Northeast Office:
10755 Kenworthy Street
El Paso, Texas 79924

Eastside Office:
3660 Joe Battle Blvd., Ste. 8
El Paso, Texas 79938

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Phone 915-821-5900 • Fax 915-821-5902

PATIENT REGISTRATION FORM

Patient Name: ________________________________ Sex: M OR F Birthdate: ____-____-_____
(As it appears on the insurance card)

Cell Phone: (___) ____-_____ Home Phone: (____) ____-_____

Parent or Legal Guardian Name: ________________________ Birthdate: _____-____-_____

Address: ____
(Parent or Legal Guardian Info.) City ST. ZIP CODE

SSN: ____-___-______ Relationship to patient: ________________ Home Phone: (____) ____-______
(Parent or Legal Guardian)

Email: ____

Medicaid Insurance

Insurance Name: ______________ ID#:________________ ID# is for: ___ Mom ___Child

Name on Medicaid card ***if it is not*** the childs: ______________________ Birthdate _____/___/_____
(as it appears on the insurance card)

SSN: ____-___-______ **(responsible parent/guardian #)**

(If the patient is covered by any other Medical insurance you must fill out the information below.)

Other Medical Insurance

Insurance Name: ____________________ ID#: ________________________ Group #: __________

Insurance Phone: (____) __________ **Policy holder's (name on card):** _______________________
(as it appears on the insurance card)

Birthdate: ____-____-____ SSN: ____-___-______ Home Phone: (____) _________ Cell:(___)__________
(Policy Holder Info)

Policy Holder Address: ____
City ST ZIP CODE

Who to call in case of an emergency:

Name: ________________________ Home Phone: (___)__________ Cell Phone: (___) ___________

I(PATIENT, PARENT or LEGAL GUARDIAN) authorize the release of any medical information necessary to process this bill to the medical insurance company, and request payment of benefits to Northeast Cornerstone Pediatrics. I acknowledge that I am financially responsible for payment of services whether or not covered by medical insurance. I am also responsible for uncollectable charges due to not disclosing full information such as other *medical insurances* on this form. I have filled out *ALL* information accurately.

PRINT NAME: __________________________ Date:________________

SIGNATURE: __________________________ RELATIONSHIP TO PATIENT: ______________

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CONSENT FOR TREATMENT/ RELEASE OF INSURANCE ASSIGNMENT/MEDICAL INFORMATION

The following information is to be completed by the patient or the patient's parent/legal guardian:

Yes ___ I, hereby authorize Northeast Cornerstone Pediatrics (NEC Pediatrics) to render any and all medical treatment or other related service, for myself or for the patient for whom I am the parent/legal guardian, that the physician feels are necessary or advisable to the patient in conjunction with the physicians' referral.

Yes ___ I assign payment of medical benefits directly to NEC Pediatrics.

Yes ___ I authorize NEC Pediatrics to share patient health information according to federal and state law for treatment, payment, and operations.

Yes ___ I authorize the release of any medical information necessary, in accordance with federal and state law, to process this claim to insurance company representatives. I also give my authorization to release my records, progress notes and verbal reports if/when needed. I also authorize the request of an appeal or a fair hearing with my insurance or Medicaid insurance if payment is denied.

Yes ___ I understand that the patient or parent/legal guardian is responsible for all charges incurred, regardless of the patient's insurance status. The patient or parent/legal guardian agrees to pay for services as the patient incurs the charges.

Patient or Parent/Legal Guardian Signature: ______________________________ Date: ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Northeast Cornerstone Pediatrics Notice of Privacy Practices ("Notice"):

- It tells me how NEC Pediatrics will use my health information for the purposes of my treatment, payment for my treatment, and NEC Pediatrics health care operations.
- The Notice also explains in more detail how may use and share my health information for other than treatment, payment, and health care opeations.
- NEC Pediatrics will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: ____
(please print)

Patient's SSN: ____________________________ Patient's DOB: ____________________________

Signature: ____________________________________ Date: ___________________________
(Patient or Legal Guardian)

Relationship of Legally Authorized Representative to Patient: ______________________________

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PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at time of service. We will collect the co-payment at the time of the service.
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved.
- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you. Therefore our charges or your care and treatment are due at the time of service.
- Unless either you or your health coverage carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience we will accept VISA, Discover and MasterCard.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge.
- For all services provided by our physician(s) in the hospital, we will bill your health plan. Any balance due is your responsibility.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I understand that I am responsible for all charges regardless of my existing medical coverage or payment plan. I understand that I am responsible for meeting insurance deductibles, co-insurance and non-covered services. If the account becomes past due, the balance becomes my responsibility and is immediately due. I also agree to pay all collection costs incurred, in an amount not to exceed (50%) of the unpaid balance. Should any unpaid balance be referred to a collection agency or referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

Copy Requests fees PER CHILD:

Medical Record Fee $35.00
Loss of Referral form, Lab forms, school note, etc. $10
Shot record $7 to $15
Miscellaneous $10 to $35

I also understand and agree that such terms may be amended from time-to-time by the practice.

____

Signature of Patient or Responsible Party if Minor Date

____

Print name of Responsible Party Relationship to Patient Print name of Patient

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PATIENT CONSENT LETTER BY PARENT

Dear Medical Staff:

I hereby give authorization and consent for my child to be brought in by the person(s) listed below. To be seen by the doctor for scheduled or walk in appointments and make any medically decisions as necessary. This person will be of legal age. However, I do understand that the Physician still has the right to refuse medical service(s) for any reason. I do understand also that any payment necessary to be made will still be paid upfront in order to receive medical service for my child. Authorized person will have photo identification at the time of service.

______________________	____________
NAME (child)	**DOB**

NAME (authorized person)	**RELATIONSHIP TO CHILD**
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________

______________________	____________
Parent/Guardian (signature)	Date

____
Parent/Guardian name (printed)

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

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. C-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.***

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

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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: __________

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Patient Family History Form

Patient's Name: ______________________________ DOB: _________ Sex: male or female

Birth/Delivery

G_____ P_____ AB ____ Mother's age at birth _____

Place of Birth ____________ Term _________ Type of Delivery: vaginal or c-section
Birth Attendant ___________ Premature (weeks) ______ Breech *Y or N* Multiple Birth
More than 2 weeks over due ____

Nursery Course:

Birth weight _______ Birth length______
__ Difficulty w/initial breathing __ Infections __ Jaundice req. treatment
__ Heart murmur __ Transfusions __ Seizures
Age at discharge _____ Newborn Screening (date/location):1._____/2______

Child Medical History:

Immunizations current: yes___ no___ Record unavailable___

__ Trauma/Injuries
__ Hospitalizations
__ Surgery
__ Hearing Problems
__ Pneumonia
__ Strep throat
__ Ear Infections
__ Seizures
__ Allergies
__ Developmental delays
__ Vision Problems
__ Substance use (alcohol, drug, tobacco.)
__ Medications
__ Asthma
__ Eczema
__ Bladder/Kidney infection
__ Other

Past Medical and Social History:

Do the following illnesses exist in the patient's parents, grandparents, or aunts/uncles? *"Yes" or "No"*

___ T/B
___ Anemia/Blood disorder
___ Kidney Problems
___ Heart Problems
___ Birth Defects
___ High cholesterol
___ Cystic Fibrosis
___ Diabetes
___ Arthritis
___ Asthma
___ Psychiatric disorder
___ Domestic Violence
___ Seizures
___ Cancer
___ High Blood Pressure/Stroke
___ Gastrointestinal
___ Drug Abuse
___ Alcohol Abuse