Beaumont Pediatric Center, PLLC

3127 College Street Beaumont, TX 77701 (409) 899-1433 Fax (409) 981-9089

☐Dr. Hubbell ☐Dr. Brown ☐Dr. Worley ☐Dr. Roesler ☐Dr. Bartz ☐Misty Moss, FNP ☐Cheryl Smith, FNP

PATIENT INFORMATION SHEET

Please fill out all information below.

Patient

NAME:____________________ DOB:__________ GENDER: M F

ADDRESS:____________________ HOME PHONE:____________________

CITY:__________ ST:______ ZIP:________ SSN:____________________

Parents/Guardians

MOTHER:____________________
DOB:__________ SSN:__________
ADDRESS:____________________
CITY:__________ ST:_____ ZIP:________
HOME PHONE:____________________
MOTHER EMPLOYER:____________________
MOTHER WORK #:____________________
MOTHER CELL# ____________________
Drivers License #:____________________

FATHER:____________________
DOB:__________ SSN:__________
ADDRESS:____________________
CITY:__________ ST:_____ ZIP:________
HOME PHONE:____________________
FATHER EMPLOYER:____________________
FATHER WORK #:____________________
FATHER CELL #:____________________
Drivers License #:____________________

Emergency Contact – someone not living in the same household

NAME:____________________
ADDRESS:____________________
CITY:__________ ST:______ ZIP:________

HOME PHONE:____________________
RELATIONSHIP:____________________
CELL PHONE:____________________

Information on Insurance Carrier other than parent (grand parent, step parent, etc.)

NAME:____________________
ADDRESS:____________________
CITY:__________ ST:______ ZIP:________

DOB:____________________
RELATIONSHIP:____________________
CELL PHONE:____________________

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I am the parent of ____________________ by signing below I authorize the following people other than the biological mother and/or father, to bring my child to the providers at Beaumont Pediatric Center, PLLC for treatment. (please print name and relationship to patient)

Name	Relationship to Patient

I have received from Beaumont Pediatric Center, PLLC a copy of the company HIPPA Policy, Financial Policy and Office Policy. By signing below I understand my financial obligations to the practice as well as the Office Policy, HIPPA Policy, and obligations of the practice to protect my child's health information.

Messages may be left regarding my child at the following locations:

☐ Home Phone Ans. Machine ☐ Mothers Work ☐ Fathers Work

☐ Mothers Cell ☐ Fathers Cell ☐ ________________

____

Parents Signature **Date**

<u>INSURANCE</u> is a contract between you, your employer and the insurance company. We are not party to that contract. It is very important that you understand the provisions of your policy. It is your responsibility to verify that we are an in-network provider on your specific plan. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will be covered. It is the responsibility of the parent to provide accurate and timely insurance information. Therefore, we ask you bring your current insurance card and driver's license to each visit. Inaccurate or untimely information given to the staff that results in denial or not coverage by your insurance company will result in a guarantor being responsible for the payment.

Initial:__________

Carl J. Hubbell, MD
T. Renee Brown-Nembhard, MD
Kyle E. Worley, MD
Misty Moss, FNP
Nathan Roesler, MD
Roger Bartz, MD
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Beaumont Pediatric Center, PLLC

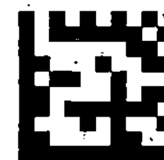
Date:______________

Please list the first and last name of all siblings living in the household, date of birth and age.

Name	Date of birth	Age

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(Please print clearly)

Child's First Name ____ Child's Middle Name ____ Child's Last Name ____

Child's Date of Birth (mm/dd/yyyy) ___/___/____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone ____ - ____ - ____

Child's Address ____ Apartment # ____ Email address ____

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	☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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, 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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.**

Confidential Medical History Form for Children

Please bring this completed form to your child's office appointment

Name: ______________________ DOB: __________ Today's Date: __________

Birth History for Patient:

Was the pregnancy full term? Y or N
Were there complications with the pregnancy or delivery? Y or N
Did you go home in 24 - 48 hours? Y or N
If not why? ______________________
How much did your child weigh at birth? ______________

Past Medical History: Has the child had any of the following Conditions?

