[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

**2022**

19333 Hwy 59 North, Suite 145

Humble, TX 77338

Phone (281) 540-5437

Fax (281) 540-2630

**CONSENT FOR MINORS**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL CONSENT FOR TREATMENT OF MINOR**

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**. Patients Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ (**Please Initial**) 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.

**\*Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NURSE PRACTIONER (NP) CONSENT FOR TREATMENT**

This facility has on staff, Nurse Practitioners (NP’s), to assist in the delivery of medical care. A Nurse Practitioner is a licensed, autonomous clinicians focused on managing people’s health conditions and preventing disease. NP’s are not a doctor. A Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the nurse practitioner may treat minor lacerations and other minor injuries. “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.

**PHYSICIAN ASSISTANT (PA) CONSENT FOR TREATMENT**

This facility has on staff a Physician Assistant to assist in the delivery of medical 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.

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

-I understand that at any time I can refuse to see the nurse practitioner and or physician assistant and request to see a doctor in office.

\***Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENTAL PREAUTHORIZATION FOR MINORS DELEGATION OF CONSENT**

**When I am unavailable to give consent, I hereby authorize to the following individual(s):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS FORM IS LEFT INTENTIALLY BLACK**

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

19333 Hwy 59 North, Suite 145

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**2022**

**PATIENT REGISTRATION FORM**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD**

Childs Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childs Address ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and apt#, City, State, Zip)

Primary Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternative Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: (Circle) Male Female SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?  Siblings come here  Family  Facebook  Google  Family Friend  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**SIBLINGS**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age:\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age:\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age:\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Age:\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**MOTHER (LEGAL GUARDIAN)**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 (LEGAL GUARDIAN)**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_

***\*Does the parent have medical authority over the patient? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_***

***If No, can you please provide legal documentation statin otherwise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**EMERGENCY CONTACT**

Name of person **NOT** living with child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

**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.**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. PLEASE PRESENT INSURANCE CARD AT EACH VISIT.

Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary PPO/HMO/POS indemnity/ IPA Network/Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* **Please check one:** I do\_\_\_\_\_ I do not\_\_\_\_\_\_ have Medicaid Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. I also authorize for my child’s medical records be send to insurance plan as documentation of services rendered.

Parents/Guarantor/Legal guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guarantor/Legal guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)**PATIENT PORTAL**

eClinicalWorks' Patient Portal is a Web-based communication module, designed to be used with the eCW application, that facilitates communication between a practice and its patients, improving the quality of care. It is accessible by both our patients and members of our staff. Parents can view patients visit summary, future appointment dates and times, request shot record, appointment reminder via email/text/automated call, as well as view labs, send messages to medical staff etc.

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_I accept to participate in the Patient Portal**:

Parents/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_I decline to participate**:

Parent/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*You can opt-out of the patient’s portal at any time of you chose to do so.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT OF OFFICE NOTIFICATIONS**

**CALL/ VOICEMAIL / TEXT / E-MAIL NOTIFICATIONS**

As a service to our patients, WeeKare Pediatrics provides courtesy appointment reminder calls/texts/email and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls, texts, E-mail at the cell phone number you have provided to our office. You also agree for our office staff to call you. \_\_\_\_\_\_ **(Please Initial)**

**TRIAGE CALLS**

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 at the cell phone number you have provided to our office. \_\_\_\_\_\_ **(Please Initial)**

**MAILED LETTERS/NOTICES**

We may also provide written notifications; in the event we are unable to get ahold of you regarding results or any other office communication. However, no patient test or lab results will be used using this form of communication. By initialing below, you consent to receiving such calls 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)**

**ANSWERING SERVICE / AFTER HOURS CALLS**

We offer afterhours answering service from 5pm-8am for our establish patients. Answering service has our office prompt and will follow that based on matter. Not all calls will be patched through the provider as we have set a protocol to screen calls. Messages are taken and delivered to the office staff for non-urgent matters and urgent matters following our office protocol will send a message to the provider on call. Provider on calls will typically call back to find out additional information regarding your child’s medical concern and provide advice and help you decide what to do next. Emergent matters must call 911 \_\_\_\_\_\_\_ **(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.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian name, if patient is under 18:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Patient’s parent/guardian, if patient is under 18:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient’s parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

**NOTICE OF PRIVACY PRACTICE AND PATIENT CONSENT**

**FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 our offices:

**WeeKare Pediatrics Humble WeeKare Pediatrics Houston**

19333 Hwy 59 N. Ste.#145 14630 Woodforest Blvd.

Humble, TX 77338 Houston, TX 77015

Fax: (281) 540-2630 Fax: (713) 640-5254

Office # (281) 540-5437

[wkpkids@weekare.net](mailto:wkpkids@weekare.net)

***\*Office Use Only\****

 Received  Declined Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

19333 Hwy 59 North, Suite 145

Humble, TX 77338

Phone (281) 540-5437

Fax (281) 540-2630

**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.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

**NOTICE OF INSURANCE OF CONFORMITY FOR OUR PATIENTS**

To our valued patients and their legal guardians:

Health care fraud and abuse have been identified as a national problem that cost a billion of the taxpayers literally dollars each year. We want you to know that all of our employees, doctors and mid-level providers continually undergo training so that they can understand and comply with government rules and regulations regarding Medical Medicare, Workers' Compensation, federal and state of care laws and regulations. of health. We strive to reach the highest levels of ethics and integrity in the execution of services for our patients.

