USMD

Pediatric new patient information

Patient name (first, middle, last): _____

Address: _____

City:_____ State: _____ ZIP: _____ Email: _____

Date of birth: _____/_____/_____ ○ Male ○ Female

Main Contact:

Parent or guardian name: _____ Relationship: _____

Occupation:_____ Home Phone:_____ Work Phone: _____

Parent or guardian name: _____ Relationship: _____

Occupation:_____ Home Phone:_____ Work Phone: _____

○ Divorced ○ Separated

Are there any special custody arrangements we should be aware of ? ○ Yes ○ No

Brothers or Sisters:_____ Date of birth: _____/_____/_____

Brothers or Sisters:_____ Date of birth: _____/_____/_____

If yes, please describe: _____

_____

_____

Living arrangements: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Referring doctor: _____ Phone: _____

Other patient information

Which race does the patient identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____

What's the patient's ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's preferred language? ○ English ○ Spanish ○ Other: _____

Pediatric new patient information

Patient name: _____ Date of birth: _____ /_____ / _____

Health insurance information

Primary health insurance:_____ Policy or ID number: _____

Name of policy holder: _____

Date of birth: _____/_____/_____ Group or account number: _____

Employer: _____ Employer address: _____

City: _____ State: _____ ZIP: _____ Work phone: _____

Secondary health insurance:_____ Policy or ID number: _____

Name of policy holder: _____

Date of birth: _____/_____/_____ Group or account number: _____

Employer: _____ Employer address: _____

City: _____ State: _____ ZIP: _____ Work phone: _____

General consent form

Patient name:_____ **Date of birth:**_____/_____/ _____

Assignment of benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient initials: _____

Consent for treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD's expense.

Patient initials: _____

Electronic prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of others in care. I authorize USMD to discuss my/the patient's care and medical needs with the following persons:

Name	Date of birth (for identification)	Relationship	Phone number

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient initials:** _____

May we contact you by phone and leave a message about your care?

Primary phone number:_____ Secondary phone number: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient financial policy

I acknowledge receipt of the "Patient Financial Policy." **Patient initials:** _____

Notice of privacy practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient initials:** _____

Notice of telehealth/telemedicine services

I acknowledge receipt of the "Notice of Telehealth/Telemedicine Services." **Patient initials:** _____

Minor patient photograph (when applicable)

I consent for USMD to photograph the minor patient for identification purposes only. **Patient initials:** _____

Print name of patient or personal representative | Signature of patient or personal representative | Date

Financial policy

Please read prior to receiving services.

USMD Physician Services ("USMD") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient's responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.

- **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

Financial policy

- **PROMPT PAYMENT DISCOUNTS:** USMD offers a prompt payment discount to patients who do not have insurance and who pay in full at or before the time of service. Prompt payment discounts cannot be applied to co-pays or deductibles. Patients paying at the time of visit should be aware that additional charges related to the visit may be billed at a later time.

- We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

- Repeat no shows or cancellations within 24 hours could result in discharge from the clinic.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.

Notice of Telehealth/Telemedicine Services

Please read prior to receiving services.

I understand that I have the following rights with respect to telehealth/telemedicine:

1. Definition of telehealth/telemedicine. Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

2. Right to care. I understand that the same standard of care that applies to an in-person visit will apply to a telemedicine/telehealth visit. I understand that I have the right not to participate or decide to stop participating in a telehealth/telemedicine visit and that my refusal will not affect my ability to seek care or treatment in the future.

3. Patient information & confidentiality. I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

4. Communication risk & consent. I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. I understand that my consent will be obtained to receive SMS messages to my mobile device according to the Texting Terms and Conditions available at www.usmd.com/texting-terms.

5. Insurance & Billing. I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my telehealth/telemedicine visit. I understand that health plan payment policies for telehealth/telemedicine may differ from in-person visits.

I acknowledge that I have read this document or have had it read to me, that I have asked for clarification on any part of this document that I do not understand, and that I understand its contents.

