To all our new patients:

Welcome to River Valley Pediatrics

This is an immunizing clinic. We will not accept patients who choose not to immunize. We believe in protecting our children and everyone else around them to the best of our knowledge, and we cannot condone willingly withholding life-saving immunizations for any reason other than medically indicated (for example, a child who had a serious reaction, or an immune deficiency. These are special cases).

We will only use AAP (American Academy of Pediatrics)-approved immunization schedules. This means we will not stagger immunizations, accept "pick-and-choosing" of immunizations, or using non-AAP approved schedules like Dr. Sears or Dr. Bob.

If you choose not to immunize, or immunize in a non-conventional manner, please alert the front office personnel so they can assist you in finding another practice. This may include giving you the number to your HMO so you can call and inquire about practices.

If you choose to immunize according to the AAP, please sign below and feel free to your child in.

I, _____ consent to immunize my child _____ according to conventional AAP approved schedules.

Ivonne Sahagun-Carreon, MD

Fellow, American Academy of Pediatrics _____ _____

Parent/Guardian Signature

Date

2115 Stephens Place #100, New Braunfels, TX, 78130 Tel: (830) 627- 9878 Fax: (830) 627- 9879

Patient information

Date:_____

Patient name: _____ Gender: ___M ___F
Home address:_____
City:_____ State:_____ Zip code:_____
Date of birth:_____ SS#_____

Parent/Guardian #1 name:_____ DOB:_____
Home phone:_____ Cell phone:_____ Work phone:_____
Alternate phone numbers:_____

Parent/Guardian #2 name:_____ DOB:_____
Home phone:_____ Cell phone:_____ Work phone:_____
Alternate phone numbers:_____

Emergency contact:_____ Phone number:_____

SIBLING NAMES:_____

Primary Insurance Information

Who is responsible for this account?_____
Relationship to patient: _____
What type of insurance? ___ Commercial ___CHIP ___Medicaid ___No insurance

Insured name: _____ DOB:_____ SSN:_____
Address: _____
City, state and Zip code: _____
Insurance company: _____
Insured ID # _____
Employer: _____

Health History

Name of child: _____ DOB: _____ Date: _____

Prenatal and Infant Health History:

Hospital of birth: _____

Pregnancy complications: _____

Was the pregnancy full-term? If not, how many weeks early _____

Birth weight: _____ Birth length: _____ Days in nursery/NICU: _____

Birth defects or illnesses: _____

Past Medical History:

Past surgeries: _____

Past admissions to the hospital: _____

Allergies to medications: _____

Important diagnoses (epilepsy, autism, any syndromes, congenital heart disease, learning disabilities, ADHD and others): _____

_____

Important Family History:

_____

_____

_____

Medications:

_____ _____

_____ _____

_____ _____

Previous physician:

_____

Specialists still seen by child:

_____

Office Policies

1. No walk-ins after 10:30 am or after 3:00 pm. Walk-ins will be taken only if there is availability or in case of an emergency. Otherwise they will be scheduled for the next available slot. Walk-ins should expect a reasonable wait time since patients with appointments will be given priority.

2. Please check in at the front window. If a child is not checked in, the appointment will be cancelled and rescheduled to the next available.

3. Anyone more than 15 minutes late will be rescheduled, unless directed otherwise by the physician.

4. In case of an emergency or if there is a need to cancel or reschedule an appointment, please call the office **BEFORE** the appointment time. If there is no notification, we will consider the patient a **NO SHOW** and it will be reported to your insurance. You may be asked to leave the practice after three no-shows at the discretion of the physician.

5. Patients are to watch their children at all times. Children must be accompanied to the restroom and anywhere in the treatment area. If the patient is 16 years or older, the physician may allow the child to come unaccompanied.

6. Anyone other than the legal guardians who comes in with the child, should bring a written permission from the child's legal guardian. This allows the physician to discuss the child's diagnosis and treatment with the designated person.

7. Any messages left will be returned the same business day. If it is an emergency, the call will be returned between patients. Use common sense. Call 911 if the child has a life-threatening emergency. Quality health care cannot always be provided over the phone and we may ask you to make an appointment for your child.

8. Please allow up to 48 hours for prescription refill requests or school/therapy/other paperwork to be completed. If your child takes a controlled substance, you must also sign the Controlled Substance Agreement Form provided by us.

