



New Patient Information

Patient Name _____ Nickname _____

Date of Birth(mm/dd/yyyy) _____

Sex M / F

Address _____

City _____

State _____

Zip _____

Primary Language Spoken _____ Race/Ethnicity _____

Preferred Pharmacy _____ Pharmacy Phone Number _____

Sibling Names _____

Parent Information

Mothers Name	Mothers Phone Number	Mothers Email
Fathers Name	Fathers Phone Number	Fathers Email
Guardian Name	Guardian Phone Number	Guardian Email

****I give consent for the following emails to have access to a portal account for the above named patient
MUST CHECK AT LEAST 1!**** () Mother's Email () Father's Email () Guardian's Email

Financial Information

Person responsible for patient's account and relationship. _____

Responsible persons Social Security Number. _____ - _____ - _____ DOB _____

Insurance Information

*Primary Insurance Name: _____ Policy # _____ Group# _____

Name of Policy Holder _____ DOB of policy holder _____

Secondary Insurance Name: _____ Policy # _____ Group# _____

Name of Policy Holder _____ DOB of policy holder _____

Please give any insurance card(s) to the receptionist with this form.



Medical Records Request

Patient Name (Please Print)

Patients Date of Birth (mm/dd/yyyy)

Previous Doctor Seen

I _____ Authorize:
Printed Name of Parent or Legal Guardian

Name of Doctor/Clinic _____

Address: _____

City, State, Zip Code _____

Phone Number: _____ Fax Number: _____

To Release To:
Dino Pediatrics, PLLC
ATTN: Medical Records
1613 NE Big Bend Trl Suite C
Glen Rose, TX 76043
Phone: 254-635-6236
Fax: 833-972-1617

I request and authorize the release of my health information noted below: (please check all that apply)

- ☐ All Vaccine information
- ☐ Any Important Medical / Diagnosis Information

*I understand that I am entitled to receive a copy of this authorization.

*I understand that I may withdraw this authorization in writing at any time.

*Unless otherwise specified field below. I understand that this authorization will expire 90 days from the request date. I request this expire on (Specify date) _____

Signature of Parent/Guardian

Date

Phone Number



HIPAA Privacy Disclosure

I understand that I have the right to restrict how my Health information (defined below) is used or disclosed by Dino Pediatrics and its affiliated companies) hereinafter collectively referred to as "Dino Pediatrics") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions in writing, however, I understand that Dino Pediatrics is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical services at Dino Pediatrics.

RELEASE OF INFORMATION: I consent and authorize Dino Pediatrics and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at Dino Pediatrics or by practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B, C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory test results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare/Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my Dino Pediatrics bill or conducting utilization management/review and financial medical audits;
2. To any person entity affiliated with or representing Dino Pediatrics and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuum of care to induce prospective or current home health company, to referring facility health care staff or to Dino Pediatrics.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask Dino Pediatrics if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my child's Health information as described in the Privacy Notice.

Moreover, I understand that the Privacy Notice may be amended by Dino Pediatrics from time to time and that I may obtain an amended Privacy Notice at any time by contacting Dino Pediatrics registration/front office personnel.

I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to release Health Information in writing at any time, unless action has already been taken in reliance there upon; in which case, I may revoke this Consent for future communications.

I give my permission to Dino Pediatrics and its agents, employees and representatives to use the contact information, including cell phone numbers, I have provided to contact me for payment (including but not limited to autodialed or prerecorded collection calls), treatment or any other health care purposes.

MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare."

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS: I hereby irrevocably assign, transfer and convey to Dino Pediatrics and any practitioner providing care and treatment to my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive from



HIPAA Privacy Disclosure Cont.

Dino Pediatrics. I agree to assist Dino Pediatrics in processing claims for such benefits including providing all necessary information to Dino Pediatrics or the payor in a timely manner. If my child's treatment was caused by events which result in legal action, I assign to Dino Pediatrics an interest in any claims my child may have arising from or in connection with the delivery service by Dino Pediatrics to my child. I understand that Dino Pediatrics's charges for the services rendered or products received are set out in Dino Pediatrics's Charge Master and I hereby promise to pay the full billed charges for all of the services rendered to my child less any applicable contractual discounts. In cases where no insurance policy is applicable or my insurance considers Dino Pediatrics out-of-network, I understand that I may be responsible for the full billed charges. I understand I am responsible for all health insurance copayments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if Dino Pediatrics eligible criteria are met.

DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint Dino Pediatrics (and its agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim; (3) appeal and adverse benefit determination; and/or (4) file a legal action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by my child at Dino Pediatrics, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to Dino Pediatrics.