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (817) 514-5200.

Pediatric new patient medical history form

DATE TODAY: _____

Patient Name: _____ _____ _____ DOB ____/____/____
First M.I. Last

☐ M ☐ F

REASON FOR VISIT TODAY: _____

_____

_____

ALLERGIES (Include medications, foods, x-ray dyes) or ☐ NONE KNOWN

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ NONE

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone: _____

Address: _____ City: _____ State/ZIP: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. List any additional information on back of sheet) or ☐ NONE

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ NONE

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

FAMILY HISTORY – Is there a family history of:

Is there a family history of:	YES	NO	Relationship	Onset age	Cause of death?
ADD/ADHD	☐	☐			
Allergies	☐	☐			
Asthma	☐	☐			
Birth defects	☐	☐			
Cancer	☐	☐			
Cardiovascular disease	☐	☐			
Coronary artery disease	☐	☐			
Deafness	☐	☐			
Depression	☐	☐			
Developmental delay	☐	☐			
Developmental dislocation of hip	☐	☐			
Diabetes	☐	☐			
Eczema	☐	☐			
Elevated lipids / cholesterol	☐	☐			
Eye problems	☐	☐			

Is there a family history of:	YES	NO	Relationship	Onset age	Cause of death?
Genetic disease	☐	☐			
Heart attack - at less than 55	☐	☐			
Hemoglobinopathy/sickle cell	☐	☐			
High blood pressure	☐	☐			
Kidney disease	☐	☐			
Learning disability	☐	☐			
Mental disability	☐	☐			
Migraines	☐	☐			
Obesity/overweight	☐	☐			
Scoliosis	☐	☐			
Seizure disorder	☐	☐			
Stroke < 55	☐	☐			
Sudden infant death syndrome	☐	☐			
Thyroid disease	☐	☐			
Other: _____	☐	☐			

Pediatric new patient medical history form

Patient Name: _____ _____ _____ DOB _____/_____/_____
First M.I. Last

MEDICAL HISTORY

Please write an "X" next to the complaint(s) or ailment(s) that apply to the patient. If you are unsure, place a question mark (?)

Abdominal pain	☐ Yes	☐ No	Overweight / obesity	☐ Yes	☐ No	Seizure disorder	☐ Yes	☐ No
Acne	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Sickle cell	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No	Prematurity	☐ Yes	☐ No	Speech delay	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Psychiatric / mental health problems	☐ Yes	☐ No	Stomach ache / GERD	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Pyelonephritis	☐ Yes	☐ No	Strabismus / eye problems	☐ Yes	☐ No
Allergic rhinitis	☐ Yes	☐ No	Renal disease / kidney problems	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No	Underweight	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Seizures, febrile	☐ Yes	☐ No	Urinary tract infection	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No				Vision problems	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No						
Cancer	☐ Yes	☐ No						
Cardiovascular disease	☐ Yes	☐ No						
Chickenpox	☐ Yes	☐ No						
Congenital heart disease	☐ Yes	☐ No						
Concussion	☐ Yes	☐ No						
Constipation	☐ Yes	☐ No						
Coronary artery disease	☐ Yes	☐ No						
Deafness	☐ Yes	☐ No						
Depression	☐ Yes	☐ No						
Developmental delay	☐ Yes	☐ No						
Developmental dislocation of hip	☐ Yes	☐ No						
Diabetes	☐ Yes	☐ No						
Eating disorder	☐ Yes	☐ No						
Eczema	☐ Yes	☐ No						
Elevated lipids / cholesterol disease	☐ Yes	☐ No						
Fainting	☐ Yes	☐ No						
Food allergy	☐ Yes	☐ No						
Fracture	☐ Yes	☐ No						
Genetic disorder	☐ Yes	☐ No						
Growth / weight problems	☐ Yes	☐ No						
Headaches	☐ Yes	☐ No						
Head injury	☐ Yes	☐ No						
Hearing problems	☐ Yes	☐ No						
Heart murmur	☐ Yes	☐ No						
History of wheezing	☐ Yes	☐ No						
High blood pressure	☐ Yes	☐ No						
Inhaler/neb use	☐ Yes	☐ No						
Learning disability	☐ Yes	☐ No						
Migraines	☐ Yes	☐ No						
Otitis media, recurrent	☐ Yes	☐ No						

Other?_____
_____
_____
_____
_____

BIRTH HISTORY

Place of birth: _____

Child's birth weight: ____ lb. ____ oz.

