BLUE FISH

PEDIATRICS

www.bluefishmd.com

Understanding Our Registration Forms

Thank you for choosing Blue Fish Pediatrics. To register a new patient, please fill out all of the following forms. In order to minimize wait time at your initial office visit, please have all forms completed, signed, and dated before you arrive at the office.

Below is a brief explanation of each form you will be filling out.

New Patient Registration
This form records general and health insurance information about the patient.

Patient Medical History Questionnaire
This form records the medical background of the patient and blood relatives.

Acknowledgement of Review of Notice of Privacy Practices
This form is an acknowledgment that you have read and understand our Notice of Privacy Practices.

Texas Department of State Health Services Immunization Registry (ImmTrac)
This form allows the Texas Department of State Health Services (DSHS) to have an electronic copy of your child's immunization records. If you consent and you ever lose your child's immunization records, DSHS can replace them for you. If you *do not consent*, please notify the front office staff.

Texas Vaccines for Children (TVFC) Disclaimer
This form is a disclaimer stating that your child is not qualified for TVFC and that the parent/guardian is responsible for all costs associated with vaccinations. *If your child is not qualified for TVFC, please sign and date.*

Texas Vaccines for Children Form (TVFC) Patient Eligibility Screening Record
This form determines whether your child is eligible for TVFC. *If your child is qualified for TVFC, please sign and date.*

Health Insurance Portability and Accountability Act (HIPAA) Authorization
This form explains the privacy rights of the patient's medical records.

Patient Financial Responsibility Agreement
This form explains our financial responsibility policy for the services rendered at Blue Fish Pediatrics.

If you need any assistance filling out these forms, please contact our office. If it is after hours, please leave a message and a receptionist will contact you the following business day.

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Patient Registration

Child's Name: _____ **Date of Birth:** _____

First/Middle/Last mm/dd/yyyy

Gender: ☐ Male ☐ Female

Street Address: _____

City, State Zip Code: _____ Patient Phone Number (if over 13 years old): _____

Who referred you to our office?

Demographic Information

Race: American Indian | Asian | Black or African American | Hispanic or Latino | White | Other: _____ | Decline to Answer

Preferred Language: English | Spanish | Korean | Japanese | Other: _____ | Decline to Answer

Parent(s) / Guardian Information

Father's Name:		**Mother's Name:**	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Employer Name:		Employer Name:	
Employer Address:		Employer Address:	
Occupation:		Occupation:	
Home Phone:		Home Phone:	
Cellular Phone:		Cellular Phone:	
Work Phone:		Work Phone:	
Email Address:		Email Address:	

Siblings: Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Do they attend this office? Yes No If no, do you plan to bring them to this office? Yes No

Emergency Contact Name: _____ Phone: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Blue Fish Pediatrics, LLP for services rendered by its physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, i.e. lab work, blood tests, x-rays etc., that are not covered by insurance will be my financial responsibility.

Authorization to Release Information

I hereby authorize the physicians of Blue Fish Pediatrics, LLP to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Name (Please Print) _____ Date _____

Parent/Guardian Name (Please Print) _____ Signature _____

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Patient Name: _____ DOB: _____ Completed by: _____ Relation: _____

PREGNANCY & BIRTH

Mother's age at pregnancy?

Any illnesses during pregnancy? ☐ YES ☐ NO

Medication during pregnancy? ☐ YES ☐ NO

(exclude vitamins & iron)

☐ Smoking ☐ Alcohol ☐ Street drugs – during pregnancy?

At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)

Type of delivery? Birth Weight: Breech?:

Complications? ☐ YES ☐ NO Apgar:

Problems with baby at birth? Breathing: ☐ YES ☐ NO Jaundice: ☐ YES ☐ NO

Other:

Pass Hearing Screen? ☐ YES ☐ NO Mother's Blood Type:

Were you ever told baby was breech in the third (3rd) trimester? ☐ YES ☐ NO

PAST MEDICAL HISTORY

Allergic reactions? Medicine: ☐ YES ☐ NO

Food: ☐ YES ☐ NO Animals: ☐ YES ☐ NO Insect Bites: ☐ YES ☐ NO

Medications taken on a regular basis? (exclude vitamins)

Immunizations – up to date? ☐ YES ☐ NO Do you have records? ☐ YES ☐ NO

Hospitalizations – (when-where-why?)

