Mansfield Pediatrics
OFFICE FINANCIAL POLICY

Please read the following carefully and direct any questions you may have to the front office staff.

PAYMENT FOR SERVICES WITHOUT HEALTH INSURANCE:
Payment for services is due on the day of your child's visit. Our cash prices are based on an insurance reimbursement average.

PAYMENT FOR SERVICES USING HEALTH INSURANCE:
Please sign in at the front desk and present your child's current insurance card at every visit. This is your verification of the correct insurance and consent to bill for services on your child's behalf.
IF THE INSURANCE PLAN THAT YOU DESIGNATE IS INCORRECT OR NOT IN FORCE, THEN YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT AND YOU WILL BE BILLED FOR THE VISIT UNTIL YOU PROVIDE THE CORRECT INSURANCE PLAN INFORMATION FOR THE OFFICE TO FILE FOR PAYMENT OF SERVICES. THIS INFORMATION MUST BE RECEIVED WITHIN 30 DAYS OF THE DATE OF SERVICE DUE TO INSURANCE FILING DEADLINES. . . NO EXCEPTIONS!

Some insurance plans will not pay for services unless your child's physician is designated as his Primary Care Provider (PCP). Make sure that your child's physician's name or phone number appears on your card and /or the insurance company has been informed of your child's PCP name as of the date of service, **OTHERWISE YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT.**

IF YOUR CHILD'S PHYSICIAN DOES NOT ACCEPT OR PARTICIPATE IN YOUR INSURANCE PLAN, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR CHILD'S VISIT.

If you participate in a **HIGH DEDUCTIBLE HEALTH PLAN**, you are required to **PAY IN FULL THE ALLOWED AMOUNT ON YOUR INSURANCE UNTIL YOUR DEDUCTIBLE IS MET.**

COPAYMENTS:
Co-payments are due **AT THE TIME OF SERVICE** and are collected at **CHECK-IN** at the front desk.
THE PARENT, LEGAL GUARDIAN, AUTHORIZED RELATIVE OR OTHER AUTHORIZED ADULT WHO IS ACCOMPANYING THE CHILD IS RESPONSIBLE FOR PAYING THE CO-PAY ON THE DAY AND TIME OF SERVICE.
COPAYMENTS MAY NOT BE WAIVED.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS:
You are responsible for knowing what benefits and services your health insurance covers for your child. Insurance benefits **VARY WIDELY**. **Not all services provided in the office are covered by every insurance plan.** For example, some plans do not cover well child visits at all or have a limited maximum amount for well child care per year, or cover only immunizations required by the state. Please check with your insurance plan before scheduling annual health check-ups especially after the age of 4. NOTE: Some annual well child check-ups are covered once every 365 days whereas other health plans allow 1 well child check-up per calendar year.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS – Cont.:
This office does try to verify your child's insurance coverage and benefits several days in advance of your child's scheduled well child visit, but Y**OU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES DETERMINED NOT TO BE COVERED BY YOUR PLAN.**

BALANCES AND BILLS:
You will be advised of any outstanding balances due when you **CHECK IN AT THE FRONT** desk for your child's visit. Payment of outstanding balances **MUST BE ADDRESSED** prior to your child's visit. Balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB) by the billing department. Your bill is due upon receipt of your bill by mail. Please contact the billing office at the number on your statement to discuss bills, balances and payment questions during office business hours.

NON-SUFFICIENT FUNDS CHECKS:
Please save everyone time, money and embarrassment by not writing a potential NSF check.
Please inform the front desk receptionist of any problem you have making proper payment and let her assist you.

There is a $35.00 fee for each check returned for NSF or any other reason AND you will need to pay with cash or valid credit/debit card for any visits in the future.

MISSED APPOINTMENTS:
As a courtesy to other families in the practice who may need appointments for sick children, please give at least 24-hour notice to the office when you will not be able to keep an appointment previously scheduled. **Missing 3 scheduled appointments without prior notice to the office may be grounds for your child's dismissal from the practice.**

I have read and understand the office financial policy and agree to comply and accept responsibility for any payment that becomes due as outlined.