Duration of pregnancy:_____

Mom's age _____ Dad's age _____

Problems with pregnancy? ☐ Yes ☐ No

(if Yes please specify) _____

Prenatal care given? ☐ Yes ☐ No

(if Yes please specify) _____

Type of delivery: ☐ Vaginal ☐ C-section ☐ Forceps / vacuum

If C-section, why? _____

_____

Was baby breech? ☐ Yes ☐ No

Any medications/smoking during pregnancy? ☐ Yes ☐ No

(if Yes please specify) _____

Problems with labor/delivery? ☐ Yes ☐ No

(if Yes please specify) _____

Length of stay in nursery:_____

Any nursery complications? ☐ Yes ☐ No

(if Yes please specify) _____

Birth defects? ☐ Yes ☐ No

(if Yes please specify) _____

Child's discharge weight: ____ lb. ____ oz.

Is the baby circumcised? ☐ Yes ☐ No

HepB given? ☐ Yes ☐ No Date_____

Passed hearing test? ☐ Yes ☐ No

Pediatric new patient medical history form

Patient Name: _____ _____ _____ DOB _____/_____/_____
First M.I. Last

ADOLESCENT HISTORY

OB/GYN HISTORY (females only)

Has your period started? ☐ Yes ☐ No Last menstrual cycle: _____duration (days)_____ No. of pregnancies: _____ No. of deliveries: _____

TOBACCO HISTORY

Is child an active cigarette smoker? ☐ Yes ☐ No

Has child ever been a cigarette smoker? ☐ Yes ☐ No *If Yes, smoked average of _____ packs/day for _____ years. Quit in _____ (yr)

Does child use other tobacco products? ☐ Yes ☐ No *If yes, please specify _____

Does anyone smoke inside/outside house? ☐ Yes ☐ No

ALCOHOL AND DRUG HISTORY

Has child ever been diagnosed with alcoholism? ☐ Yes ☐ No Does child currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Has child ever used: Alcohol ☐ Yes ☐ No Marijuana ☐ Yes ☐ No Recreational drugs ☐ Yes ☐ No

Metabolic steroids ☐ Yes ☐ No Abused prescription drugs ☐ Yes ☐ No

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Signature_____ Date_____
Patient or legal representative

_____ Date_____
Relationship to patient

_____ Date_____
Witness

Authorization to release medical information to USMD Physician Services

Patient name: _____ D.O.B. _____ Age: _____
LAST FIRST M.I.

I, _____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person or entity who should release records)

_____
(Address of person or entity who should release records)

to release the following information by mail, fax, electronically or orally to USMD Physician Services:

Address: _____

_____

Phone: _____

Fax: _____

Information is for:

☐ Dr. _____

For the purpose of: _____

- ☐ All health information
- ☐ Statements of charges or payments
- ☐ AIDS or HIV information *Initials* _____
- ☐ History and physical examination
- ☐ Copies of records of reports provided to the above named (i.e. hospital, lab, clinic, etc.)
- ☐ Mental health and/or alcohol & drug abuse treatment *Initials* _____
- ☐ Progress notes
- ☐ Substance abuse records *Initials* _____
- ☐ Genetic information (inc. genetic test results) *Initials* _____
- ☐ Discharge summary
- ☐ Consultation reports
- ☐ Hepatitis information
- ☐ Photographs, videotapes, digital, or other images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. USMD Physician Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient or legal representative signature Date

_____ _____
Relationship to patient Expiration date of authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of minor individual Date

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 dddress

Apartment number

Telephone

City

State

ZIP

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.***