

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 (Mom/Dad):

Printed Name

Relationship to Child(ren)

Printed Name

Relationship to Child(ren)

Authorized Person(s) (Grandma/pa, Aunt, Uncle, Friend, Neighbor):

Name

Relationship to Child(ren)

Name

Relationship to Child(ren)

Name

Relationship to Child(ren)

Name

Relationship to Child(ren)

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 **YOU 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_____

_____ Date_____

Parent Name(s) (printed)

Mom_____

Dad_____

Parent Signature_____

Relationship to child/patient_____

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)

<input type="checkbox"/> All Health Information	<input type="checkbox"/> Past/Present Medications	<input type="checkbox"/> Billing Information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Diagnostic Testing & Results	<input type="checkbox"/> EKG/Cardiology Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Report and Images	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Operative Record & Pathology	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other

Initials are required to release the following information:

<input type="checkbox"/> Mental Health Records (excluding psychotherapy notes)	<input type="checkbox"/> Genetic information (including Genetic test results)
<input type="checkbox"/> Drug, alcohol, or substance abuse records	<input type="checkbox"/> 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

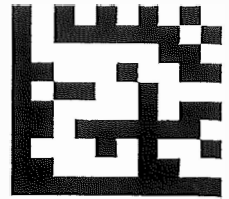
ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

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.**



IMMUNIZATION REGISTRY (*ImmTrac2*)
Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

*Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Date of Birth

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

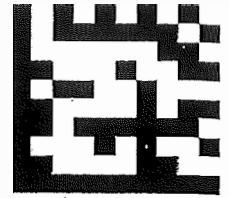
PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. **DO NOT** fax to ImmTrac2. Retain this form in your client's record.



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 if 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-way 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 send 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-related 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** / **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 Patient Information

Patient Information:

Name: _____
Date of Birth: _____ Sex: M / F **Mother's Maiden Name:** _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____

SIBLINGS:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

****Preferred Pharmacy (Name, 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 _____ Cell Phone: _____

E-Mail: _____

Father's Name: _____ DOB _____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone: _____

E-Mail: _____

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: _____

Subscriber Name: _____ Subscriber DOB: _____

Primary Insurance: _____

ID Number: _____ Group 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/GYN Referral ____ Mansfield Methodist Hospital ____ Other _____ 08/22