PATIENT REGISTRATION FORM

PARENTAL MEDICAL CONSENT FORM FOR A MINOR CHILD

General Consent for Treatment

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient: _____ (name of patient).

I voluntarily authorize and consent to the medical care, treatment, and diagnostics tests that the providers of WeeKare Pediatrics and their designated associates or assistants believe are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent._____ (**Please Initial**)

Voicemail/Text Notifications/Triage Calls

As a service to our patients, WeeKare Pediatrics provides courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. We also may provide triage calls to our patients regarding patient care as well as parent concerns. Our Medical Assistants may also leave voicemails, however no patient test or lab results will be left using this form of communication. By initialing below, you consent to receiving such calls/texts at the cell phone number you have provided to our office. _____ (**Please Initial**)

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize WeeKare Pediatrics to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists, or until I withdraw my consent._____ (**Please Initial**)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it._____ (**Please Initial**)

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Name of Patient's parent/guardian, *if patient is under 18*:

_____ (Printed)

Relationship of Patient's parent/guardian, *if patient is under 18*:

_____

Signature of Patient's parent/guardian: _____Date:_____

PARENTAL PREAUTHORIZATION FOR MINORS
DELEGATION OF CONSENT

Name of Patient: _____

Patient's Date of Birth: _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

Name of Person	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To consent to any and all medical care and attention for my child that is deemed necessary and appropriate by a licensed healthcare provider of WeeKare Pediatrics. This consent includes but is not limited to medical, and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (if 18 years or older): _____

Relationship to Patient: _____

Date: _____

Witness: _____

Translator/Reader (if applicable): _____

Wee Kare Pediatrics

Advance Practice Nurse
Consent for Treatment

This facility has on staff an advance practice nurse to assist in the delivery of medical (may indicate specialty) care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

Physician Assistant
Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical (may indicate specialty) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Patients Name:	Date
Signature:	Witness: (optional)

19333 Hwy 59 N. Suite #145
Humble, TX 77338
Phone (281) 540-5437
Fax (281) 540-2630

Notice of Privacy Practice and Patient Consent
For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that WeeKare Pediatrics may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

WeeKare Pediatrics has a detailed document called the "Notice of Privacy Practice". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, WeeKare Pediatrics will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow WeeKare Pediatrics to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that WeeKare Pediatrics has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our "Notice" at any time by contacting: WeeKare Pediatrics•19333 Hwy 59 N. Ste.#145•Humble, TX 77338•(281) 540-5437•weekare1@hotmail.com.

Office Use Only

☐ Received ☐ Declined

Witness: _____

Wee Kare Pediatrics

PATIENT REGISTRATION FORM

Today's Date _____

CHILD

Childs Full Name_____

Childs Address _____(Street and apt#, City, State, Zip)_____

Primary Telephone Number _____

Sex: (Circle) Male Female Date of Birth _____ SSN#: _____--_____--_____

Who Referred Patient? _____

Which physician will be your child's pediatrician? _____

Have you arranged for your child's medical records to be transferred here from another pediatrician? YES NO

SIBLINGS

Name _____ Sex: M F Birthday _____

Name _____ Sex: M F Birthday _____

Name _____ Sex: M F Birthday _____

Name _____ Sex: M F Birthday _____

Have any of these children been seen by this practice? (YES or NO)

MOTHER

Full Name _____ Date of Birth _____

Home Address_____(Street and apt#, City, State, Zip) _____

Telephone Number _____ Work Number _____

Employer/Occupation _____

SSN No._____ Driver's License No._____ State_____

Does the parent have medical authority over the patient? Yes_____ No_____

If no, Can you please provide legal documentation stating otherwise?_____

FATHER

Full Name _____ Date of Birth _____

Home Address_____(Street and apt#, City, State, Zip) _____

Telephone Number _____ Work Number _____

Employer/Occupation _____

SSN No._____ Driver's License No._____ State_____

Does the parent have medical authority over the patient? Yes_____ No_____

If no, Can you please provide legal documentation stating otherwise?_____

PATIENT REGISTRATION FORM

EMERGENCY CONTACT

Name of person NOT living with child _____ Date of Birth_____

Home Address _____ (Street or Apt #, City, State, Zip)_____

Home Telephone Number _____ Work Telephone Number_____

Relationship to Child_____

PAYMENT

I have received a copy of the current year's financial policy and understand that I am personally responsible for payment on this account.

