICITY_____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

ADRESS_____CITY_____STATE_____ZIP_____

PARENT INFORMATION

MOTHER NAME: _____ DOB: _____ SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

FATHER NAME: _____ DOB: _____ SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURANCE INFORMATION

INSURED NAME_____DOB_____ SS #_____

RELATIONSHIP_____

INSURANCE _____ POLICY#_____ GROUP#_____

EMERGENCY CONTACT

NAME_____ TELEPHONE NUMBER_____

RELATIONSHIP_____

REFERRAL INFORMATION

REFERRED BY_____ PREVIOUS PHYSICIAN_____

Medical records requested from previous physician_____ If yes, date requested_____

I authorize the release of any medical or other information necessary to process a claim. I permit that a copy of this authorization be used in the place of the original. I authorize payment of medical benefits to this practice on my childs behalf for covered services rendered. I request that payment be made directly to this practice.

SIGNATURE:_____ DATE:_____

Notice of Privacy Practice Policy (HIPAA)

Patient Name: _____ DOB: _____

Patient Address:

Street/P O Box _____

City, State, and Zip Code: _____

PLEASE CHECK OR RESTRICT ALL THAT APPLY:

Telephone Numbers:

Home: _____
Work: _____
Cell: _____
Fax: _____
Other: _____

_____ _____
Signature: Parent/Legal Guardian Date

PLEASE LIST ALL PEOPLE ALLOWED TO BRING IN YOUR CHILD FOR APPOINTMENTS AND MEDICAL TREATMENTS:

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

_____ _____
Signature: Parent/Legal Guardian Date

PLEASE LIST IF YOU AUTHORIZE OFFICE TO SEND YOU ELECTRONIC INFORMATION AT YOUR REQUEST: Ex: copy of labs, visits, statements, excuses, receipts.

Email: _____ Text: _____ Fax: _____

_____ _____
Signature: Parent/Legal Guardian Date

CONSENT FOR TREATMENT

Written Acknowledgement of Receipt of Edinburg Children's Clinic Integrated Delivery System Notice of Privacy Practices

_____
(Please initial)

I acknowledge receiving Edinburg Children's Clinic Integrated Delivery System (ECC IDS) Notice of Privacy Practices (The Notice). The Notice explains how ECC IDS may use and disclose your protected health information for treatment, payment and healthcare operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

If you have questions about the Notice, Please contact the ECC IDS Privacy Office. You may find their contact information located in the Notice.

General Consent to Treat

_____
(Please initial)

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.
I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Dr. Livania Zavala-Spinetti MD PA and her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____
(Please initial)

In agreement with federal and state law, I agree to allow Edinburg Children's Clinic to deliver the necessary care to this child in order to provide continuity of care and treatment. Edinburg Children's Clinic and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard t o disclosures that have already been made in reliance on such consent.

_____
(Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Electronic Prescriptions (E-Prescribing)

_____
(Please initial)

I voluntarily authorize Edinburg Children's Clinic to allow E-Prescribing for the patient's mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

Name of Patient _____ Patient's Date of Birth _____

Printed Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____ Date_____

INITIAL HISTORY QUESTIONAIRE

_____ _____ _____
NAME DOB AGE

BIRTH HISTORY

Birth Weight: _____ was the baby born at term? _____ Early? ____ Late? ____
During the pregnancy did the mother Smoke □Yes □ No Drink Alcohol □ Yes □ No
Use drugs or medications □ Yes □ No What _____ When _____
Was initial feeding □ Breast? □ Bottle?
Did the baby leave the hospital with the mother? □ Yes □ No

GENERAL

Do you consider your child to be in good health? □ Yes □ No _____
Does your child have any serious or medical condition? □ Yes □ No _____
Has your child had any surgery? □ Yes □ No _____
Has your child ever been hospitalized? □ Yes □ No _____
Is your child allergic to medicines or drugs? □ Yes □ No _____
Are you concerned about your child's physical development? □ Yes □ No _____

