PATIENT REGISTRATION FORM

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ABC Pediatrics Vaccine Administration Policy

At ABC Pediatrics we are dedicated to providing the highest quality of evidence-based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious disease, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyze reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect your child. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At ABC Pediatrics we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, ABC Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also puts the health of others at risk.

Please be advised that if you desire an alternative vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of ABC Pediatrics, the AAP, the AAFP, and the ACIP. We believe that this decision puts your child at risk for vaccine preventable disease and increases health risks for others.

ABC Pediatrics respectfully declines to be your children's pediatricians.

Parents Signature

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Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2) Many Conserve House

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(Please print clearly)	
Child's Last Name	
Child's First Name	Child's Middle Name
*Children vourige: Child's Date of Birth	than 18 years old only. Child's Gender: Male Female
Child's Address	Apartment # Telephone
City	State Zip Code County
Mother's First Name	Mother's Maiden Name
immunization registry is a secure and confidential ser of age) immunization records. With your consent, you Doctors, public health departments, schools, and other to ensure that important vaccines are not missed. The Texas Department of the construction of the cons	service of the Texas Department of State Health Services (DSHS). The vice that consolidates and stores your child's (younger than 18 years or child's immunization information will be included in ImmTrac2. Immatrized professionals can access your child's immunization history of State Health Services encourages your n in the Texas immunization registry.
I understand that, by granting the consent below, I am and I further understand that DSHS will include this in Once in Imm Trac2, the child's immunization information a public health district or local health department, a physician, or other health-care provider legally at a state agency having legal custody of the child; a Texas school or child-care facility in which the climater approximation of the child; a payor, currently authorized by the Texas Department.	for public health purposes within their areas of jurisdiction; athorized to administer vaccines, for treating the child as a patient; fill is enrolled; nent of Insurance to operate in Texas, regarding coverage for the child. Ide information on my child in the Imm Trac2 Registry and my consent we written communication to the Texas Department of State Health
By my signature below, I <u>GRANT</u> consent for re Texas immunization registry. Parent, legal guardian, or managing conservato	
Date	Printed Name 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.sdr.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 * Imm Trac Group - MC 1946 * P. O. Box 149347 * Austin, TX 78714-9347

PROVIDERS REGISTERED WITH Imm Trac2: Please enter client information in Imm Trac2 and affirm that consent has been granted DO NOT fax to ImmTrac2. Retain this form in your elient's record.

Pediatric - Patient Questionnaire

Completed By: Reason for today's Visit: PREGNANCY AND BIRTH Mothers age at pregnancy? Y N Medications during pregnancy? Y N Medications from type of Delivery: Birth Weight. Complications? Y N Problems with Baby at birth? Breathing Y N Jaundice Y N Cother Cother Cother Problems soon after? Nursery or home? Problems with Patch (M) Mother (S) Sizer Father (M) Mother & Other (MF) Mother's Settler (MF) Mother's Mother's Settler (MF) Mother's Settl	PT Name:	Date:
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ABC Pediatrics

3004 S WS Young Dr.

Killeen, TX 76542

Agreement Regarding Payment and Collection On Accounts

I agree that I am responsible for all amounts not paid/covered by my insurance for medical services rendered by ABC Pediatrics. I further agree that in the event my account is referred to a collection agency for any delinquent amounts owed, I will be responsible for payment of all collection fees charged by that agency in addition to all amounts owed the clinic. I acknowledge this amount is 35% of the total balance due. I further agree that in the event a lawsuit is initiated, I will be responsible for court costs, and attorney fees. Regarding physicals, I am aware that most insurance companies pay for one per year after the age of 2. If my child sees another physician for a physical then comes to ABC for the physical, I will be responsible for any charges incurred.

Signature of Parent/Guardian	Date
Agreement Regarding Release of I	Medical Records
I understand there is a charge for hand carried medical record and .50 each additional page. I understand that I will have to rather than sent directly to another physician. I further under released free of charge one time. Any additional copies will count by the providers will be \$7 for the first page, \$2 each additional of request	pay this charge if records are handed to me stand that immunization records will be ost \$5. Additional charges for forms filled
Signature of Parent/Guardian	Date

Agreement Regarding No Shows

I understand that if I no show for 2 consecutive appointments without prior cancellation, I may be discharged from this practice. ABC Pediatrics understands things come up, we just ask that you communicate with us, and call to cancel. I also understand that if I no show to my appointment, I will be responsible for a \$25 fee that is an out of pocket expense, not covered by insurance. Everyone's time is valuable. Not showing up, and not canceling is disallowing the chance for another patient who may need an appointment slot.

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an appointment slot.				
Signature of Parent/Guardian		Date		
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ABC PEDIATRICS

3004 South WS Young Drive Killeen, Texas 76542 254-634-7337

January 21, 2019

Attention Parents:

Sincerely,

If your child requires a referral, we MUST be shown as the Primary Care Physician on your insurance. If your child's insurance shows another provider, we will not be able to place a referral for any specialist. This includes Orthopedics, ENT, Speech Therapy, etc.

