Dr. Edward Moayyad
Pediatric Clinic, Assoc.

PATIENT REGISTRATION

Kids Doc Pediatric Clinic

Patient Information: (*Please use full legal name, no nicknames*)

Last Name: _____ First Name: _____ Middle Name: _____

SSN#: _____ DOB: _____ Sex: Male _____ Female _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell/Work Phone: (_____)_____

Emergency Contact Name: _____ Emergency Phone: (_____)_____

Parent Information:

(*List person or Insured name – Use full legal name, no nicknames please*)

Mothers First & Last Name: _____ DOB: _____ SSN#: _____

Fathers First & Last Name: _____ DOB: _____ SSN#: _____

Address (if different from above): _____ City/State/Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Married _____ Divorced _____ Single _____ Siblings: _____

Relationship of Guarantor to Patient: Parent ____ Other: ____ Relationship & Name of Other: _____

Insurance Information

Primary Insurance:

Policy Holder's Name: _____ SSN#: _____ DOB: _____

Relationship to Patient: _____ Employer's Name: _____

Insurance Name: _____ Policy ID#: _____ Group#: _____

Effective Date: _____ Insurance Claim Address & Phone#: _____

Secondary Insurance:

Policy Holder's Name: _____ SSN#: _____ DOB: _____

Relationship to Patient: _____ Employer's Name: _____

Insurance Name: _____ Policy ID#: _____ Group#: _____

Effective Date: _____ Insurance Claim Address & Phone#: _____

Signature: _____ **Date:** _____

KIDS DOC PEDIATRICS
TREATMENT AUTHORIZATION

I, _____,
(Parent/Guardian First & Last Name)

Hereby, give permission for:

1. _____, _____
(Authorized Person First & Last Name) (Relation)

2. _____, _____
(Authorized Person First & Last Name) (Relation)

to authorize treatment and bring my child and/or children:

1. _____
(Child First & Last Name)

2. _____
(Child First & Last Name)

3. _____
(Child First & Last Name)

4. _____
(Child First & Last Name)

to the Doctor's Office for appointment(s).

Should you have any questions, I can be reached at:

_____ or _____
(Phone #1) (Phone #2)

Parent/Guardian Signature: _____ **Date:** _____

KIDS DOC PEDIATRICS
FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **DOB**: _____
First Middle Last

I understand and agree that I will be financially responsible for any and all charges for office visit services not paid by my insurance. This includes any Medical services or visit, Preventative exam or Physical, Lab testing, X-ray, EKG, and any other screening service or Diagnostic testing ordered by the Physician or the Physician staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or Physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the Physician or the Physician's Staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the Physician or Provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the Physician or Provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to bring my current insurance card to each office visit. If I fail to Bring my current insurance card to an office visit it will result in rescheduling of the appointment. I understand this and agree.

Appointments

I understand and agree it is my responsibility to call the office **24hrs** before the appointment and Cancel or Reschedule. If I fail to call in to cancel or reschedule my appointment on the third no show incident, I understand I will be dismissed from the practice and a termination letter will be mailed out.

Signature: _____ **Date:** _____
(Parent or Guardian)

Parent/Guardian's Name: _____
(Please Print Name)

KIDS DOC PEDIATRICS
PATIENT REGISTRATION FORM DISCLOSURE & CONSENTS

Patient Name: _____ **DOB:** _____
First Middle Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Dr. Moayyad Pediatrics Clinic/ Kids Doc Pediatrics or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-payment or balance due that Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics is unable to collect from my insurance carrier for whatever reason.

MEDICAID/MEDICARE/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent(s) authorized benefits be made directly to Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics or the physicians on my behalf.

I do ☐ **I do NOT** ☐ have other insurance coverage in addition to Medicaid/Medicare/Champus at this time.
If yes, specify other insurance company: _____.
Failure to provide all information on other health coverage will result in your obligation of all medical charges.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics, Patient Information Privacy Policy. I hereby authorize Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including by not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not re-imbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Dr. Edward Moayyad Pediatrics Clinic/ Kids Doc Pediatrics physicians or his or her designee.

Signature: _____ **Date:** _____
(Parent or Guardian)

Parent/Guardian's Name: _____
(Please Print Name)

KIDS DOC PEDIATRICS

Office Guidelines

Welcome to the practice of Edward E. Moayyad, M.D. and Stephanie P. Gold, M.D. We would like to thank you for choosing to become a part of our practice. We will strive to provide the best care for your children. We would like to introduce you to our office guidelines. These guidelines will help make your visit and other related needs go smoothly.

