Stephenville Medical & Surgical Clinic
Proud Member of Privia Medical Group
Community Health Clinic
Eye Care Consultants

Pediatric Patient Information Form

1. PATIENT INFORMATION:

PATIENT NAME: LAST | FIRST | MIDDLE

PREFERRED NAME/ NICKNAME | SOCIAL SECURITY# | DATE OF BIRTH MM/DD/YYYY

SEX: M F | MARITAL STATUS | EMAIL ADDRESS

MAILING ADDRESS: | DRIVER LICENSE#

CITY | STATE | ZIP

IS THIS A WORK RELATED INCIDENT? YES NO | PRIMARY CARE PHYSICIAN:

RACE:
_____ ASIAN OR PACIFIC ISLANDER _____HISPANIC
_____ BLACK OR AFRICAN AMERICAN _____ WHITE
_____ OTHER: _____
_____PREFER NOT TO PROVIDE RACE/ETHNICITY

ETHNICITY:
_____ HISPANIC OR LATINO
_____ NOT HISPANIC OR LATINO

PATIENT PREFERRED LANGUAGE:
_____ENGLISH
_____SPANISH
_____OTHER:_____

2. EMERGENCY CONTACT INFORMATION:

NAME | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

3. GUARANTOR INFORMATION: Patients under 18 need a Guarantor (who is responsible for the bills and where they will be sent)

NAME | DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY#

RELATIONSHIP TO PATIENT | GUARANTOR ADDRESS | GUARANTOR EMPLOYER

4. COMMUNICATION AUTHORIZATION:

	PHONE NUMBER	OK TO LEAVE A DETAILED MESSAGE YES OR NO
Cell Phone		☐ ☐
Cell Phone Carrier:	☐Verizon ☐Cellular One ☐T-Mobile ☐ Sprint ☐AT&T ☐Cricket Wireless ☐Other : _____	☐ ☐
Home Phone		☐ ☐
Day Phone		☐ ☐
Guarantor Phone		☐ ☐

WOULD YOU LIKE TO RECEIVE TEXT MESSAGE REMINDERS* _____ **YES** _____ **NO**

***Text messages sent through unsecured message- we will not send any personal information through text message. Message and data rates may apply.**

PREFERRED TO BE CONTACTED BY: ____ **Cell** _____**Home** ____ **Day** ____**Patient Portal** ____**Email**

5. WHAT PHARMACY(S) DO YOU USE: 1) 2)

X_____ _____ _____

Signature of Patient or Legally Responsible Party **Relationship to Patient** **Date**

Revised 3/10; 1/11; 6/11; 6/13; 7/18;1/19; 12/19; 2/20

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Birth through 20 years Health History

NAME:	**MEDICAID ID:**
DOB:	**INFORMATION/RELATIONSHIP**
AGE: **GENDER:**	**MEDICAL HOME:**

IF CHILD OVER 5 YEARS: uncomplicated pregnancy, labor, delivery and nursery course: Y* N

**If yes, proceed with "Family and Personal Medical History."*

IF OVER 5 YEARS OLD

PREGNANCY

G ☐ P ☐ AB ☐

Total number of living children: _____ Weight gain/loss: _____

Mother's age at birth: _____

Number of years between previous pregnancy and this child: _____

Trimester Prenatal Care Began: 1 ☐ 2 ☐ 3 ☐

Prenatal Care Provider: _____

Vitamins: Y ☐ N

MATERNAL COMPLICATIONS

	Vaginal bleeding		Flu-like illness or high temp
	Anemia		Kidney or bladder infection
	Hypertension		STIs
	Rh negative		Hepatitis (A, B, or C)
	Diabetes		Exposure to TB or had TB
	Premature labor		Exposure to lead/chemicals
	Dental disease		Injury/hospitalization/surgery

MATERNAL SUBTANCE USE

	OTC meds:
	Prescription meds:
	Tobacco:
	Alcohol:
	Street drugs:
	Caffeine:

BIRTH/DELIVERY

Place of birth:

Birth attendant:

Hours of labor:

	Term	Premature (weeks):
	More than two weeks overdue	

Type of delivery:

	Vaginal		C-Section		Forceps	Other/Explanation:

NURSERY COURSE

Birth Weight:		Birth Length:	FOC:
	Difficulty with initial breathing		Transfusion
	Jaundice req. treatment		Heart murmur
	Infection		Seizures

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:

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/blood disorder		HIV + individual in household (do not identify)
	Heart disease before age 50		Other immunosuppression
	Cholesterol req. treatment		Dental decay
	Hypertension/stroke		Tobacco use
	Asthma/allergy		Learning disorder
	Cancer		Mental retardation
	Diabetes		Psychiatric disorder
	Epilepsy/seizures		Physical/sexual/emotional abuse
	Genetic disease or major birth defects		Childhood hearing impairment
	Tuberculosis		

Other/Explanation:

PERSONAL MEDICAL HISTORY

Immunizations current:	Y	N	Record Unavailable
Dental care current	Y	N	Sealants: Y N

	Trauma/injuries		Vision problems
	Hospitalizations		Hearing problems
	Surgery		Seizures
	Medications		Environmental toxin exposure (lead, etc.)
	Anemia		Allergies
	Early childhood caries		Cancer
	STIs		Asthma
	Strep throat		Eczema
	Ear infections		Substance use (alcohol, drug, tobacco)
	Pneumonia		Developmental delays/learning disorder
	Physical/sexual/emotional abuse		Immune suppression
	Muscle/bone disease		Psychiatric disorder

Other/Explanation:

DATE: _____

Signature/title: _____

Signature/title: _____

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Financial Policy

Thank you for choosing Stephenville Medical & Surgical Clinic (SMSC), and/or Community Health Clinic (CHC), and/or Eye Care Consultants (ECC), for your health care needs. We are committed to delivering outstanding health care services to you, our patient. As a part of our professional relationship, it is important that you understand our financial policy.

