

# PATIENT INFORMATION FORM

TODAY'S DATE \_\_\_\_\_ APPOINTMENT TIME \_\_\_\_\_

## PATIENT PROFILE

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

SEX:    M    F PATIENT SS # \_\_\_\_\_ RACE: \_\_\_\_\_ ETHNICITY \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## PARENT INFORMATION

MOTHER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

FATHER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

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 child's behalf for covered services rendered. I request that payment be made directly to this practice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# INITIAL HISTORY QUESTIONNAIRE

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: \_\_\_\_\_



**DR. LIVANIA ZAVALA MD, PA FAAP**  
**4709 SOUTH JACKSON**  
**EDINBURG, TX 78539**

# Consent for Medical Treatment

I, \_\_\_\_\_ do hereby grant consent for medical treatment only when accompanied by a parent(s), legal guardian, unless otherwise authorized in writing and brought at the time of service.

I allow that my child/children have LABS, PROCEDURES, IMMUNIZATION VACCINES, AND INJECTABLES, done in the office.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Signature: Parent/Legal Guardian

\_\_\_\_\_  
Date



# 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: \_\_\_\_\_





# PATIENT FINANCIAL POLICY SHEET

September 2013

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: \_\_\_\_\_**



### 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](mailto:edinburgclinic@aol.com).

## **The Patient Portal Provides the Following Services:**

- Patient May Schedule Own Appointments/Cancel (with Mrs. Hernandez 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.