Payments: payment is expected at time of visit. We accept payment by Visa, Master Card, Discover, American Express, Checks and Cash. We cannot accept temporary checks. If unexpected circumstances should happen that prevent your ability to pay, you may be asked to reschedule. If your appointment is for a non-urgent visit such as a well child exam, we can reschedule your appointment at our next available opening. If your child is ill, we will keep your appointment. However, payment will be expected promptly. Remember, insurance companies require both the provider and patients to keep co-payments paid and current. This is a part of our contractual agreements. It will be necessary to bring your insurance card with you to each visit, so please give to the receptionist before your scheduled appointment. Always notify the receptionist of any changes in the patient's information. This includes, but is not limited to, address of patient or parent, phone number of patient or parent, insurance information, work and cell phone numbers of parents.

Immunization Records: Remember to bring your child's shot record at every visit. We ask that you do this so we can update your personal copy as we administer immunizations. This way you will always have a current copy of your child's immunizations on hand. Immunization records are very important document. This record will need to follow your child through out school, college and possibly their career. It is best that parents keep a copy at home with the child's birth certificate. There is a $10.00 fee whenever there is a request for a copy of the shot record or an update to the shot record outside of your child's office visit. If request for shot record are made during the office visit, there is no charge.

Referrals: In the event that your child is referred to a specialist, it is the patient's responsibility to verify if a referral is needed by the insurance company. If your child is on an insurance plan that requires our office to obtain a referral before your child's appointment, we will need 5 to 7 business days to obtain the referral. When leaving a message for that referral, please provide the specialist physician's name and phone number, appointment date, your current insurance, reason or diagnosis for the visit and who referred you.

Parents/Guardian Present at Visit: Since we are a pediatric office, all children under the age of 18 years old must be accompanied by an adult. If for any reason the parent or legal guardian will not be able to bring the child in, we have a form that allows you to list persons authorized to bring your children to the appointment. We will not be able to keep an appointment without an authorized adult present.

Controlled Substance Prescriptions: If your child is on any controlled substance medication, it is written on a state required prescription pad. These prescriptions are only good for 7 days from the date written on the prescription. Our office requires a 24 hour turn around time on these written prescriptions. If the prescription is not filled within the 7 days, we WILL NOT change the date. The original prescription must be returned to our office. A new prescription will need to be requested following the same 24 hour turn around time and there will be a $10.00 duplicate charge fee.

Medical Record Request: When records are requested, a medical record release form will need to be signed. If records are sent to another physician, there is no fee. When a parent or guardian requests a complete copy of the medical records for personal use a fee will apply. The fee is $25.00 for the first 20 pages and $0.15 per page thereafter per child. If a parent is requesting only growth chart, physical form or shot record, a $10.00 fee will apply.

Form Fees: During your child's office visit, discuss any required forms that you may need for school or daycare. These could include physical forms, medication administration forms, daycare acceptance forms, ….etc. When a form is required to be competed and singed by the physician outside of a regular office visit, there will be a 24 hour notice required and a $10.00 form fee. The fee applies when a school faxes forms to be completed at our office. The fee does not apply when presented at the time of the office visit. All FMLA forms will need a 3 to 4 business day notification. The fee for these forms is $10.00.

Annual/Monthly (under 18 months) Well Child Exams: After the age of 2 years, it is recommended that your child come in annually for preventative office visit. Well exams are important to maintaining a healthy child. A well exam is a time for the physician to check developmental milestones both mentally and physically. It is a time to review nutrition, safety, update immunizations and any other concerns that you may have. If your child is under two, try to book the next appointment after your current well exam. If booking for an annual well exam, it is best to schedule a couple of months in advance. Check with receptionist for availability. For families that have more than two children, we may limit only two children in a family on one day. On the day of an appointment, if you are more than 15 minutes late, the appointment will need to be rescheduled. We recommend that adolescent children get their physicals in the early summer months. This will help lower the stress of the back to school rush. Please provide all sports physical forms and medication forms at time of visit. Check with your schools web site for access to these forms.

No Show Policy: A missed appointment is a loss to everyone. Please call our office 24 hours in advance to cancel or reschedule your appointment. This will create an opening for another child that needs to see the physician. A **NO SHOW** is when a patient does not keep their scheduled appointment and fail to call 24 hours in advance to cancel or reschedule the appointment. After 2 missed appointments within a year, we will contact you about those missed appointments; the 3third missed appointment will result in dismissal from our practice.

Thank you for letting us be an important part of your children's lives.