- ☐ Abdominal problems?
- ☐ Any serious injury?
- ☐ Asthma?
- ☐ Behavior Problems?
- ☐ Broken Bones?
- ☐ Chronic Cough?
- ☐ Constipation?
- ☐ Sickle Cell
- ☐ Frequent Temper Tantrums?
- ☐ Hay fever/Sinus Problems?
- ☐ Hearing Problems?
- ☐ Heart Problems?
- ☐ Joint/Bone Problems?
- ☐ Kidney or Bladder infections?
- ☐ Many ear infections?
- ☐ Over Weight?
- ☐ Pneumonia?
- ☐ School Problems?
- ☐ Seasonal Allergies?
- ☐ Seizures?
- ☐ Skills are behind other kids?
- ☐ Underweight
- ☐ Vision Problem?
- ☐ Other? ______________

Any Allergies to Medications? ______________________
Any Medications/Supplements taken frequently? ______________________

Any Surgeries / Hospitalizations? ______________________
____

Social History:

Child has how many sisters? ____________ Brothers? ____________
Grade in school/Preschool ______________________
Usual Grades received? ____________ (A,B,C's, Etc.)
Is your child in daycare/after school care? ______________________
Who lives in your home? ______________________

Exposures:

- ☐ Is there a smoker in the home/at babysitter's?
- ☐ Do you always use seatbelt or car seat in your vehicle?

Family History: Has any blood relative of your child had... (List Relative beside illness)

- ☐ Alcoholism?
- ☐ Allergies?
- ☐ Asthma?
- ☐ Bleeding Disorder?
- ☐ Blood Clots?
- ☐ Cancer?
- ☐ Deafness?
- ☐ Depression?
- ☐ Diabetes?
- ☐ Drug Addiction?
- ☐ Heart Problems?
- ☐ Heart Vessel Surgery?
- ☐ High Blood Pressure?
- ☐ High Cholesterol?
- ☐ Lung Disease?
- ☐ Mental Illness?
- ☐ Seizures?
- ☐ Strokes?
- ☐ Tuberculosis (TB)?
- ☐ Other conditions?
- ☐ Sickle Cell

Parents Signature: ______________________________

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Vaccination Policy

I understand that Beaumont Pediatric Center requires all of its patients to receive the state-required vaccinations in accordance with the Centers for Disease Control and the Advisory Committee on Immunization Practices.

By signing below I agree that my child will receive the state-required vaccinations in accordance with the recommendations of the Centers for Disease Control and the Advisory Committee on Immunization Practices.

I understand that if I refuse to vaccinate my child, as outlined above, that my child/children will be dismissed from the practice.

Patient Name:________________________________DOB:______________

Parent's Signature:____________________________Date:______________

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Beaumont Pediatric Center, PLLC
Notice of Privacy Practice

To our patients:
This notice describes how protected health information (PHI) about your child/children, as a patient of Beaumont Pediatric Center, may be used and disclosed, and how you can get access to your child's health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your child/children's health information. We are required by law to maintain the confidentiality of your child/children's health information.
We realize that these laws are complicated, but we must provide you with the following information:
Use and disclosure of your child's health information in certain special circumstances.

The following circumstances may require us to use or disclose your child's health information:

1. **To public health** authorities (health departments, schools or other medical facilities) and health oversight agencies that are authorized by law to collect information.

2. **Lawsuits** and similar proceedings in response to a court administrative order.

3. **Law enforcement** official and/or Child Protected Services.

4. **To Reduce or prevent** a serious threat to your child's health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

5.**Payments:** Our practice may use and disclose your child's PHI to your insurance company in order to bill and collect payment for services you may receive from us. We may also disclose your child's PHI to other health care providers and entities to assist in their billing and collection efforts.

6. **Treatment:** Our practice may use your child's PHI for treatment such as laboratory tests, radiology tests, pharmacy when ordering prescriptions, home health agencies, DME (durable medical equipment) facilities and to other physicians and/or health care facilities and entities. Many of the people who work for our practice, including, but not limited to, our doctors and nurses, may use or disclose your child's PHI in order to treat or to assist others in your child's treatment. Additionally, we may disclose your child's PHI to others who may assist in your child's care not mentioned above.

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Your rights regarding your child's health information:

1. **You can request** that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work, leave a voice mail or a message with a grandparent or other relatives. We will accommodate reasonable requests.

2. **You have a right** to request that we restrict our disclosure of your child's health information to only certain individuals involved in your child's care or the payment for your child's care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. **You have the right** to inspect and obtain a copy of the health information that may be used to make decisions about your child, including patient medical records and billing records. You must submit your request in writing to **Beaumont Pediatric Center. Note:** We must respond to this request within 15 days.