Family History

Nasal Allergies □ Yes □ No Who: _____
Asthma □ Yes □ No Who: _____
Tuberculosis □ Yes □ No Who: _____
Heart Disease □ Yes □ No Who: _____
High Blood Pressure □ Yes □ No Who: _____
Anemia □ Yes □ No Who: _____
Bleeding Disorder □ Yes □ No Who: _____
Liver Disease □ Yes □ No Who: _____
Immune problems, HIV, or AIDS □ Yes □ No Who: _____

PAST HISTORY

Does your child have, or has he/she ever had

Nasal Allergies □ Yes □ No When: _____
Problems with eyes or Vision □ Yes □ No When: _____
Asthma, bronchitis, bronchiolitis, or pneumonia □ Yes □ No When: _____
Any heart problem or heart murmur □ Yes □ No When: _____
Anemia or bleeding problem □ Yes □ No When: _____
Blood Transfusion □ Yes □ No When: _____
Frequent abdominal pain □ Yes □ No When: _____
Constipation requiring doctor visits □ Yes □ No When: _____
Frequent Headaches □ Yes □ No When: _____
Convulsions or other neurologic problem □ Yes □ No When: _____
Diabetes □ Yes □ No When: _____
Thyroid or other endocrine problem □ Yes □ No When: _____
Any other significant problem □ Yes □ No When: _____

TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Please check the first category that applies; check only one.

(a) ☐ Is enrolled in Medicaid, or

_____ _____
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is an American Indian, or

(c) ☐ Is an Alaskan Native, or

(d) ☐ Does not have health insurance (uninsured), or

(e) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP) and is being seen at a facility that bills CHIP, or

_____ _____
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(f) ☐ Is underinsured:

- ☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- ☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- ☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: _____ Insurer Contact Number: (_____) _____
Area Code + number

Policy/Subscriber Number: _____ Group Number (if applicable): _____

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: _____ Date: _____
(mm/dd/yyyy)

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Clinic Use Only

I certify any services for CHIP members will be billed to CHIP; ☐ Yes ☐ No

TVFC Eligible: ☐ **Yes** ☐ **No**

Screener's Initials: _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / ***Children under 18 years only.***

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac 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.state.tx.us 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 ImmTrac 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 • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.* ***DO NOT fax to ImmTrac. Retain this form in your client's record.***

PATIENT FINANCIAL POLICY SHEET September 2015

WE at Edinburg Children's Clinic (ECC) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your Edinburg Children's Clinic financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and ECC with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS:

Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.
For all services rendered to a minor patient, we look to the adult accompanying the patient and the parent or guardian with custody for payment.

NEWBORN PATIENTS:

All newborn patients have until they are 30 days old to present insurance information. If no insurance is presented at the end of 30 days the parent or legal guardian of the minor will be responsible for all acquired charges until that date.

REGARDING DIVORCE:

Edinburg Children's Clinic does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE:

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do _____ do not _____ currently have Medicaid or Any Managed Care Insurance (Please Initial Response)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)

Each time you make an appointment with Edinburg Children's Clinic, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan.
Please plan to show your current card at each visit.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call Edinburg Children's Clinic in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to Edinburg Children's Clinic. Any changes in this authorization must be received in writing within 30 days of the effective date.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to the release of any and all medical information, including laboratory test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature: _____ Date: _____

Print Name: _____ Guarantor Date of Birth: _____

Relationship to Patient: _____

PATIENT(S) NAME: _____ Date of Birth: _____

EDINBURG CHILDREN'S CLINIC

Records Released From

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, ZIP _____

Patient Contact Information

Name of Patient _____ Date of Birth _____

Dates of Service _____ Phone _____

Reports to be Disclosed

Please indicate those reports that you would like to be disclosed.

History and Physical Exam	_____	Growth Chart	_____
Consultation Reports	_____	Operative Reports	_____
Progress Notes	_____	Billing Claims Forms	_____
Radiology Reports	_____	All Medical Notes	_____
Laboratory Reports	_____	Immunization Record	_____
Pathology Reports	_____		

Authorization

I authorize the third party named in the above section to disclose the protected health information about my child (or the patient) as described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration _____
- I may revoke this authorization at any time by notifying Edinburg Children's Clinic in writing. If I revoke the authorization, I understand that it will have no affect on actions Edinburg Children's Clinic took in good faith before receiving the revocation.
- Edinburg Children's Clinic may not condition treatment or payment on my completion of this form.
- Edinburg Children's Clinic reserves the right to verify my identity or guardianship.