It is our responsibility to correctly determine the exact remuneration for our services in accordance with government rules, laws, and regulations. We are here to ensure that the practice never contributes in any way to the growing problem of incorrect expenses. As part of this plan, we have implemented a complication program that we believe will help us prevent any Medicaid or Sickness Insurance, Service or billing errors of workers' compensation and federal or state violations.

We also know that we are not perfect! Due to this fact, our policy is to listen to our employees and our patients without any thought of penalties from them if they feel that an event in any way compromises our integrity policy. But so, we welcome your opinion regarding billing to and or maintain a problem so that we can remedy the situation promptly. Thank you for being one of our highly valued patients.

**CONSENT TO DISCLOSE PRIVATE HEALTH CARE INFORMATION FOR THE**

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (parent or guardian) hereby authorize and consent to the WeeKare Pediatrics, 19333 Hwy 59 North Suite 145, Humble, TX 77338 to release any and all medical, I psychological reports or records, including but not limited to, medical notes, narrative doctor, office notes, operational notes, postoperative reports, postoperative diagnosis, pathology reports, x-rays, MRIs, anyone records the reflex treatment for substance abuse, mental illness, AIDS, Virus HIV, alcohol abuse, including and x-rays, diagnostic studies, laboratory slides, clinical extract, stories, letters, and other information contained in this, whatever documents and opinions are relevant to the last, present, or physical and mental condition future, treatment, hospitalization care, and any other personal health information regarding my medical assistance as necessary to perform the treatment, obtain payment, or health care operations.

The release of the materials listed above is being authorized for the purposes of obtaining medical treatment, payment for such services and other health care operations. A copy of this authorization is agreed by the undersigned to have the same effect and strength as an original.

This consent to disclose private health care information may be revoked in writing. However, such revocation will not be effective in an entity that has taken the action in confidence on this consent before its revocation and this consent was obtained as a condition of obtaining insurance and a law provides the insurer with the right to dispute a claim under policy.

Any person, firm, or entity that launches matters pursuant to this authorization is hereby absolved of any liability that might otherwise result from the form of the release of those matters.

I acknowledge more than the information used or disclosed pursuant to this authorization may be subject to re-access of the recipient and no longer protect by privacy regulations.

I understand that I have the right to review the Pediatric WeeKare notice and request restrictions.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19333 Hwy 59 North, Suite 145

Humble, TX 77338

Phone (281) 540-5437

Fax (281) 540-2630

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)

19333 Hwy 59 North, Suite 145

Humble, TX 77338

Phone (281) 540-KIDS - Fax (281) 540-2630

**MEANINGFUL USE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

**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

**\*Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for choosing Wee Kare Pediatrics!**

**[](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiiq9n6ieXPAhXm7IMKHdC2C6YQjRwIBw&url=http://weekare.net/&bvm=bv.135974163,d.amc&psig=AFQjCNGrzJFp4chJBpvB9hkwptLBxbvIfA&ust=1476904915017910)**

**OFFICE POLICIES**

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

\*\*Please read and initial each line for our office policies.

**\_\_\_\_\_** **NEW PATIENT POLICY** - Each physician/provider requires a legal guardian/parent present 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.

\_\_\_\_\_\_ SCHEDULING **SIBLINGS:** We will schedule sibling together as long as our schedule can permit it. If patients no show to their sibling scheduled appointments two (2) times, we will no longer be able to schedule sibling together. It will be vital to call and reschedule or cancel appointments versus no showing as this will count toward not being able to schedule them all together. Cancelations must be done within 24 hours from 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.

\_\_\_\_\_\_ **PARENTAL MEDICAL CONSENT-** WeeKare will not serve the patient who is accompanied by someone other than the parent or legal guardian without written consent prior to the appointment.

**\_\_\_\_\_** **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, consolidate records into one. You may access your child’s account through patient portal at your leisure free of charge.

\_\_\_\_\_ **PRIMARY CARE PROVIDER (PCP) POLICY-** We require that WeeKare Pediatrics is 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. This can result in delaying or canceling your scheduled child’s appointment.

\_\_\_\_\_ **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 your appointment will be rescheduled.

**\_\_\_\_\_** **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.

\_\_\_\_\_ NO **SHOW POLICY-** Our policy is 3 no show appointments without proper notification to our office will result being reported to your insurance company. **We can also terminate patient from our practice for not complying and numerous now shows.**

\_\_\_\_\_\_ **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-** EClinicalWorks service will confirm appointments 2 days prior to appointment via call/text, our Patient Portal will email 2 days prior. Our staff will also make calls to confirm appointments day before and or day of appointment.