Surgeries (when-where?)

	YES	NO		YES	NO		YES	NO
Red Measles	☐	☐	Mumps	☐	☐	German Measles (3 day)	☐	☐
Chicken Pox	☐	☐	Whooping Cough	☐	☐	Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐	Ear Infections	☐	☐	Strep Throat	☐	☐
Asthma/Wheezing	☐	☐	Eczema/Hives	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐	Problems with hearing	☐	☐
Bleeding Tendency	☐	☐	Urinary Infections	☐	☐	Problems with vision	☐	☐
Blood Transfusions	☐	☐	Joint Problems	☐	☐	Other	☐	☐

FEEDING & NUTRITION

Food Allergies

Appetite usually good? ☐ YES ☐ NO

Colic or feeding problems during the first 3 months? ☐ YES ☐ NO

Breast fed? ☐ YES ☐ NO Number of months?

Formula? ☐ YES ☐ NO Current brand?

Vitamins? ☐ YES ☐ NO Brand? Flouride? ☐ YES ☐ NO

FAMILY PROFILE

Parents ☐ Married ☐ Separated ☐ Divorced

Father's Age? Highest school grade? Health?

Mother's Age? Highest school grade? Health?

(List child's brothers, sisters, and their ages)

FAMILY MEDICAL HISTORY

Anemia/Blood Dis

Asthma

Mental Retardation

Drug Problem

Alcoholism

Cancer

Aids

Cystic Fibrosis

Musc. Dystrophy

Tuberculosis

Arthritis

Epilepsy / Seizures

Heart Disease

High Blood Pressure

Cholesterol Problem

Migraine

Sudden Infant Death

Birth Defects

Early Deafness

Diabetes

DEVELOPMENT & BEHAVIOR

Age at which child:

Sat alone: Walked: Bicycled:

Toilet trained: Used sentences:

Development compared to other children?

Grade in school:

Problems in school? ☐ YES ☐ NO

Learning problems? ☐ YES ☐ NO

Getting along with other children? ☐ YES ☐ NO

Behavior problems? ☐ YES ☐ NO

Bad Habits? ☐ YES ☐ NO

Bedwetting? ☐ YES ☐ NO

Nail biting? ☐ YES ☐ NO

Sleeping? ☐ YES ☐ NO

Hobbies / sports?

Use of street or illegal drugs? ☐ YES ☐ NO

SYNOPSIS

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

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

Child's Date of Birth _____ / _____ / _____ *Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply):

☐ American Indian or Alaskan 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 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 ImmTrac2. 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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 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 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 _____

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

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac DC

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

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Texas Vaccines for Children (TVFC) Disclaimer

As a service to our patients, our office participates in the Vaccines For Children (VFC) program, which provides vaccines at no charge for those patients who meet the program's eligibility requirements.*

A patient who meets any one of the following requirements is eligible and automatically **qualifies** for the VFC program:

- is enrolled in Medicaid
- is enrolled in Children's Health Insurance Plan (CHIP)
- does not have health insurance
- is underinsured (has health insurance that DOES NOT pay for vaccines**)
- is an American Indian
- is an Alaskan Native

** Overseas travelers insurance policy holders (e.g. AIU) are considered underinsured.

If your child meets any of the requirements listed above, please complete, sign, and return the TVFC Patient Eligibility Screening Record to our front office staff instead of this disclaimer form. **The TVFC Patient Eligibility Screening Record form must be completed and signed for EACH child that is eligible for the VFC program.**

If your child **DOES NOT** meet any of the requirements listed above, please sign below and return this disclaimer form to our front office staff.

