**Nassau Bay Pediatrics**
**2640 E. League City Parkway, STE 114**
**League City, TX 77573**

**Phone: 281-212-2400**
**Fax: 281-212-2499**

**Patient Information:**

Last_____ First_____ MI_____

DOB_____ Gender_____ SS#_____

Address_____ City/State/Zip_____

**Parent Information:**

**Mother**: Last_____ First_____ MI_____

DOB_____ SS#_____ Marital Status_____

Home Phone:_____ Cell Phone:_____

Driver's Lic#_____ Exp. Date_____ State_____

Email Address_____

Employer Name_____

Address_____ Phone#_____

**Father**: Last_____ First_____ MI_____

DOB_____ SS#_____ Marital Status_____

Home Phone:_____ Cell Phone:_____

Driver's Lic#_____ Exp. Date_____ State_____

Email Address_____

Employer Name_____

Address_____ Phone#_____

**Nassau Bay Pediatrics** **Phone: 281-212-2400**
**104003776** **Fax: 281-212-2499**
**League City, TX 77573**

**Insurance Information:**

**Primary Insurance Name** _____

Claims Mailing Address _____

Insurance ID # _____ Group # _____

Subscriber Name _____ DOB _____

Address _____ City/State/Zip _____

Phone # _____

Employer _____ Work # _____

Subscriber's Relationship to patient _____

**Secondary Insurance Name** _____

Claims Mailing Address _____

Insurance ID # _____ Group # _____

Subscriber Name _____ DOB _____

Address _____ City/State/Zip _____

Phone # _____

Employer _____ Work # _____

Subscriber's Relationship to patient _____

**Emergency Contact: In the event of an emergency, please list a contact person, not living with you.**

Name: _____ Phone # _____

Address _____ Relationship _____

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**(Patient name)** **(Patient DOB)**

To Our Valued Patient:

Today we are pleased to welcome you as one of our newest patients. It is our primary goal to provide you with quality medical care.

Due to the effect that missed appointments could have on your health, we have established the following guidelines regarding missed appointments.

Each time a patient does not show up to their scheduled appointment without prior notification, the office will attempt to notify the patient by phone and/or mail to reschedule your appointment.

Your physician will be notified of missed appointment(s).

If there is a pattern of repeated missed appointments, the appointments you missed will be reviewed and a determination made whether we can continue to provide you with medical care.

Please make it your utmost concern to arrive at you appointment time. If for some reason you are not able to keep you appointment, except in the case of emergencies, please provide our office 24 hour notice so we can help you reschedule.

**I have read and understood the Policy regarding missed appointments.**

**Signature of patient or responsible party** **Date**

# *Nassau Bay Pediatrics, P.A.*

**2640 E. League City Parkway, STE 114**
**League City, TX 77573**
**P- 281-212-2400 F-281-212-2499**

**Annette B. Ingraham,MD**
**Rajamma E. Kalia, MD**
**Marissa S. Perona, MD**

## INSURANCE COVERAGE ACKNOWLEDGEMENT

Benefits available to you through your insurance company differs depending on your employer and your coverage. Unfortunately, there is no uniformity which makes it difficult for you to know exactly what your plan covers. To become an informed consumer, we encourage you to review details of your plan available to you through insurance web sites and printed materials.

Nassau Bay Pediatrics does check or "verify" coverage. However, information available to us may not be complete. Certain services that are medically recommended may not be a "covered service" as defined by the limits of your insurance policy. Deductible amounts and copays also change periodically, even with the same employer and same coverage options.

At the time of service, we try to make you aware of non covered services if that information is available to us. The "waivers"are an attempt to make you aware that certain charges may not be covered and therefore you might incur additional charges.

Yours truly,

Nassau Bay Pediatrics

_____ _____

(Parent/Guardian Signature of Acknowledgement) (Date)

# Nassau Bay Pediatrics, PA

## Acknowledgement of Notice of Privacy Practices

_____ _____

(Patient Name) Date

Was a notice of Privacy Practices given to the patient or the personal representative?