If your insurance chooses not to pay for an office visit due to another provider being shown on your insurance, you ARE responsible for the bill.

It is the parent's responsibility to keep up to date on who is showing as the PCM on your child's insurance and correct it. We cannot do this for you.

Most Insurances require a referral prior to receiving care from any provider other than your assigned primary Care Provider (PCM) to avoid cost to you. This includes Urgent Care Facilities and after hours walk-in facilities. Most Insurance beneficiaries may ONLY receive emergency care at 24 hour emergency facilities without a referral from their PCM.

The on-call ABC Pediatrics clinic provider may be reached by dialing the clinic number after hours 254-634-7337. Please leave a clear and concise message (containing patients name, patients date of birth, patients symptoms and phone number where you may be reached) so that the on-call provider may call you back. Blocked calls will not be returned.

OUR CLINIC WILL NOT SUBMIT RETRO REFERRALS

ABC Pediatrics		
Child's Name		
Parent's Signature		

ABC PEDIATRICS

MANZOOR FAROOQI MD

MICAH DAVIS FNP

Authorization for medical treatment of minors

If your child needs medical, dental or hospital services a parent must give permission. It's the law. What if you cannot be reached to give permission? A child may be treated without parental consent when a physician determines a true emergency exists. A true emergency means the child needs immediate medical care and attempting to obtain parental consent would result in a delay that could increase the risk to the child's life or health.

Sometimes, however, a child may need unexpected care which is not a true emergency. In such cases, attempting to contact a parent for permission can delay treatment and create unnecessary anxiety for the child. To alleviate treatment delays, make sure your child's caregivers know how to contact you at all times. When it may be difficult to contact you, you can appoint an adult to consent to medical treatment for your child.

This document allows you to appoint relatives, friends, caregivers—anyone 18 years of age or older—to consent to medical treatment for your child. Complete this form and give it to the adult(s) who have your permission to seek medical treatment. A copy will be placed in your child's medical record. If your child needs medical care, the designated adult should present this document at the time of treatment. It is especially important to prepare this form for those occasions when we may be unable to reach you.

Name of minors	Date of birth	Allergies/special conditions	
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I/we, being the parent(s) or legal guardian(s) of the	e above named minor(s) do hereby	y appoint	
Name	Address	Phone Number	
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·			-
			•
to authorize unexpected medical, dental, surgical of Pediatrics.	are, and hospitalization for the abo	ove named minor(s) during the period of my/our at	osence, from ABC
This document shall be presented to a physician, de hospitalization may be required.	entist or appropriate hospital repre	sentative at the time any unexpected medical, dent	tal, surgical care or
Signature of parent or guardian date	Address	Phone Number	
Signature of witness	date	· · · · · · · · · · · · · · · · · · ·	
ngirance coverage for the above named minor(a)	_1	4 95 1 8	•
Insurance coverage for the above named minor(s) -	please include insurance compa	any and policy information	•

3004 S WS YOUNG DR, KILLEEN, TEXAS 254-634-7337 254-634-2592

ABC Pediatrics

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed ABC Pediatrics' Notice	of Privacy Practices,	which explains how	my medical
information will be used and disclosed.	I understand that I an	n entitled to receive	a copy of this
document.	•	•	

Print Name of Patient
Date
Signature of Patient, Parent or Guardian
Print Name of Parent or Guardian (if Applicable)
Relationship of Parent or Guardian to Patient

A copy of the Notice of Privacy Practices is available on our website (http://abckilleen.com/bfd_download/nppeng/) for your reference. If you would like to retain a copy of the Notice for your documents, or do not have Internet access, you may keep the copy given to you to read. However, in the interests of conserving our paper resources, please return the Notice if you have no further need for it.

Medical Records Release Form

Patient Name:	
	te of Birth:
(Last Name, First Name, MI) Please release the following health information:	
Medical Chart Immunization Record Chart & Record Other (describe)	
Limit the release of information subject to this Release Form as follows: None One Time Use Only Limit As Indicated	
he reason(s) for this release of information: Moving Out of Area Transferring Care Locally Other (describe)	
his authorization shall be in force and effective until the following event and/o	r date:
<u>Disclosures</u>	
understand that additional information about this Medical Release is available from t rom them.	he Organization and that I may obtain a copy of that information
understand that information disclosed because of this authorization may be divulged by the recipient to others and as such may no longer be prote y federal medical privacy regulations.	
understand that the Organization, and the recipient of the information, will not condit or the requested use or disclosure.	ion my treatment and payment on whether I provide authorization
understand that I have the right to revoke this authorization, in writing, at any time by	sending a written potitication to the person listed below. I
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