**\_\_\_\_\_ WELL CHILD APPOINTMENT**: Our well visits are primarily scheduled 1-2 months in advance Please schedule your child’s well appointment during the month of their birthday on or after their birthday. Contact our call center should your phone number change.

**\_\_\_\_\_\_ SICK (ACUTE) APPOINTMENTS:** Due to COVID-19 our scheduling has been updated. We will see sick acute visits Monday-Friday after 2:00pm.

**\_\_\_\_\_\_ SPORTS PHYSICALS:** Patient(s) must have a current well child exam for the sports physical to be scheduled. If the patient is not up to date both well and sports physical must be booked. **Parents are responsible to provide us with the sports physical forms and parents must complete all necessary information prior. If form is not brought during the appointment a fee will be collected and there is a 3 day turn around time.**

\_\_\_\_\_\_ **REMOVAL FROM PANEL OR TERMINATION FROM PRACTICE-** We reserve the right to remove a patient from our office and/or terminate our relationship in the following situations- refusal of payment, 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.

\_\_\_\_\_\_ **MINOR MEDICAL CALLS ANSWERED BY A MEDICAL ASSISTNAT-** Weekare Pediatrics offers a medical assistant who answers calls for your minor medical questions only for our established patients. Calls are returned the same day; in case you are unsure if a visit is necessary, please make an appointment.

**\_\_\_\_\_ CLEARANCE APPOINTMENTS:** Must be scheduled at least 1-2 weeks prior to the procedure date.

\_\_\_\_\_\_ **MEDICATION REFILLS**- WeeKare Pediatrics does not refill antibiotics and other medications. A follow-up visit or a child's visit may be required. If the patient has not been seen more than 4-month refills will not be authorized a new visit will need to be scheduled. If your medication has refills, please call your pharmacy.

**As of December 7, 2020, we no longer OFFER walk in Monday’s morning available. Schedule your child’s appointments.**

**PAPERWORK REQUEST FEES**

All requests will be process in the order request was received and require a 3-business day turn around. Request must be done in office and paid in full in order to process the request.

**SHOT RECORDS**

$5 for each shot record card requested or to consolidate shot records cards per child. We will not add vaccines that were given in other clinics.

**FORMS**

$5 for each forms, per child (i.e. sport physical, daycare, school, and camp forms, clearance forms) or any form not completed at the time of your child’s visit.

**LETTER REQUESTS**

$10 for each letter requests per child (ie: Immigration, IRS, SS Administration etc.)

**FMLA**

$30 FMLA forms that need to be completed by the physician.

**MEDICAL RECORDS**

The request for personal medical records fee is $25 for the first 20 sheets. $0.50 for any additional sheets.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read and understand the above office policies and agree to comply with office policies and office fees for paperwork requests.**

**\*Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**OFFICE USE ONLY**

**MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date Received: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ROI Status:  Processed  Returned to Requester  Encounter

 Chart Review

 Document(s) released in accordance with scope of patient request

Date records were provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completed by: \_\_\_\_\_

**INTERNAL USE ONLY:**





19333 Hwy 59 North, Suite 145 • Humble, TX 77338

Phone (281) 540-5437 - Fax (281) 540-2630

14630 Woodforest Blvd • Houston TX 77015

Phone (281) 540-5437 – Fax (713) 640-5254

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\*\*\*Please mail or fax to address or number above\*\*\*

DO NOT MAIL CD

**Please read all information and instructions before completing and signing the authorization form.**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print) LAST FIRST MI

|  |  |
| --- | --- |
| INFORMATION TO BE RELEASED **BY**: | INFORMATION TO BE RELEASED **TO**: |
| **REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Organization/Person Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address City, State, Zip  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone # Fax # | **REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Organization/Person Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address City, State, Zip  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone # Fax # |

**TYPE OF MEDICAL INFORMATION REQUESTED:**

* Complete medical records
* Labs
* H & P Progress Notes
* Immunizations
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE INCLUDE MEDICAL RECORDS PERTAINING TO**: (initial requested area):

* Emotional Mental Health / Psychiatric Condition
* HIV /AIDS/ STD’s
* Drug / Alcohol / Substance Abuse

**REASON FOR REQUEST:**  Personal  Moving to new area  Moving to closer clinic  Patient has outgrown pediatrics age

 Transferring Care to a new Pediatrician due to:

 Medical Care of child(ren)

 Wait time in office

 Difficulty Scheduling appointment

 Interaction with office staff

I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity names above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicated that I hereby agree to and authorize the release of patient health information to the above-named person or organization. You have the right to revoke or cancel this authorization, in writing at any time

**THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORDS UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.**

Parent or Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(You may be required to provide legal documentation as proof for power of attorney or guardianship)