

Welcome to 1st Choice Pediatrics! We are excited that you have chosen us to provide your child's primary care; we are looking forward to working with your family. Attached you will find our patient registration forms. Please complete and submit documents to our office prior to or at the time of your visit.

It is also important that you contact your insurance company to notify them that 1st Choice Pediatrics will be serving as your child's primary care provider. Also, please bring your insurance card(s) so that we may courtesy bill on your behalf.

Thank you,

1st Choice Pediatrics



Financial Policy

1st Choice Pediatrics recognizes the need for a clear understating between patient and medical providers regarding financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning payment for professional services.

- 1. Payment: Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed if you have an HMO or PPO plan, you are responsible for any balance after insurance processes your claim. Any balance remaining after insurance processes claim is due immediately. Accounts not paid in full may be referred to an outside collection agency.
- 2. Self Payment: If you have no insurance coverage or are underinsured we offer a reduced price for services and vaccines, to be paid in full when services are rendered. We must be notified before you see the doctor if you will need the discount. The discount is only applied if you do not have a balance and it must be paid in full at the time of service. State funded vaccines are available at a discounted price with proper paperwork.
- 3. Managed Care: All managed care (HMO, PPO, etc) co-payment amounts are due at the time of service. By signing below, the patient (parent) acknowledges that it is the patient's (parent) responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.
- 4. Children of Divorced Parents: The parent or guardian who brings the child for any visits is the responsible party. Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of 1st Choice Pediatrics.
- 5. Returned Checks: There will be a \$30 charge for returned checks.
- 6. Also, if you receive non-preventive services (sick) during preventive visit (well), additional co-pays, deductibles or co-insurances may incur.

1st Choice Pediatrics firmly believes that a good patient/primary care provider relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide that highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (903) 230-0235.

Acceptance of Financial Terms

By signing this agreement, I accept the financial terms noted above and certify that the information contained on the 1st Choice Pediatrics forms is true and correct. Furthermore, I understand it is my responsibility to present 1st Choice Pediatrics with valid insurance and contact information at each visit and notify the office of any changes at any time in the future

| Patient Name (Please | Print) | Patient's Date of Birth | |
|----------------------|--------|-------------------------|--|
| Parent's Signature | | Date | |



Patient Registration

| Last Name: | First Name: | MI: |
|--|-----------------------------------|--|
| Date of Birth:/ Sex: | Primary Language: | n en |
| Ethnicity: Hispanic / Non-Hispanic / Unkno | own / May decline Race: Asian / I | Black / Hawaiian / White / May decline |
| Primary Mailing Address: | | E to a secure conservation of the conservation |
| (Street or PO Box) | (City) | (State & Zip) |
| Primary Phone: () | | |
| E-mail address:appointment reminders) | (this e-mail | address will be used for patient portal and |
| Insurance: | | |
| Primary Policy: Policy Holder's Name: | | - To de demigranisti is i popul ye a little d |
| Policy Holder's Birth Date: | Policy Holder's Sex: Male | / Female |
| Insurance Carrier: | Patient's Relation to Police | cy Holder: |
| ID#: | Group #: | |
| Parent/Legal Guardian Information | | |
| Contact 1: Name: Lives with patient? Yes / No | Relation to Patient: _ | |
| Cell Phone: () | Value of the second | The second of th |
| Email: | | e i realis establicado de la composición del composición de la com |
| Contact 2: Name: | R | elation to Patient: |
| Lives with patient? Yes / No Work Phone: () | | |
| Email: | | |
| Employer: | Occupation: | |



Additional Contact Questions: Who should receive billing statements? May all contacts have access to the patient's records electronically (patient portal)? Yes / No / Please provide names of siblings that are also patients: Additional Person(s) (Other than parent or guardian) allowed accompanying child or receive medical information: Emergency Contact, other than parents: Name & Relationship 1: ______ (if individual is not listed, please send note authorizing consent for treatment) If parents are divorced or separated please fill out this section: Who has custody? Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No If yes, please explain and provide a copy of any legal paperwork that supports this restriction. How did you hear about us (if new patient): I/We Agree to: 1. Give the providers and staff of 1st Choice Pediatrics permission to examine and treat my child. 2. Authorize release of information to my insurance carrier for the purpose of processing claims. I hereby assign medical insurance benefits, to include major medical to the medical providers of 1st Choice Pediatrics. Pay for services when rendered unless other arrangements are made prior to the visit. 3. Should my account become delinquent, I agree to pay the necessary collection and/or attorney's fee. 4. Be financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state the procedure is a "non-covered benefit" and "patient is not responsible."

Signature:



Relationship to patient

Release for Release of Medical Records

| I hereby authorize: | | |
|--|--|--|
| | ous Provider's office, Clinic, Dept | of Health) |
| | To release the information to | o: |
| | 1 st Choice Pediatrics | |
| | 1205 North 6 th St. | |
| | Longview, TX 75601 | |
| | 903-230-0235 Fax: 903-230-02 | 242 |
| Patient Name: | y a araginet était d'allitair | richille in Artini i i vanco |
| astro version of the second of | , attended and later defer to | and the appendix to the second |
| Social Security # | Date of bi | rth |
| Information to be released: | | |
| Initial examination | Discharge summary | Office notes |
| Follow-up care/Progress notes | Office visit notes | All records |
| | d all medical records regarding nuding but not limited to: psychol | my treatment, hospitalization and/or logical or psychiatric impairment, drug |
| This authorization will expire thirty (3 event or condition. | 30) days from the date of my sign | nature or as otherwise specified by date, |
| Signature of parent/legal guardi | ian Da | ite |
| | | |

Witness Signature

TEXAS DEPARTMENT OF STATE HEALTH SERVICES IMMUNIZATION REGISTRY (ImmTrac) MINOR CONSENT FORM



| MINOR CONSENT FORM | | | | | |
|---|-----------------------------|--|--|--|--|
| (Please print clearly) | | | | | |
| | For Clinic/Office Use | | | | |
| Child's Last Name | | | | | |
| Child's First Name | Child's Middle Name | | | | |
| / / / *Children under 18 years only. Child's Date of Birth | Child's Gender: Male Female | | | | |
| Child's Address | Apartment # Telephone | | | | |
| | Apartment # Pelephone | | | | |
| City | State Zip Code County | | | | |
| Mother's First Name | Mother's Maiden Name | | | | |
| records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry. | | | | | |
| Consent for Registration of Child and Release of Immunization Records to Authorized Entities | | | | | |
| I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by: • a public health district or local health department, for public health purposes within their areas of jurisdiction; • a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient; | | | | | |
| a state agency having legal custody of the child; | | | | | |
| • a Texas school or child-care facility in which the child is enrolled; | | | | | |
| • a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347. | | | | | |
| By my signature below, I <u>GRANT</u> consent for registration. I wish to <u>INCLUDE</u> my child's information in the Texas immunization registry. | | | | | |
| Parent, legal guardian or managing conservator: | | | | | |
| Printed Name | | | | | |
| Date Signature | | | | | |

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.bx.us for more

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

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 • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7 Revised 05/18/2012





<u>PROVIDERS REGISTERED WITH ImmTrac</u> – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.