Kerrville Pediatrics Patient Registration

Child 1: Last Name: _____ First Name: _____ MI:____

DOB: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Child 2: Last Name: _____ First Name: _____ MI:____

DOB: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Child 3: Last Name: _____ First Name: _____ MI:____

DOB: ____/____/____ Sex: _____ Primary Language: _____

Ethnicity: Hispanic / Not Hispanic / Unknown Race: Am. Indian or Alaskan / Asian / Black / Hawaiian /White / Unknown

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Parent Name: _____

Biological Relation to Patient: _____ Lives with Patient? Yes / No

Date of birth ____/____ / _____ Last four digits of social security number: _____

Email Address: _____

Work phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Kerrville Pediatrics Patient Registration

Parent Name 2: _____

Biological Relation to Patient: _____ Lives with Patient? Yes / No

Date of birth ____/____ / _____ Last four digits of social security number: _____

Email Address: _____

Work phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Preferred Pharmacy: _____

Primary Care Provider: _____

Insurance:

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____/_____/_____& social security number: _____-_____- _____

Policy Holder's Sex: Male / Female

Insurance Carrier: _____ ID# _____

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____/_____/_____& social security number: _____-_____- _____

Policy Holder's Sex: Male / Female

Insurance Carrier: _____ ID# _____

Billing:

Who should receive billing statements? _____

Kerrville Pediatrics Patient Registration

If parents are divorced or separated, please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No (circle one)

If yes, please provide a copy of any legal paperwork that supports this restriction.

Emergency Contacts, other than parents:

1. _____ Relationship: _____ Phone: (____) _____ - _____

2. _____ Relationship: _____ Phone: (____) _____ - _____

3. _____ Relationship: _____ Phone: (____) _____ - _____

How would you prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Work Phone / Cell Phone / Email

Recall Notices: Home Phone / Work Phone / Cell Phone / Email

Billing Statements: Home Phone / Work Phone / Cell Phone / Email

Patient Portal Notifications: Home Phone /Work Phone/Cell Phone /Email

May all contacts have access to the patient's records electronically? Yes / No (circle one)

Kerrville Pediatrics Patient Registration

J. Christopher Meriwether, MD, FAAP

Carena Sears, MSN, RN, CPNP-PC

Baileigh Hill, MSN, RN, FNP-C

Macalah Jenschke, MSN, RN, CPNP-PC

1331 Bandera Highway, Suite 10
Kerrville, Tx 78028
(P) 830-257-1440, (F) 830-257-2542

General Consent for Treatment

I, the undersigned parent or guardian of _____, knowing that the child is suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care into such medical, surgical, or other services under the general and specific instructions of either J. Christopher Meriwether, M.D., or Baileigh Hill, APRN-CNP, or Carena Sears, CPNP, or Macalah Jenschke, CPNP, or their assistants, or their designate as is necessary in their judgement. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me, as a result of treatments or examination by either J. Christopher Meriwether, M.D., or Baileigh Hill, APRN-CNP, or Carena Sears, CPNP, or Macalah Jenschke, CPNP.

Insurance Assignment and Release

I, the undersigned, do hereby authorize J. Christopher Meriwether, M.D., and/or Baileigh Hill, APRN-CNP, and/or Carena Sears, CPNP, and/or Macalah Jenschke, CPNP to release to my insurance company any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains to or relates to my child's medical care. This authorization in consent is granted for the sole and limited purpose of facilitating the quality of medical care conducted by J. Christopher Meriwether, M.D., and/or Baileigh Hill, APRN CNP, and/or Carena Sears, CPNP, and/or Macalah Jenschke, CPNP. I am releasing those rights and claims of confidentiality and privilege concerning the information I described which may otherwise exist, when used for the purposes I described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the office of Kerrville Pediatrics, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the office of the written notice of withdrawal.

Payment Policy

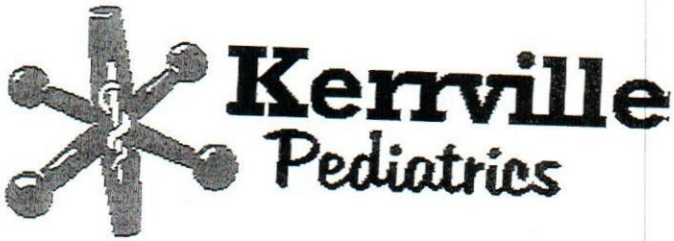
All professional services rendered or charged to the patient; the patient is responsible for payment regardless of insurance coverage. Full payment is expected at the time of each service unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurers.

Authorization of Payment

I authorize the release of any medical information necessary to process a claim. I also request payment of benefits to either myself or to the party who accepts assignment.

_____ _____

Signature Date



J. Christopher Meriwether, MD, FAAP
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HIPPA NOTICE OF PRIVACY PRACTICE

PATIENT CONSENT/ACKNOWLEDGE FORM

I hereby acknowledge receipt of the Notice of Privacy Practice.

With this consent, Kerrville Pediatrics may call and leave a message on voice mail or in person, mail, email to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment, Healthcare Operations, pertaining to my clinical care, including laboratory test results, or items such as appointment reminder cards and patient statements.

I have the right to request that Kerrville Pediatrics restrict how it uses or discloses my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Kerrville Pediatrics to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, Healthcare Operations.

Restrictions:_____

Disclose my Protected Health Information (PHI) to:

_____ _____

Contact #1 Phone #

_____ _____

Contact #2 Phone #

Kerrville Pediatrics may leave a detailed message: YES NO (circle one)

_____

Signature of Patient/Guardian

_____ _____

Print Name of Patient Date

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 this document.

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

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____ - ____ - ____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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, and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ Signature _____ Date _____

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)

Provider Statement

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

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347