230 E. Sycamore St. STE 100
Sherman, TX 75090
Phone: 903-202-2900
Fax: 903-202-2901

Pediatric and Adolescent Medicine

Patient Name – PRINT _____ Date of Birth _____ Social Security Number (Optional) _____

CONSENT FOR TREATMENT

The patient and/or parent/guardian/legal representative agree and consent to general medical treatment by all Texoma Physicians Group, PLLC physicians and providers and furthermore consent to the full access, review and use of the patient's medical records by all Texoma Physicians Group, PLLC. The patient and/or parent/guardian/legal representative also agrees and consents for Texoma Physicians Group, PLLC to view the patient's Rx History from an external source.

UNDERSTANDING OF FINANCIAL RESPONSIBILITY

All professional services rendered will be charged to the patient and/or guarantor. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed that the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Texoma Physicians Group, PLLC to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any Texoma Physicians Group, PLLC physician or provider. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about the patient may be used and disclosed and how I can get access to this information. Per my signature below, I acknowledge that Texoma Physicians Group, PLLC Note of Privacy Practices has been provided to me if requested.

Please call our office if you are going to be late or miss an appointment. No show fee is $25.00. If your family has three no shows within a 12 – month period, you will be dismissed from TPG.

PRINT – Patient/Parent/Guardian/Legal Representative _____ Relationship to Patient _____ Date _____

SIGNATURE – Patient/Parent/Guardian/Legal Representative _____

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Texoma Physicians Group

Pediatric and Adolescent Medicine Patient Registration Form

PATIENT INFORMATION *(Please Print ONLY)*

Patient's Last Name:	First Name:	M.I.:	Birth Date:	Age: ___ Sex: ··· Male ··· Female Social Security No.:
			– –	/ /

Street Address:	City:	State:	ZIP:	Home Phone No.:
				( ) –

Other family members treated here:

PARENT(S) / LEGAL GUARDIAN INFORMATION

Mother's Last Name:	First Name:	M.I.:	Birth Date:	Social Security No.:
			– –	/ /

Street Address: (or same as above)	Home Phone No.:	Work Phone No.:	Cell Phone No.:
	( ) –	( ) –	( ) –

Occupation:	Employer:	Name of Spouse: (if not Father/Legal Guardian)

Father's Last Name:	First Name:	M.I.:	Birth Date:	Social Security No.:
			– –	/ /

Street Address: ··· *Check here if same as above*	Home Phone No.:	Work Phone No.:	Cell Phone No.:
	( ) -	( ) –	( ) –

Occupation:	Employer:	Name of Spouse: (if not Mother/Legal guardian)

INSURANCE INFORMATION

Primary Ins. YES NO	Policy Holder:	Relationship to Patient:

Insurance Company:	Insurance Address:	Insurance Phone No.:

Member/Subscriber ID:	Group/Plan Number:	Deductible: $	Co-Payment: $

Secondary Ins: YES NO	Policy Holder:	Relationship to Patient:

Insurance Company:	Insurance Address:	Insurance Phone No.:

Member/Subscriber ID:	Group/Plane Number:	Deductible: $	Co-Payment $

IN CASE OF EMERGENCY

Name of friend / relative (not living at same address):	Relationship to patient:	Work Phone No.:	Cell Phone No.:
		( ) –	( ) –

CONSENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to Texoma Physicians Group PLLC. I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

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Parental Authorization for Treatment of a Minor

State of: _____

County of: _____

I, _____, parent/guardian of _____, a
Parent/Guardian Name Patient's Name

minor child born on _____/_____/_____ hereby authorize:

_____ _____
Name of authorized individual/relation Name of authorized individual/relation

_____ _____
Name of authorized individual/relation Name of authorized individual/relation

To give consent for the medical treatment of the above-named child for any condition that he/she may encounter and to give consent for all well child checkups, including vaccinations, at Texoma Physicians Group, PLLC. I also authorize the providers within the group to give information to the individual(s) named above regarding the diagnosis, plan of treatment and any information necessary for the care of the above-named child. I hereby release Texoma Physicians Group, PLLC of any liability regarding the release of this information on the above-named child.

Optional: I hereby authorize my child (ages 16 years and up only) to receive medical treatment without an authorized person accompanying him/her. _____
Initial

Executed this _____ day of _____, 20_____.

_____
PRINT – Parent/Guardian Name

_____
SIGNATURE – Parent/Guardian Name

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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, and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ Signature _____ Date _____

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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information
Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

TPG

Pediatric and Adolescent Medicine

Medical Records/Information Release FROM Outside Entity

Please release all information from the record of:

_____	____/____/____	_____-_____-_____
Patient Name – PRINT	Date of Birth	Social Security Number

_____	_____
Date(s) of Treatment – <ALL DATES>	Phone Number

I hereby authorize_____ to release information to:
Sending Clinic/Hospital/Entity/Custodian of records

Texoma Physicians Group, PLLC – Pediatric and Adolescent Medicine
230 E. Sycamore St. STE 100
Sherman, Texas 75090
Phone: 903-202-2900
Fax: 903-202-2901

Information to be released:

*Entire Chart/Record	*Laboratory Reports
*Vaccination Record	*Radiology Reports
*Clinic Progress Notes	*Face Sheet
*Emergency Notes	*Other: _____

Reason for patient information request:_____
-- If necessary. (Examples: continuation/transfer of care, legal purposes, personal use, school...)

I understand that my records are confidential and cannot be disclosed without my direct written authorization, except when otherwise permitted by law. I understand the specific information to be disclosed may include but is not limited to history of drug and alcohol abuse, mental health treatment or information concerning communicable disease such as Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) and laboratory results, treatment progress or any other such related information.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will expire 365 days from the date if my signature or as otherwise specified by date, event, or condition as follows: _____.

I further authorize that a photocopy or facsimile of this authorization is acceptable as an original.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in circumstances such as for participation in research programs or authorization of the release of testing results for the pre-employment purposes. Also, I understand I may be charged a retrieval/processing fee for obtaining copies of my medical records according to Texas Law.

_____	_____	____/____/____
PRINT – Patient/Parent/Guardian/Legal Representative	Relationship to patient	Date

_____
SIGNATURE – Patient/Parent/Guardian/Legal Representative

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical records or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5000 in the case of each subsequent offense.