Welcome

to

Jollyville Pediatrics

Dr. Evelyn Spencer & Dr. Nitzia Cepeda

We are so excited you are here.

Please let us know how you heard about our practice.

- ☐ Google
- ☐ Yelp
- ☐ Flyer
- ☐ Yodle
- ☐ Apartment complex flyer? (Name of apt. complex?) ______________
- ☐ Family, Friend, Physician? (Tell us who, we would like to thank them.)

____

PATIENT INFORMATION

First Name________________________Middle Initial_____ Last Name __________________________

Mailing Address___________________________________City/ State________________Zip________

Birth Date___/___/___ Male __ Female__1st contact #______________2nd contact #_______________

Email Address____________________________can we send confirmations for visits? Y/N (Circle one)

PRIMARY INSURANCE

Subscriber's Name___________________________Mailing Address____________________________

City/ State __________________Zip_____Birthdate_____________relation to patient______________

Social Security #__________________Employer_____________________ Effective date_____________

Name of Insurance Co______________________ Member ID #________________Group#___________

SECONDARY INSURANCE (Check none, If applies)

Subscriber's Name___________________________Mailing Address____________________________

City/ State __________________Zip_____Birthdate_____________relation to patient______________

Social Security #__________________Employer_____________________ Effective date_____________

Name of Insurance Co______________________ Member ID #________________Group#___________

Father's Name________________DOB________	Mother's Name________________DOB________
Occupation_______________SS#____________	Occupation_______________SS#____________
Mailing Address___________________________	Mailing Address___________________________
City______________State_______Zip________	City______________State_______Zip________
Home #_____________Cell #_______________	Home #_____________Cell #_______________
Work #_____________ Email_______________	Work #_____________ Email_______________

CONSENT TO SEE PATIENT WITHOUT PARENT PRESENT

I Hereby authorize ___________________________ to bring my child(ren)______________________ to their appointment if I am unable to do so. I understand that medical advice will be relayed to them on my behalf. ______initial

Please check______ if this person may also be listed as the emergency contact. If so please complete the following. Emergency Contact Name______________________________ Relationship_______________

Contact #___________________ Work#__________________ Address_________________________

City__________________ State__________ Zip_______________.

I understand that, even though I may have insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware that co-payment is required at each visit, and if there is no insurance coverage, payment in full is required for services provided unless prior payment arrangements have been discussed. I will also be responsible for all collection fees, should my account be assigned to a Collection Agency.

Parent/Guardian Signature____Date__________________

JOLLYVILLE PEDIATRICS
11851 JOLLYVILLE ROAD, SUITE 204
AUSTIN, TEXAS 78759
PHONE: 512.219.5550
FAX: 512.219.5551

PATIENT INFORMATION

Patient Name_________________________ Date of Birth_________________________

DELIVERY HISTORY

Delivered at:_________________________Obstetrician:_________________________

Condition at birth: Preemie/ Full Term (Circle one) Complications: _________________________

Miscarriages_____________ Mo. ________ Cause____________

Birth Weight _____________ Height_____________

Feeding: Breast / Formula (Circle one) if on formula please indicate name:_________________

FAMILY HISTORY

Please check each member that has the following condition:

CONDITION	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
Asthma						
Diabetes						
Heart Disease						
Cancer						
High Blood Pressure						
Epilepsy						
Kidney Disease						
Hay Fever						
Food Rashes						
Rheumatic Fever						
Tuberculoisis						
Other(List)						

Name of Siblings	Age

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PATIENT INFORMATION

FAMILY PROFILE

Child lives with: ____ Mother ____ Father____ Stepparent____ Grandparent____ Other

Total Adults in home:____________ Total children in home:____________

Primary caretaker for this child:______________________________ Pets:______________________

Medical History (Circle One)

1. Is the child having any medical problems at this time? Yes or No
2. Prior medical problems? Yes or no

PHYSICIAN REVIEW

1. Has parent family history / information sheet been reviewed?
   - ☐ **Yes**
   - ☐ **No**
2. Has parent provided medical records from previous physican?
   - ☐ **Yes**
   - ☐ **No**

FAMILY MEDICAL/ SOCIAL HISTORY

1. What is the overall health condition in the immediate family environment:
   - ☐ **Good**
   - ☐ **Poor Health**
2. Are there any current family issues that might be affecting the child? (Divorce, death, family problems, etc.)
   - ☐ **Yes**
   - ☐ **No**
3. Are there any current social issues that might be affecting the child? (Smoking, alcohol, school, daycare, sports, etc.)
   - ☐ **Yes**
   - ☐ **No**
4. Other Findings? ______________________

   ____

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OFFICE POLICY – PLEASE READ CAREFULLY

- Co- Payment is due at the time of service unless prior arrangements are made. We accept Cash, Personal Check, MasterCard, Discover and VISA. If co – payments are not paid, a $5.00 service fee will be charged.

- Deductible policies will be charged contracted rate at time of service.