Guarantor Signature _____ Date _____

Print Name _____ Relationship to Patient _____

Patient(s) Name _____

INSURANCE INFORMATION

Please complete the following section ONLY if you do not have a copy of the child's insurance card to present to the practice.

Insurance Company _____ Phone Number _____

Primary/Secondary PPO/HMO/POS indemnity/ IPA Network/Other _____

Policy Holder Name _____

Employer _____ Policy ID _____

SSN. _____ PCP _____ Group No._____

I do _____ do not _____ have Medicaid Insurance (Please check one)

PATIENT PORTAL

The Patient Portal is a service provided to our patients by our eclinical works system.

It allows you to: access the time and date of your appointment *requires appointments* request your shot record *appointment reminder emails

I accept: Email_____ Parents/Legal Guardian Signature_____

I decline: Parent/Legal Guardian Signature_____

You can opt-out of the patients portal at any time of you chose to do so.

Wee Kare Pediatrics
19333 Hwy 59 North, Suite 145
Humble, TX 77338
Phone (281) 540-5437- Fax (281) 540-2630

Request for Medical Records

Please mail or fax to address or number above

Date: _____

* Patient Name: _____ * D.O.B: ___/___/_____

* Guardian Name: _____

* Address: _____ * City: _____ TX * Zip_____

* Home #: _____ * Cell #: _____

* I, _____ hereby request to obtain/release medical information from/to:

_____
* Name of previous Clinic/Doctor

_____
Address

_____
City, State, Zip Code

(_____)_____
Office Phone #

(_____)_____
Office Fax #

OFFICE USE ONLY

Med Rec. Req by: _____
Date Req: ____/____/_____

Rec Received on: ____/____/_____
Received by: _____

Expiration Date: ____/____/_____

Please include the following records: (Check all that apply)

_____All Medical Records
_____Labs
_____H & P Progress Notes
_____Immunizations

Please include medical records pertaining to (initial requested area):

_____Emotional Mental Health/Psychiatric Condition
_____HIV/AIDS/STD's
_____Drug/alcohol/Substance Abuse

For the reason(s) indicated below:

PCP Change _____
Specialist _____
Personal Records _____

_____ _____/_____/_____
* Parent/Guardian Signature * Date

Patient HIPAA Compliance Consent Form

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that the doctor and all staff member continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule".

The Department of Health and Human Services has established a "Privacy Rule" to help insure that your personal health information is protected from unnecessary distribution. The Privacy rule has also been created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations. We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone but you without your expressed written consent.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also want you to know that we support your full access to your personal medical records. Other business that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations or payment. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have to right to refuse to treat you under this law. Should you disclose your information to us, but refuse to allow us to disclose it to your insurance company, you will be responsible for the full balance on your account at the time of service, instead of the customary 30 day grace period that we allow for 3rd parties to pay.

I, _____ DO hereby consent for Wee Kare Pediatrics to release the minimum amount of my personal health information necessary for treatment, health care operations or payment to any necessary entity, business or person. I understand that no information will be released that is not absolutely necessary to the situation.

I, _____ DO NOT consent for any of my personal health information to be released by Wee Kare Pediatrics., to any entity, business, or person other than myself, unless I specifically, in writing, authorize this release of information each and every time it is needed. I understand that this decision means that I am responsible for all balances on my account at the time of service, and that I am responsible for filing my own insurance claims for reimbursement.

Print Patient Name:_____ Responsible Party Name:_____

Responsible Party Signature:_____ Date:_____

OFFICE POLICIES

OFFICE HOURS- Monday – Friday 8 am – 5 pm (Closed for Lunch Hour 12 pm – 1 pm)

NEW PATIENT POLICY - Each physician/provider requires a legal guardian/parent at the first visit. At that visit is when the parent can delegate consent to another adult to accompany the child to future visits. Must bring immunization record to first visit, failure to do so will result in cancelation of appointment.

INSURANCE/PHOTO ID CARD POLICY - We require that you present your insurance card and photo identification at every visit for the protection of our patients.