All patients must read & sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you are financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
  - We may accept assignment of insurance after verification of your coverage. Please be aware that your insurance company may not fully cover some, or perhaps all, of the services provided. **You are financially responsible for services not considered a benefit by your insurance company.**
  - Before receiving services, verify we are participating providers for your insurance plan. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
  - Copayments, coinsurance and/or deductibles are due at the time of service. We may estimate the amount you owe based on information we received from your insurance company. You are responsible for paying the full amount determined by your insurance company after your claim is processed – **regardless of our estimation**.
  - If you do not have insurance, a discount for professional services may be given if 1) your balance is paid in full on the day services are rendered and 2) there is no outstanding balance on your account. Discount does not apply if payment method is CareCredit.
- **It is your responsibility to provide us with your most current billing information.**
  - You must provide your most current billing address, all available telephone numbers and other contact information. **If your address or contact information changes, it is your responsibility to provide updated information.**
  - We will send a statement (to the billing address you provide) notifying you of balances owed. If you have any questions or dispute the validity of the balances, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You may call 254-968-6051 ext. 4204.
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due.
  - If you are not able to pay the balance due in full, contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. **You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.**
  - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Texas law.
  - **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at time of service. We accept cash, check (with appropriate ID), debit/credit card, & CareCredit. I have read and understand this Financial Policy.

_____ _____
Patient Name (Printed) **Patient Date of Birth**

X _____ _____ _____
Signature of Patient or Legally Responsible Party **Relationship to Patient** **Date**

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HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of Medical Information to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My Spouse: _____
- ☐ My Children: _____
- ☐ My Parents: _____
- ☐ Other: _____

I consent and authorize the release of Financial Information to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My Spouse: _____
- ☐ My Children: _____
- ☐ My Parents: _____
- ☐ Other: _____

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

Yes No

Do you have an advanced directive (Living Will)?

Yes No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

Yes No

_____ _____
Patient Name (Printed) **Patient Date of Birth**

X_____ _____ _____
Signature of Patient or Legally Responsible Party **Relationship to Patient** **Date**

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Authorizations, Forms, and Consents

CONSENT TO TREATMENT: I, the undersigned, as the patient (or on behalf of the patient) do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the practitioner on duty. I understand that no guarantee or assurance has been made as to the results that may be obtained.

ASSIGNMENT OF BENEFITS: I hereby authorize that any benefits or fees payable to me by any insurance companies be paid directly to the Stephenville Medical & Surgical Clinic, PA, Community Health Clinic, LLP, Eye Care Consultants and/or any ancillary providers. I understand that this order does not relieve me of my obligation to pay the account. I understand that I am responsible for health insurance deductibles and coinsurance.

ACCESS TO MEDICAL INFORMATION: I give consent to release, permit access to, or inspection of my medical records by my Health Plan, State and Federal regulatory authorities and/or their authorized representatives. I further consent and authorize Stephenville Medical & Surgical Clinic, PA, Community Health Clinic, LLP, and Eye Care Consultants to release or review my medical record as necessary for determination or collection of insurance benefits and/or in the performance of quality review, maintaining measures of confidentiality and security.

MEDICARE & MEDICAID BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVIII of the Social Security Act and/or Title XIX is correct. I authorize the release of all records required to act on this request so that payment of authorized benefits be made to Stephenville Medical & Surgical Clinic, PA and/or Community Health Clinic, LLP and/or Eye Care Consultants.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED IN WRITING BY THE PATIENT.

Patient Name (Printed)	Patient Date of Birth	
X Signature of Patient or Legally Responsible Party	Relationship to Patient	Date

SMSC/CHC/ECC Employee

Employee Name (Printed)

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Consent for Treatment

By signing this consent, I am authorizing my physician(s) and/or another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Privia Medical Group Norht Texas, Stephenville Medical & Surgical Clinic, Community Health Clinic, or Eye Care Consultants unless revoked by me in writing.

Patient Name (Printed)	**Patient Date of Birth**

X		
Signature of Patient or Legally Responsible Party	**Relationship to Patient**	**Date**

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Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Patient Name (Printed)	**Patient Date of Birth**

X_____	_____	_____
Signature of Patient or Legally Responsible Party	**Relationship to Patient**	**Date**

Take Control of Your Healthcare with the New Patient Portal

- **Messaging.** Ask your doctor or care team a question, share an update, and/or send an attachment
- **Appointments.** View and request appointments
- **Medications.** Request refills and/or renewals and review your prescription medications
- **Health Record.** View visit summaries, lab results, and other documentation
- **Pay Bills.** Pay your medical bills online

How can it help me?

The new PXP Patient Portal helps you conveniently and securely connect with your (or your dependents) doctor, manage care, and view health information on web-enabled devices.

How can I get started?

1. Provide your email address to your doctor's office. Once you receive your invitation, follow the link to https://www.txhealthcare.com/ and click on Patient Portal.
2. Create a username and password, then follow the onscreen prompts to activate your account.
3. Use your secure portal to stay in touch with doctors and access your health information anytime, anywhere.

SCAN ME

to LOG IN TODAY!

For help setting up your new portal, contact our Portal Support Line at 817-740-8555.