- 24 – Hour notice of appointment cancellation is required to avoid no show fee of 25.00 for sick visits and 35.00 for wellness visit / medication evaluations. Visits scheduled the day prior or same day will require a 2 hour notice to avoid no show fee. Multiple no shows will be subject to dismissal.

- In the event that your health plan determines a service to be "Not Covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- In the event that your health plan applies charges for procedures performed in the office to your deductible, you will be responsible for the charges.

- Our office is not a Medicaid Provider. You will be responsible for balances not covered by your primary or secondary insurance.

Please sign here that you have read and agree to this policy.

______________________________ ______________________

Parent or Legal Guardian signature **Date**

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by the physicians and staff associated with Jollyville Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photo of this form is considered valid as the original.

______________________________ ______________________

Parent or Legal Guardian signature **Date**

To Our Valued Patient:

You are scheduled today for your preventive care visit. These visits are used to access your general health status, review your personal and family health history and make recommendations for keeping your child healthy. They often include tests and lab work that your provider will use to evaluate your health and make recommendations for prevention of disease(s).

Sometimes during your preventive visit other medical problems are encountered and may need to be addressed. Frequently, patients wish to address these additional problems while in the office for their preventive visit so that they do not have to come in for a separate visit. Examples include acute issues such as sore throat, sinus infections, ear infections, injuries, new or ongoing symptoms that have not been assessed or diagnosed, and on going conditions such as ADHD, anxiety and the like. Time permitting, we are happy to address these types of Issues in addition to your routine preventive visit. Please be aware that these additional conditions are not covered by insurance companies under the preventive visit and are billed separately under a sick office visit code. Your insurance company will apply a copay, deductible or co-insurance depending on your plan benefits and you will be responsible for paying these additional charges.

Patient Name: ______________________________

Patient/Guardian Signature: ______________________________

Date: ______________

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Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third – party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

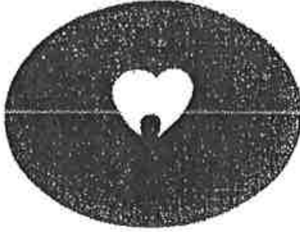
I understand and have been provided with a **NOTICE OF PRIVACY PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object the use of my health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent to writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

________Accepted ________Denied

Signature X____ Date____________________

Signature of Patient or Legal Representative Witness________________________________



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TRANSFER IN

Authorization for Release and Disclosure of Protected Health Information

Indicate name of physician, hospital, medical center or lab that you are requesting records from:

To: ______________________________ Phone#______________________

Address: ____

City/State/Zip: ____________________________________

I am requesting that the medical information for patient names (listed below) be transferred to:

❑ **Nitzia Cepeda, MD, FAAP** ❑ **Evelyn Spencer, MD, FAAP**

Jollyville Pediatrics
11851 Jollyville Road, Suite 204
Austin, Texas 78759

Please release the following information:

_____ Problem List _____ Lab Reports _____ Immunization Record
_____ Progress Notes _____ Medications _____ Specialist Reports
_____ History & Physical Exam _____ X-Ray Reports _____ Other (Specify)

This information is necessary for the following purpose:

_____ Continued Patient Care _____ Personal Use _____ Attorney / Legal
_____ Insurance _____ Other (Specify)

Establishing with: ❑ **Nitzia Cepeda, MD, FAAP** ❑ **Evelyn Spencer, MD, FAAP**

Name: ______________________________ Date of Birth: ________________

Name: ______________________________ Date of Birth: ________________

Name: ______________________________ Date of Birth: ________________

Name: ______________________________ Date of Birth: ________________

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signed: ______________________ Relationship: ______________ Date: ______________

AUTHORIZATION AND CONSENT TO TRANSMIT PROTECTED HEALTH INFORMATION AND ELECTRONIC PROTECTED HEALTH INFORMATION VIA UNSECURED TEXT MESSAGE OR INTERNET/EMAIL

Patient's Name: ____ **Date of Birth:** ____________

I, ____, expressly request, authorize, direct, permit and unequivocally consent to Jollyville Pediatrics to transmit my Protected Health Information ("PHI") and Electronic Protected Health Information ("ePHI") to me via unsecured text message/Internet/email. I expressly and unequivocally acknowledge that Jollyville Pediatrics does not have the capability to send text messages/emails in an encrypted or secured format. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via unsecured text messages/email. I fully understand that third parties may attempt to or actually access, use and disclose PHI or ePHI transmitted by Jollyville Pediatrics to my cellular phone via text message/email or computer via email. I fully understand the risks of transmitting unencrypted text messages/email containing ePHI, I am willing to accept those risks. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Jollyville Pediatrics or any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via unsecured text messaging, Internet or email. I intend to be legally bound hereby.

Cell Phone Number: ________________________________

Email Address: ____

________________________________	____________	________________________________
Signature of Patient, Patient Representative or Legal Guardian	Date	Relationship to Patient

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth __ / __ / __ **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac 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.

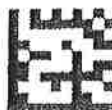
Parent, legal guardian or managing conservator: ____________________
Printed Name

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

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/27/11



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