Signature _____ Date _____

Printed Name _____ Relationship to Patient_____

Send Records To:

Edinburg Children's Clinic
4709 South Jackson Rd
Edinburg, TX 78539
Phone: (956) 682-4500 Fax: (956) 682-4505

Employee Requesting Record: _____

PATIENT PORTAL AGREEMENT

Edinburg Children's Clinic provides this site in partnership with e-MDs for the exclusive use of its established patients. This patient portal is designed to enhance patient-physician communication. ALL users must be established patients with Edinburg Children's Clinic.

At Edinburg Children's Clinic we strive to keep ALL information in your records correct, complete and up to date. If you identify any discrepancies on your record, you AGREE to notify us IMMEDIATELY. Additionally, by using the patient portal, you as the user, agree to provide us with factual and correct information.

The information on the patient portal is maintained by Edinburg Children's Clinic at its current physical address of 4709 S Jackson Rd, Edinburg, TX 78539. For questions about this site, contact Lizbeth Miranda at (956) 682-4500 or by email at edinburgclinic@aol.com.

The Patient Portal Provides the Following Services:

- Patient May Schedule Own Appointments/Cancel (with Miss Ariana de la Garza only)
- Appointment Wait List (Dr Zavala)
- Medication Refill Request
- Communication of Laboratory Results from Staff to Patient
- Review of Patient's Medical Summary, Medication List, Treatment History, and Visit Dates
- Limited Communication of Current (on-going) Treatment with OFFICE (medical assistants, front staff and Mrs. Hernandez)

The Patient Portal is NOT Indented for Following Services:

- Provide Internet Based Triage and Treatment Request. Diagnosis and Treatment can only be made after the patient is physically SEEN in person by the physician.
- No Emergent Communication or Services. Any emergency conditions should be SEEN by Urgent Care, Emergency Department, or 911.
- No Request for Antibiotics.
- No Refill of Medications if Patient has NOT been seen in the last 30 days.
- No Personal Conversations with Staff or Profanity will be Tolerated

The patient portal is provided as a courtesy to our valued patients. While some offices charge for this service on an annual basis, we are focused on providing the highest level of service and health care. However if abuse or negligent usage of patient portal persists we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

The patient portal is provided in partnership with e-MD's our EHR software vendor and provider. The data is stored at Edinburg Children's Clinic. The data is on HIPPA compliant VPN with high level encryption that exceeds the HIPPA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Edinburg Children's Clinic undergoes rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPPA policy for information on how private health information (PHI) is used at Edinburg Children's Clinic. All new and established patients have signed a HIPPA Agreement Form and have been given a copy of our HIPPA policy. If you do not recall having signed a HIPPA Agreement Form or need to reacquaint with our HIPPA policy, a print copy will be provided for you to review.

Once you have signed the PATIENT PORTAL CONSENT AGREEMENT and have provided Edinburg Children's Clinic with a legitimate email address that is secure, you will be given a system generated unique User Identification.

1. Directly by going to this URL: https:www.gotomyclinic.com/ecc/
2. Edinburg Children's Clinic website: http://www.edinburgchildrensclinic.com/

Upon acceptance by our patient portal system, on the email reply, it will contain your unique user id and password along with PDF Patient User's Guide. While patient portal is user friendly, limited technical support questions can be directed to edinburgclinic@aol.com.

If you have reasons to believe that breach of HIPPA exists with the patient portal and Edinburg Children's Clinic has not satisfactorily remedied the situation, you may file a complaint to the Texas Medical Board at:

Texas Medical Board #
Investigations Department, MC263 #
P.O. Box 2018 #
Austin, TX 787682018 #
For additional information, please visit #
http://www.tmb.state.tx.us or call #
(512) 305-7100

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of the patient portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Edinburg Children's Clinic should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

_____	_____	_____
Parent/Guarantor Signature	Print Name	Date

EMAIL ADDRESS: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____