Please be aware that if your child does not meet the VFC requirements and your insurance does not cover the cost of the vaccination(s), you will be responsible for payment.

There are four public health clinic locations in the city of Houston that provide all necessary vaccinations for a nominal fee. Please let us know if you need this information.

Disclaimer

I have read and understand the VFC information above. By signing below, I acknowledge that my child is **not qualified** for the Texas Vaccine for Children (TVFC) program.

_____
Full Name of Child (PLEASE PRINT)

_____
Name of Parent / Guardian (PLEASE PRINT)

_____ _____
Signature of Parent / Legal Guardian Date

Texas Vaccines for Children Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____ _____ _____
Last Name First Name MI

2. Child's Date of Birth: ____ / ____ / _____

3. Parent, Guardian, or Individual of Record: _____ _____ _____
Last Name First Name MI

4. Primary Provider's Name: _____ _____ _____
Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. *If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC eligible children.*

**** Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC Program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

Patient Name: _____
Patient DOB: _____

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HIPAA: Authorization of Use and Disclosure of Protected Health Information

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Blue Fish Pediatrics ("BFP")?
(Please check all that apply)

___Cell Phone ___Primary Telephone ___ Secondary Telephone

___ Regular Mail ___ Email ___ Fax Machine

Other: _____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at BFP? (Check one)

___ Yes ___ No ___ N/A

If "No," how else may we contact you regarding this information?

_____

Please list any other restriction regarding messages or reminders about your healthcare:

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your protected health information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to BFP of your decision to revoke the authorization. You have the right to request restrictions on use or disclosure of your health information.

___ I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

Patient Name: _____
Patient DOB: _____

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HIPAA Authorization (page 2)

Use and Disclosure of Information:

___ I authorize the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at BFP.

___ I do not authorize the following information to be disclosed to any other parties except to me as the patient (please specify):

Persons Authorized to Receive Information:

The following health information and medical treatment BFP collects or receives about you may be disclosed to the following authorize persons to be obtained and received:

_____
Name of person / relation / organization

_____
Name of person / relation / organization

Expiration Date of Authorization

This authorization is effective through ___/___/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to BFP. You should contact the office manager to terminate this authorization.

Potential for Re-Disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____
Name of Patient (print or type)

_____
Signature of Patient (print or type)

_____
Signature of Patient Representative (print or type)

_____
Relationship of Patient Representative to Patient (print or type)

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Acknowledgement of Review of Notice of Privacy Practices

Please note that the Notice of Privacy Practices is available at the front desk to review, by request.

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.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHiE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange

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Patient Financial Responsibility Agreement

Thank you for choosing Blue Fish Pediatrics. We are committed to providing you and your family with the highest quality healthcare. Please read and sign the form to acknowledge your understanding of our patient financial policies.

- The patient is ultimately responsible for the payment of his/her treatment and care. This includes any and all procedures, developmental questionnaires, and vision/hearing screenings that are performed at the time of the visit.

- The patient is responsible for charges associated with Insurance co-pays, co-insurances, deductibles and or non-covered charges.

- Any outstanding patient balances should be paid at the time of service by either parent.

- For patients WITHOUT insurance benefits, payment is due in full at the time of service.

- Newborn parents should produce proof of insurance as soon as possible.

    - If the child reaches 1 month of age and no proof is provided, and we are unable to verify coverage, the parent/legal guardian will be responsible for the entire bill.

- Statements are mailed out monthly. Failure to make payments within 90 days may result in being notified to find alternative medical care.

    - Payment plans are available. Please inquire with our Billing Department.

- Returned Check policy: If payment is made by check, and the check is returned as Non-Sufficient Funds, or Account Closed, the amount of the original check will be due as well as an additional $35 fee.

By signing below, you are agreeing to and understand the above financial agreement. You are acknowledging that as the parent/legal guardian, you are responsible for any charges incurred and agree to pay as stated above.

Patient Name: _____ DOB: _____

Parent/Legal guardian: _____ Date: _____