4. **You may ask** us to amend your child's health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice.

5. **You are entitled** to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist or the office manager.

6. **If you believe** your child's privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. **Our practice** will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

In order to provide you with the best quality health care we do at times consult with our colleagues. Information regarding your child's medical history or current treatment plan may be shared with the other doctors in our office or in a different speciality.
If you have any questions regarding this notice or our health information privacy policies, please contact our Office Manager.

Beaumont Pediatric Center, PLLC
Financial and Office Policy

The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible. **Remember whether you do or do not have insurance, you are responsible for payment of your charges.**

1. **Insurance Cards:** We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.

2. **Demographic Changes:** If you have a change of address, telephone numbers(s), or employer, please notify the receptionist and we will provide you a form to update.

3. **Payments:** We will collect your deductible, co-payment or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. For your convenience, we accept cash, checks, Visa and MasterCard. If we do not participate with your insurance, payment will be due at the time of service.

4. **Insurance Denials:** If your insurance denies our charges, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our billing office to make payment arrangements. If you do not pay in a timely manner, your account may be referred to a collection agency and reported to the credit bureau.

5. **Insured Patients**: If we participate with your plan we will bill your insurance. Your co-payment will be collected at the time of service – **no exceptions**. The person bringing the child in for the visit is responsible for payment. If your co-payment is not paid at the time of service there will be a **$5 billing fee** added to your account. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP.
   INSURANCE is a contract between you, your employer and the insurance company. We are not party to that contract. It is very important that you understand the provisions of your policy. It is your responsibility to verify that we are an in-network provider on your specific plan. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will be covered. It is the responsibility of the parent to provide accurate and timely insurance information. Therefore, we ask you bring your current insurance card and driver's license to each visit. Inaccurate or untimely information given to the staff that results in denial or not coverage by your insurance company will result in a guarantor being responsible for the payment.

6. **Referrals**: If your plan requires you to have an authorization to see a specialist you will need to contact our referral coordinator **24 hours prior to your appointment with the specialist. NO RETROACTIVE REFERRALS WILL BE GIVEN.** (exception will be emergency room/minor care visits) If we are not the primary care physician of record with your insurance carrier we will be unable to obtain an authorization to see a specialist or admit to the hospital and will require payment in full at the time of service.

7. **No Insurance:** Patients that do not have insurance or proof of insurance (card or enrollment form) will be expected to pay in full at the time of service, reschedule the appointment or go to Urgent Care.

8. **No-show or missed appointments:** When an appointment is not cancelled in advance, and the patient **"no-shows"** it affects other patients. Another patient that needed to be seen was not because the time slot was already taken and not cancelled. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment **at least an hour in advance. If three appointments are missed** without cancellation you will be asked to find another physician for your child/children. **In the event you transfer care to another provider for your child/children, other than moving out of the area or to a specialist, all children in the family will be considered transferred and you will not be accepted back into the practice.**

9. **Inactive Patients:** If a patient has not been seen in **3 years** or more they will be considered a new patient.

10. **Wait Time:** We have more than one provider in the clinic at all times, therefore if you are in the waiting room more than 30 minutes please let the receptionist know so we can check on the wait for you. Our providers try their best to run on time, however, we do have emergencies and some patients require extra time for their illness. Please be patient, as we will provide you with the best possible care when we see your child/children.

11. **Vaccines:** It is the policy of Beaumont Pediatric Center that all children be vaccinated. If you choose **NOT** to vaccinate your child/children according to the recommended guidelines, you will be asked to find another physician.

12. **Refills:** Please allow at least **2 business days** on all refills including the **ADD/ADHD** medications

13. **Labs:** Routine labs will be called back at the end of the day. Please be aware that some labs take up to a week to get the results. We will call those labs as soon as we receive them. STAT labs will be called back as we receive them.

14. **Late Appointments:** If you are more than **15 minutes** late for a scheduled appointment you will need to reschedule.

15. **Changing Providers Within the Practice:** It is the policy of Beaumont Pediatric Center that patients do not change providers within the practice. BPC is a group practice and providers do cover each other's patients when your PCP is not available; however, patients cannot switch providers within the practice.

Thank you for choosing Beaumont Pediatric Center and our providers for your child/children's care. Please visit our website at bmtpedi.com and if you have any questions regarding our policies, please inform the receptionist.