Patient Name(s)_____Date_____

_____Date_____

_____Date_____

Parent Name(s) (printed)

Mom_____

Dad_____

Parent Signature_____

Relationship to child/patient_____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, 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)

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

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.**

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

REGISTRO DE INMUNIZACIÓN (ImmTrac2)
FORMULARIO DE CONSENTIMIENTO PARA MENORES

(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

__/__/____ *Solamente niños menores de 18 años.

Género: ☐ Masculino ☐ Femenino

Fecha de Nacimiento del Niño(a)

Dirección del Niño(a), Calle

Apartamento #

Teléfono ___-___-____

Ciudad

Estado **Código Postal** **Condado**

Nombre de la Madre

Apellido de Soltera de la Madre

ImmTrac2, el registro de inmunización de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud de Texas (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac2. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro médico o proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac2 y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

Al firmar abajo, YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño(a) en el registro de inmunización de Texas.

Alguno de los padres, tutor legal o administrador de bienes: _____

Escriba con letra de molde

_____ Fecha

_____ Firma

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a *http://www.dshs.texas.gov* para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

¿Tiene preguntas? (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

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.**

Mansfield Pediatrics

General Consent for Treatment and HIPAA Acknowledgement

Consent For Care And Treatment: I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Mansfield Pediatrics. Treatment provided by medical providers, nurses and medical assistants at Mansfield Pediatrics may include evaluation and management, vaccinations, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos and video of Patient may be taken in connection with such treatment and for operational, quality institution and agree that students may observe and participate in Patient's care and treatment under appropriate supervision.

Patient Rights: I have been provided information regarding Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Mansfield Pediatrics.

Communicable Disease Testing: I agree that is a Mansfield Pediatrics employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Texas law, Mansfield Pediatrics may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Text Messaging: I understand that Mansfield Pediatrics may, in its sole discretion, remove, retain or can provide notifications to my cell phone. These tests are Do Not Reply tests for informational purposes only and are not intended as a form of two-wat communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these unless I take steps to protect my phone with a password or PIN. I hereby consent to Mansfield Pediatrics sending me such texts.

PROTECTED HEALTH INFORMATION

Notice of Privacy Practices: I acknowledge that I have received the Mansfield Pediatrics **Notice of Privacy Practices.** Any questions or concerns may be directed to Mansfield Pediatrics Privacy Office at the following email address: admin@mansfieldtxpediatrics.com.

Use and Disclosure of Information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices I have received. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment (Medical information). I understand Mansfield Pediatrics must keep Patient's medical records for a time period required by law and then may dispose of them as permitted or required by law.

Consent for Electronic Sharing and Health Information Exchange: I authorize Mansfield Pediatrics to use Patient's Medical Information for Patient's treatment and related services. Unless I object below, I authorize Mansfield Pediatrics to release and sent Patient's Medical Information to Patient's non-Mansfield Pediatrics health care provider electronically and / or through a Health Information Exchange (HIE), an organization that provides services to enable the electronic sharing of health-relating information. Medical Information disclosed pursuant to this authorization may be used for treatment, payment and operational purposes. The Medical Information disclosed may become a part of my non-Mansfield Pediatrics health care providers' medical records and may be re-disclosed by the recipient and no longer protected by state or federal privacy laws. I understand that if Patient is also a Patient at Mansfield Pediatrics, the Medical Information from records may also be released by my signing this authorization.

I understand I can change my mind and withdraw this authorization at any time but cannot take back information that has already been electronically shared. This consent is valid unless I have withdrawn it.

I **DO NOT** want Patient's Medical Information shared in HIE(s). I understand, however, that if Medical Information sharing with HIE(s) is required by law, Mansfield Pediatrics must act in compliance with the law. I further understand that certain Medical Information may be shared with HIE(s) in a manner that does not identify the patient.