9. We would greatly appreciate limiting after-hour calls to emergencies only.

10. We will not tolerate rude behavior, abusive language, or threats directed at any of our employees. This is grounds for immediate dismissal and a report will be made to your insurance.

By signing this, I certify that I have read the above office policies and agree with them.

Patient name:_____

Parent/guardian name and signature:_____

Date:_____

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated You can complain if you feel we have violated your rights by contacting us using the information on the back page. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory

In these cases we *never* share your information unless you give us written permission: Marketing purposes, sale of your information, and most sharing of psychotherapy notes

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information? We typically use or share your health information in the following ways.

1. **Treat you** We can use your health information and share it with other professionals who are treating you.
2. **Run our organization** We can use and share your health information to run our practice, improve your care, and contact you when necessary.

3. **Bill for your services** We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing a threat to anyone's health or safety

Do research: We can use or share your information for health research.
Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Acknowledgement Of Receipt Of The Notice of Privacy Practices

Patient name:_____ **DOB:** _____ **SSN**:_____

I acknowledge that this practice has provided me with a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the NPP and ask questions.

May we release your health information about you to family member(s) or other care givers: **__Yes __No**

_____

Patient signature (or personal representative signature)

_____ _____

Relationship to patient **Date**

Financial Policy

Welcome to **River Valley Pediatrics**! In order for us to deliver quality healthcare, we have established a financial policy. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone number, or employer, please notify the receptionist.
3. We will collect your deductible, copay, or charge for non-covered services at the time of your visit.
4. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa and MasterCard.
5. If your insurance denies our charges, does not pay us in a timely manner or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to the Credit Bureau.
6. Effective May 1, 2007, we will assess a 1.50% monthly interest charge on unpaid balances over 90 days old.
7. PPO patients; if we participate with your insurance plan, we will bill your insurance for you. Your copay will be collected at the time of service. **NO EXCEPTIONS.**
8. If your plan requires you to choose a PCP, it is your responsibility to make sure your insurance company has the physician you're seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will verify your out-of-network benefits, file your service. If we are NOT your PCP, we will NOT be able to obtain an authorization to see a specialist.
9. MEDICAID patients; you must be eligible for Medicaid services at the time of your office visit or you will be responsible for the services rendered. A private pay agreement will also be signed.
10. PRIVATE PAY patients; patients with no insurance will be expected to pay at the time of services and must sign a private pay agreement. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to arrange payment arrangements.
11. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract.** It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact of explanation should be made to you, the policy holder. Reduction or rejection of you claim by your insurance company does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy please contact our billing department at 830-627-9878.

I have read and have a full understanding of the financial policy of River Valley Pediatrics MD PA.

Patient name: _____

Name of responsible party: _____

Signature: _____

Date: _____ **Witness**: _____

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, ImmTrac2 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

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.**

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

ImmTrac2 Immunization Registry
DISASTER INFORMATION RETENTION CONSENT FORM

(Please print clearly)

Client's Last Name

Client's First Name

Client's Middle Name

Client's Date of Birth (__/__/____)

*A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Client's Telephone (___-___-____)

City

State

Zip Code

County

Mother's First Name (if client is younger than 18 years of age)

Mother's Maiden Name (if client is younger than 18 years of age)

ImmTrac2, the Texas immunization registry, has been designated as the disaster-related reporting and tracking system for immunizations, antivirals, and other medications administered to individuals in preparation for, or in response to, a disaster or public health emergency. From the time the event is declared over, ImmTrac2 will retain disaster-related information received from health-care providers for a period of 5 years. At the end of the 5 year retention period, client-specific disaster-related information will be removed from the Registry unless consent is granted to retain the client information in ImmTrac2 beyond the 5 year retention period.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and / or
- a physician or other health-care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent to retain my disaster-related information (or my child's information if younger than age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or 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 • ImmTrac2 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.**

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

Texas Vaccines for Children (TVFC) 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: ____/____/____
   MM DD YYYY
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.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	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 the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record
(Continued)

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	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

Medicaid:

Medicaid Number: _____

Date of Eligibility: _____

CHIP:

CHIP Number: _____

Group Number: _____

Date of Eligibility: _____

Private Insurance:

Name of Insurer: _____

Insurance Name: _____

Insurer Contact Number: _____

Policy or Subscriber Number: _____