IMMUNIZATION RECORD- It is the parent's responsibility to bring the patients shot record for any well or nurse visit. There will be a $5 fee collected at the time of service if the parent requests a copy of the shot record due to loss or you may access your child's account through patient portal at your leisure free of charge.

PRIMARY CARE PROVIDER (PCP) POLICY- We require that we are the PCP the day of the visit. It is the parents' responsibility to ensure that this completed prior to the visit and to provide us with any necessary authorization numbers or contacts regarding sick office visits.

LATE POLICY- Due to limited availability of appointments we ask that you arrive for your appointment on time. Should you arrive **15** minutes past your scheduled appointment time you will be subject to reschedule.

CANCELLATION POLICY- We ask that you be courteous to others. If unable to make your appointment please call to cancel within 24 hours of your scheduled time so that we may accommodate other patients, this may also be done through the patient portal.

WALK-IN POLICY- Acute type walk-In appointments are available for established patients on Monday's only from 8:00-10am. Provider preferences will not be allowed during this time, visits are first come first serve.

WELL VISITS/PROBLEM VISITS- If a sick issue is addressed at the time of the well visit, your insurance company will be billed for both visits. Your insurance company may charge for a co-pay/deductible or co-insurance.

ANSWERING SERVICES- Our answering service is available from Monday- Friday 12-1 pm and Monday through Sunday from 5pm-8am to handle emergency cases only.

APPOINTMENT CONFIRMATIONS- Televox service will confirm appointments 2 days prior to appointment, Patient Portal will email 2 days prior. Our well visits are primarily scheduled 2-3 months in advance. Contact receptionist should your phone number change.

NO SHOW POLICY- Our policy is 3 no show appointments without proper notification to our office will result being reported to your insurance company.

REMOVAL FROM PANEL OR TERMINATION FROM PRACTICE- We practice the right to remove a patient from our office and/or terminate our relationship in the following situations- gross misconduct (yelling, not being courteous of others, disrespect, any form of physical misconduct), illegal or fraudulent acts, profanity, and verbal abuse either over the phone or in person. Your insurance company will be notified of this change.

I have read and understand the above and agree to comply.

Parent/Guardian: _____ Relationship:_____

Patient Name: _____ Date: _____

Insurance/Financial Policy

Thank you for choosing Wee Kare Pediatrics as your child's health care provider. Our office is committed to providing the highest quality care to all of our patients. We feel it is very important to establish clear insurance/payment policies to avoid misunderstandings. The following statements will help you understand our financial policy.

Due to National Insurance Documentation Requirements and Coding Guideline, any preventative office visit (Example: Sick, medication refill, follow up etc.) will be charged as two office visits. Co-pay's, Deducible and co-insurance may apply, depending on your insurance benefits.

Chip plans will be charged the co-pay at check in. Should an acute (sick) issue not be addressed during the visit, there will be a co-pay due upon check out.

Self-pay fees are due upon check in. Each self-pay patient must be checked out to ensure there is not a balance or refund at the end of your visit.

All payment of charges are due at the time of service unless other definite financial arrangements have been made with a member of our billing department prior to treatment.
We will bill and accept payment for services. You will be responsible for ALL applicable co-payments, co-insurance and deductibles that your plan required to fulfill your payment responsibility. Please bring your child's insurance card to each visit.

I have read and understand this financial policy and I agree to these terms.

_____ ____/____/____

Parent Signature /Guardian Signature Date

Meaningful Use

In order to track **Meaningful Use** of our Electronic Medical Record, we are required to maintain the information below as part of your child's medical record.

As with all of your medical information, this will be maintained CONFINDENTIALLY.

Patient Name: _____ Date of Birth: _____

Primary Language: (Check One)
_____English
_____Spanish
_____Indian
_____Russian
_____Other _____

Race: (Check One)
_____American Indian or Alaskan Native
_____Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White or Caucasian
_____ Hispanic
_____ Other Race
_____ Unreported/Prefer Not to Answer

Ethnicity: (Check One)
_____ Hispanic or Latino
_____ Not Hispanic
_____ Prefer Not to Answer

_____ / _____ / _____
Patient Printed Name | Parent Signature | Date

Thank you for choosing Wee Kare Pediatrics!