MEDICAID PATIENTS ONLY: I understand that the amount owed to Dino Pediatrics for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be billed by Dino Pediatrics for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my child's care. I understand that the Texas Health and Human Services Commission or its health insurance agent determines the medical necessity of the services or items that are received. I also understand that I am responsible for payment of the services or items I receive if their services or items are determined not to be reasonable and medically necessary for my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply.

I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order).

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF THE Dino Pediatrics NOTICE OF PRIVACY PRACTICES.

Patient's Name Printed _____

Date of Birth _____

X _____

Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative

Relationship Witness

Time of Signing: Month _____ Day _____ Year _____

Witness Signature _____ Date _____



Medical Consent: By signing this form, I am consenting to any exams, x-ray, laboratory procedures, tests, medication, medical treatment, pictures, videos, and other services determined advisable for the patient by the attending healthcare provider and or other healthcare providers. Other healthcare providers can include consulting doctors, technical assistants, nurses, or office staff.

This consent applies during the evaluation, diagnosis, and treatment of the patient being cared for by Christie Ramirez, DNP, APRN, CPNP-PC, dino pediatrics, and its affiliated.

I also consent to allow students (such as medical fellow, medical residents, medical students, nursing students, and other authorized individuals that are enrolled in profession training programs) and healthcare providers undergoing training to watch or join in the care provided as the treating healthcare provider deems appropriate and as allowed by Christie Ramirez, DNP, APRN, CPNP-PC, Dino Pediatrics policies.

Healthcare Providers and Independent Contractors- Each patient within Dino Pediatrics, is under the care of a healthcare provider. Healthcare providers are not always employees of Dino Pediatrics. Some healthcare providers may be independent contractors. All health care providers assume responsibility for the medical care they provide.

Accidental Exposure to Healthcare Workers- I understand that Texas healthcare law states that if any healthcare worker is exposed to a patient's blood or any other bodily fluid, the Dino Pediatrics may perform test(s) for HIV (the "Human Immunodeficiency Virus) on that patient's blood or bodily fluid. I give consent to test for other diseases too, including hepatitis, syphilis, and others. I understand that these test(s) are necessary to protect healthcare workers who are caring for dino pediatric patients.

Money and Personal Valuables- I understand that Dino Pediatrics will NOT be responsible for lost or damaged money or property.

The person signing this consent form certifies that: 1) He/she is either the patient, parent or legal guardian of the patient: 2) Has read (or has been read) this form and understands what it says: 3) agrees to the terms of this consent form.

Patients Name (Printed) _____ Date of Birth _____

Parent/ Legal Guardian (Print) _____ Signature _____

Relationship to patient _____ Date _____

Witness: _____ Date _____



Non-parental consent to medical/surgical care and treatment

I, _____ parent/ legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to 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 treatment deemed necessary for the well being of my child(ren).

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

Signature

Relationship to child(ren)

Date

Child(ren)

Name

Name

Name

Name

Authorized non parental person(s): (who can we talk to about your child)

Name

Relationship to child(ren)

Name

Relationship to child(ren)

Name

Relationship to child(ren)

Name

Relationship to child(ren)



Permission to Release Information Specific to Voice Mail

In addition to the information contained within Dino Pediatrics Acknowledgment of Privacy Practices, I give permission for my physician's office personnel to leave a message on my home answering machine and or cell phone in regard to my child's routine and or **NORMAL** laboratory and or **NORMAL** radiology results. I realize that I might not be the only person to hear such a message about my child:

_____ **YES**, I give permission to leave messages on my home answering machine and or my cell phone for reasons stated above. (This permission is good until the office has received a written revocation from the parent/ guardian)

_____ **NO**, do not leave a message about my child on my number listed within the file.

Please choose YES or NO above and complete the area below, including Signature

Patient Name (please print)

Date of Birth

Signature of patient's legally authorized representative

Date

Printed name of authorized representative

Relationship to patient

Witness

Date



Authorization to Photograph

I, the undersigned, do hereby grant my permission for my child's healthcare provider to photograph and/or make digital images of my child which will be placed in his or her medical record for the purpose of treatment and ongoing patient care. Also for the use of promotion. I release all rights to all images created and prepared, and release Christie Ramirez, DNP, APRN, CPNP-PC from any claims or liabilities resulting from their use.

Patient's Name (please print)

Date of Birth

Signature of Parent/Guardian

Relationship

Witness

Date



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: <input type="checkbox"/> Male <input type="checkbox"/> 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)			Ethnicity (select only one)
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Recipient Refused			<input type="checkbox"/> Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 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 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; 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 DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. 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 § 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 _____
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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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to ImmTrac2. **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