Patient(s):

Name	DOB
Name	DOB
Name	DOB
Name	DOB
Name	DOB

Parent/Guardian Names and Relationship:

Printed Name	Relationship to Child(ren)
Signature of Parent/Guardian	Date

Mansfield Pediatrics
Medical Records Release Form

I hereby authorize my child's former physician:

Dr/Hospital_____

Address_____**City**_____**State**_____**Zip**_____

Phone (_____) _____-_____ Fax (_____) _____-_____

To release the specified information below from the medical record of

Patient Name _____ **Birth Date** _____/_____/_____

Information may be released to the following party(s):

Mansfield Pediatrics
1825 Cannon Drive
Mansfield, TX 76063
(817) 453-7770 Fax (817) 453-7703
****We have EPIC EMR****
****NO CD'S PLEASE ****

INFORMATION OR MEDICAL RECORDS TO BE RELEASED BY MEANS OF THIS AUTHORIZATION INCLUDE THE FOLLOWING:

(list dates of admission and discharge or treatment)

__All Health Information	__Past/Present Medications	__Billing Information
__History & Physical	__Diagnostic Testing & Results	__EKG/Cardiology Reports
__Discharge Summary	__Radiology Report and Images	__Lab Results
__Operative Record & Pathology	__Physician's Orders	__Consultation Reports
__Patient Allergies	__Progress Notes	__Other

Initials are required to release the following information:

__Mental Health Records (excluding psychotherapy notes)
__Drug, alcohol, or substance abuse records
__Genetic information (including Genetic test results)
__ HIV/AIDS test results/treatment

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose of reason for this release is as follows: (Choose only 1 option) __Treatment/Continuing Medical Care __Personal Use __Billing or Claims __Insurance __Legal Purposes __Disability Determination __School __Employment __Other _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, alcohol or chemical dependency will not be released unless I have given my specific consent to release this information as indicated above.

I also understand that I may revoke this authorization at any time except that action has been taken in reliance upon it.
I understand that a photocopy or facsimile of this authorization is valid as the original.

_____ _____/_____/_____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian

_____
Relationship to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

Confidentiality notice:

This message is intended only for the use of the individual or entity to which it is addressed and contains information that is legally privileged and confidential. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any use, dissemination, disclosure, or copying of this communication is strictly prohibited. **If you have received this communication in error, please notify us immediately by telephone at the number listed**

above.

Mansfield Pediatrics Patient Information

Patient Information:

Name:_____

Date of Birth: ___/____/_____ Sex: M / F **Mother's Maiden Name:** _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____-_____

Parent Email _____

Preferred Pharmacy (Address, Phone Number and/or Cross Street):

_____

Parents or Guardians:

Child lives with: Mother____ Father____ Other_____

Mother's Name:_____ DOB _____

Relationship to Child: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone(_____) _____-_____

Employer: _____

Work Phone: (_____)_____-_____

Cell Phone: (_____) _____-_____

Father's Name:_____ DOB _____

Relationship to Child: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone(_____) _____-_____

Employer: _____

Work Phone: (_____)_____-_____

Cell Phone: (_____) _____-_____

Emergency Contact:(other than Parent/Guardian NOT living with you)

Name: _____ **Relationship**: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Insurance through: Mother___ Father___ Other: _____ Effective Date: _____

Primary Insurance: _____

Group Number:_____ ID Number:_____

Address:_____

City:_____State:_____Zip:_____

Phone:(_____) _____-_____

HOW DID YOU HEAR ABOUT US: *Please take a moment and let us know ~ THANK YOU!*

__ Friend / Family Referral __ Internet Search __ Chamber of Commerce __ Facebook

__ Mansfield Cares __ OB/GGYN Referral __ Mansfield Methodist Hospital

__ Other____ 05.20

MANSFIELD PEDIATRICS, PLLC

1825 Cannon Drive
MANSFIELD, TEXAS 76063
PHONE (817) 453-7770 / FAX (817) 453-7703

Non-Parental Authorization for Consent to Medical/ Surgical Care and Treatment

I, _____, parent / legal guardian of:

Child(ren):

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

Do hereby give my authorization and consent for my child (named above) to be seen by Providers at Mansfield Pediatrics, PLLC and consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations that are routinely given at the well visit.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

_____ _____ _____
Signature Relationship to Child(ren) Date

Authorized Parent / Guardian Names and Relationship:

_____ _____
Printed Name Relationship to Child(ren)

_____ _____
Printed Name Relationship to Child(ren)

Authorized Person(s):

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)