Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients' needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician's office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

Patient's Name (First, Middle, Last): ____________________

Address: ____________________

City: ____________ State: ______ Zip Code: __________ Email: ____________

Date of Birth: _____/_____/_______ Sex: O Male O Female SS # (optional): ____________

Main Contact:

Parent/Guardian Name: ____________________ Relationship: ____________

Occupation: ____________ Home Phone #: ____________ Work Phone #: ____________

Parent/Guardian Name: ____________________ Relationship: ____________

Occupation: ____________ Home Phone #: ____________ Work Phone #: ____________

O Divorced O Separated

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

Siblings: ____________ DOB: _____/_____/_____ Other Siblings: ____________ DOB: _____/_____/_______

If Yes, please describe: ____________________

____

____

Living Arrangements: ____________________

Emergency Contact: ____________ Relationship: ____________ Phone #: ____________

Referring Physician: ____________________ Phone #: ____________

OTHER PATIENT INFORMATION

Which racial category does the patient most closely identify with?

O African American O Asian O Caucasian O Hispanic

O Native American O Native Hawaiian O Pacific Islander O Other: ____________(Please Specify)

Ethnicity: What is the patient's ethnicity? O Hispanic or Latino O Not Hispanic or Latino

What is the patient's language of preference? O English O Spanish O Other: ____________(Please Specify)

USMD Health System

PEDIATRIC NEW PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ______ /_______ / ________

INSURANCE INFORMATION

Primary Insurance:______________________________ Policy/ID # ______________________

Name of Policy Holder:______________________ DOB: _____/_____/______ Group/Acct #:______________

Employer: ______________________________ Employer Address: ______________________________

City: ______________________ State: ________ Zip Code: ___________ Work #: ________________

Secondary Insurance: ______________________________ Policy/ID #: ______________________

Name of Policy Holder:______________________ DOB: _____/_____/______ Group/Acct #:______________

Employer: ______________________________ Employer Address: ______________________________

City: ______________________ State: ________ Zip Code: ___________ Work #: ________________

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

☐ 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 #: ______________________________

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

Secondary Phone #: ______________________________

- ☐ 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:** _____________

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

USMD Health System

FINANCIAL POLICY

Patient Name: ____ Patient Date of Birth:_____/_____/_______

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.

USMD Health System

FINANCIAL POLICY

- **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.

- **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**.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **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.

USMD Health System

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:______________					

USMD Health System

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 (?)

Condition	Yes	No
Abdominal Pain	☐ Yes	☐ No
Acne	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Allergic Rhinitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autism	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cadiovascular 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
Overweight / Obesity	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Prematurity	☐ Yes	☐ No
Psychiatric / Mental Health Problems	☐ Yes	☐ No
Pyelonephritis	☐ Yes	☐ No
Renal Disease / Kidney Problems	☐ Yes	☐ No
Scoliosis	☐ Yes	☐ No
Seizures, Febrile	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No
Speech Delay	☐ Yes	☐ No
Stomach Ache / GERD	☐ Yes	☐ No
Strabismus / Eye Problems	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Underweight	☐ Yes	☐ No
Urinary Tract Infection	☐ Yes	☐ No
Vision Problems	☐ 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

USMD Health System

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/Legal Representative

______________________________ Date______________________
Relationship to Patient

______________________________ Date______________________
Witness

USMD Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO USMD PHYSICIAN SERVICES

Name of Patient: ____ D.O.B.__________ Age:_____
LAST FIRST M.I.

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

____
(Name of person/entity who should release records)

____
(Address of person/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/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)

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.