YES NO

If not, why not? _____

_____ _____

Signature Date

_____

Office Use Only:

If a patient or personal representative received a Notice but refused to sign above, did you make a good faith effort to obtain this acknowledgement? YES NO

Why were you unable to obtain? _____

Restriction on use of PHI? Yes No

If "YES" please explain _____

_____

Printed Name of Associate

_____

Signature of Associate

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**2640 E. League City Parkway, STE 114**
**League City, TX 77573**

**Phone: 281.212.2400**
**Fax: 281.212.2499**

# Consent to Treatment and Acknowledgement

I consent to treatment as necessary or described for the care of the patient named, including, but not restricted to drugs, medications, lab test, or other studies, which may be used by the physicians or his/ her qualified designee.

I accept responsibility for the payment of services and agree to pay my bill in full at the time of services, unless other arrangements have been made.

I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Nassau Bay Pediatrics, PA will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a responsible period of time.

I authorize Nassau Bay Pediatrics, PA to release information as required to my insurance or third party payer for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/ or mental health issues.

I also authorize Nassau Bay Pediatrics, PA to bill my insurance or third party payer and receive payment for services rendered.

Patient, Parent, or Guardian_____
(Please Print)

Signature_____ Date_____

**Nassau Bay Pediatrics**
**2640 E. League City Parkway, STE 114**
**League City, TX 77573**
**281.212.2400**

# Medical Treatment Authorization

I, _____ the parent and/or legal

guardian of_____ _____,
(**Patient Name**) (**Date of Birth)**

hereby authorize_____
(**Name and Relationship of person BESIDES PARENTS/GUARDIAN to accompany child**)

To accompany my above-named child to office visits with Nassau Bay Pediatrics and to consent to the examination, diagnostic testing, immunization, and/or treatment of my child during office visits.

This authorization:

_____ is effective only on _____, 20____.

_____ is effective from _____, 20 ____ to _____, 20 ____.

_____ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time in writing to Nassau Bay Pediatrics.

_____ _____
**SIGNATURE (Parent/Guardian)** **DATE**

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
☐ Other

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)

**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.**

**Questions?** Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
**Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**

# Child Health History

## Child Health Records

### Pregnancy and Birth

G_____ P_____ AB_____
Total number of living children_____ Weight gain/loss_____
Mother's age at birth_____
Number of years between precious pregnancy and this child_____
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider_____
Vitamins:_____Y_____N Iron:____Y_____N
If child over 5 years: uncomplicated pregnancy, labor, and delivery and nursery course:_____Y_____N
*If yes, proceed with "Child's Medical History."*

### Maternal Complications

_____Vaginal bleeding
_____Anemia
_____Hypertension
_____Rh negative
_____Diabetes
_____Premature labor
_____Injury/hospitalization/surgery
_____Dental disease
_____Flu-like illness or high temp.
_____Kidney or bladder infection
_____STDs
_____Hepatitis (A, B, or C)
_____Exposure to TB
_____Exposure to lead/chemicals

### Maternal Substance Use

_____OTC meds_____
_____Prescription meds_____
_____Tobacco_____
_____Alcohol_____
_____Street drugs_____
_____Caffeine_____

### Family Medical History

Abbreviations for relatives listed below.

M – Mother MGM – Maternal Grandmother PGM – Paternal Grandmother
F – Father MGF – Maternal Grandfather PGF – Paternal Grandfather
S – Sibling MA – Maternal Aunt PA – Paternal Aunt
MU – Maternal Uncle PU – Paternal Uncle

_____Anemia Y N HIV + Individual in household (do not identify)
_____Heart disease before age 50
_____Cholesterol req. treatment
_____Hypertension/stroke
_____Asthma/allergy
_____Cancer
_____Diabetes
_____Epilepsy/seizures
_____Kidney problems
_____Muscle/bone disease
_____Genetic disease or major birth defects
_____Childhood hearing impairment
_____Tuberculosis
_____Other immunosuppression
_____Dental decay
_____Alcohol/drug abuse
_____Tobacco use
_____Learning disorder
_____Mental retardation
_____Psychiatric disorder
_____Physical/sexual/emotional abuse
_____Domestic violence

Explanation of positive history:

Signature/Title:_____

Date:_____

### Patient Information

Name:_____
DOB:____/_____/_____Age:_____Sex_____
SSN/Record No.:_____
Race/Ethnicity:_____
Informant/Relationship:_____
Medical Home:_____

### Birth/Delivery

Place of Birth_____
Birth attendant_____
Hours of labor_____

_____Term
_____Premature (Weeks)_____
_____More than 2 weeks overdue

**Type of delivery:**
_____Vaginal
_____C-Section
_____Forceps

**Complications:**
_____Breech
_____Mulitple births
_____Other

Explanation/Other:

### Nursery Course

Birth Weight_____ Birth Length_____ FOC_____

_____Difficulty with initial breathing
_____Heart Murmur
_____Infection
_____Transfusion
_____Jaundice req. treatment
_____Seizures

Age at discharge:_____ICN: _____days
**Newborn blood screening (date/location):**
1. _____
2. _____
**Newborn hearing test (in hospital):** _____Normal_____Abnormal
Type of test: _____ABR _____OAE _____Unknown
Referral made: _____Y _____N
Comments:

### Child's Medical History

Immunizations current: _____Y _____N _____Record unavailable
Dental care/sealants current: _____Y _____N

_____Trauma/injuries
_____Hospitalizations
_____Surgery
_____Medications
_____Anemia
_____Early childhood caries
_____Hepatitis
_____Strep throat
_____Ear infections
_____Bladder/kidney infections
_____Pneumonia
_____Developmental delays
_____Vision problems
_____Hearing problems
_____Seizures
_____Environmental toxin exposure (lead, etc.)
_____Allergies
_____Asthma
_____Eczema
_____Substance use (alcohol, drug, tobacco)
_____Other

Explanation:

Signature/Title:_____

# Nassau Bay Pediatrics, PA
## Notice of Privacy Practices
May 19, 2008

This notice describes how medical information about you may be used, and disclosed, and how you can get access to this information.

**Please review it carefully.**

If you have any questions, please contact our Privacy Officer at the address and/or phone number at the end of this notice.

Who will follow this notice?

Nassau Bay Pediatrics, PA provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practice in the notice will be followed by:

- Any healthcare professional who treats you
- All employed staff or volunteers
- Any business associates or partners of Nassau Bay Pediatrics, PA with whom we share health information

Our Pledge to you

We understand that medical information about you is personal. We are committed to protecting medical and billing information about you. We create a designated record of the care and service you receive to provide quality care and to comply with legal requirements. The notice applies to all of the records of you care that we maintain. We are required by law to:

- Keep medical and billing information about you private
- Give you this notice of our legal duties and privacy practices with respect to your protected health information
- Follow the terms of the notice currently in effect

Changes to this Notice

We may change our policies and privacy practices at any time. Changes will apply to you protected health information we already hold, as well as any new information obtained after the change occurs. When we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and/or exam rooms.

You can receive a copy of our current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice on the date of the first service delivery. You will also be asked to acknowledge in writing the receipt of this notice.

How we may use and disclose you protected health information

- We may use and disclose medical and billing information about you for treatment (such as sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company); and to support our health care operations (such as comparing data to improve treatment methods).
- We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected health information about without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, organ donations, workers' compensation purposes, and during emergencies. We may also disclose protected health information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.
- We may contact you for appointment reminder, or to tell you about or recommend possible treatment options, alternatives, health related benefits or services that may be of interest to you.
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that you family can be notified of you location and condition.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing you protected health information. If you choose to authorize our use of disclosure of you protected health information, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we will charge a fee for the cost of copying, mailing or other related supplies. If we deny you request to review or obtain a copy, you may submit a written request for a review of the decision.
- If you believe that information in you record is incorrect or if important information is missing, you have the right to request that we correct the records. Your request must be submitted in writing. A request for amendment must provide you reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclose medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written

request. The request must state the time period desired for the accounting, which must be less than a 6 year period and starting April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12 month period is free; other request will be charged according to our cost of producing the list. We will inform you of the cost before you incur any cost.

- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than you home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request in writing, that we not sue of disclose medical information about you for treatment, payment, or healthcare operations or to persons involved in you care except when specifically authorized by you, when required by law, or in an emergency. We will inform you of our decision on your request.

All written request or appeals should be submitted to our Privacy Officer listed on this notice.

<u>Complaints</u>

- If you are concerned that you privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact Christy D Cole @ 281-212-2400.

- You may also send a written complaint to the US Department of Health and Human Services Office of Civil Rights

- Under no circumstances will you be penalized or retaliated against for filing a complaint.

## Nassau Bay Pediatrics, PA

### Privacy Officer Contact Information

Kelly Coleman
Privacy Officer/Manager
2640 E. League City Blvd, STE 114
League City, TX 77573
281-212-2400
Fax 281-212-2499 Fax