Sincerely,

Dr. Edward E. Moayyad, Dr. Stephanie P. Gold and Staff

Patient's Name: _____ DOB: _____
(Print First & Last Name)

Parent/Guardian's Name: _____
(Print First & Last Name)

Parent/Guardian Signature: _____ Date: _____

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: ____/____/____ Age: _____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name MI

Provider's/Clinic's Name:

_____

Please check the first category that applies; check only one.

- ☐ (a) Is enrolled in Medicaid, or
- ☐ (b) Does not have health insurance (uninsured), or
- ☐ (c) Is an American Indian, or
- ☐ (d) Is an Alaskan Native, or
- ☐ (e) Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or
- ☐ (f) Is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

- ☐ (g) Has private insurance that covers vaccines (not TVFC eligible).

Signature: _____ Date: _____

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)

PROGRAMA DE VACUNAS PARA NIÑOS DE TEXAS
REGISTRO DE DETERMINACIÓN DEL DERECHO A LA PARTICIPACIÓN DEL PACIENTE

SÓLO PARA USO CLÍNICO:
TVFC Eligible:
☐ Sí ☐ No

Debe mantenerse un registro en el consultorio del proveedor de salud que refleje el estado de todos los niños de 18 años de edad o menos que reciban inmunizaciones por medio del Programa de Vacunas para Niños de Texas (o TVFC). Dicho registro lo puede rellenar el padre o la madre, el tutor o el individuo que consta en el registro. Puede usarse el mismo registro para todas las consultas posteriores, en tanto el estado del derecho a la participación del niño no haya cambiado. Si cambia el derecho a la participación del paciente, debe rellenarse un nuevo formulario. Aunque no se requiere la verificación de las respuestas, es necesario conservar este registro, o uno similar, de determinación del derecho a la participación para cada niño que reciba vacunas bajo el Programa de TVFC.

Fecha de la determinación: _____

Nombre del niño: _____
Apellido | Primer Nombre | Inicial del 2.° nombre

Fecha de nacimiento del niño: ____/____/____ Edad: _____
mm/dd/aa

Padre o madre, tutor o individuo que consta en el registro:

_____
Apellido | Primer nombre | Inicial del 2.° nombre

Nombre del proveedor o de la clínica:

_____

Marque la primera categoría que corresponda; marque sólo una.

- ☐ (a) Está inscrito en Medicaid, o
- ☐ (b) No tiene seguro médico (no asegurado), o
- ☐ (c) Es indio americano, o
- ☐ (d) Es nativo de Alaska, o
- ☐ (e) Es un paciente que recibe prestaciones del Plan de Seguro Médico Infantil (o CHIP), o
- ☐ (f) Está subasegurado: 1) tiene seguro médico comercial (privado), pero la cobertura no incluye las vacunas; 2) el seguro cubre sólo algunas vacunas elegidas (reúne los requisitos del TVFC sólo para las vacunas no cubiertas) o 3) el seguro limita la cobertura de vacunas a cierta cantidad. Una vez alcanzada dicha cantidad de cobertura, se categorizará al niño como subasegurado.

Los niños que tienen seguro total, privado ya no reúnen los requisitos de las vacunas por medio del TVFC.

- ☐ (g) Tiene seguro privado que cubre las vacunas (no reúne los requisitos del TVFC).

Firma: _____ Fecha: _____

Con ciertas excepciones, tiene derecho a pedir y a ser informado sobre la información que el estado de Texas reúne sobre usted. Tiene derecho a recibir y examinar la información al pedirla. También tiene derecho a pedir a la agencia estatal que corrija cualquier información que se determine es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la notificación de privacidad. (Referencia: Código gubernamental, sección 552.021, 552.023, 559.003 y 559.004)

Texas Department of State Health Services
Immunization Branch

TEXAS Department of State Health Services

Stock No. C-10
Revised 12/2011

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

ImmTrac
Texas Immunization Registry

(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

TEXAS Department of State Health Services

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.

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD DE TEXAS
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO PARA MENORES

ImmTrac
Texas Immunization Registry

(Favor de escribir claramente con letra de molde)

For Clinic/Office Use

Apellido del Niño(a)

Nombre del Niño(a)

Segundo Nombre del Niño(a)

Fecha de Nacimiento del Niño(a) **Solamente niños menores de 18 años.*

Género: ☐ **Masculino** ☐ **Femenino**

Dirección del Niño(a), Calle

Apartamento #

Teléfono

Ciudad

Estado

Código Postal

Municipio

Nombre de la Madre

Apellido de Soltera de la Madre

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud (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 ImmTrac. 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 ("ImmTrac"). Una vez que la información del menor esté en ImmTrac, 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 ImmTrac 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.state.tx.us 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) 458-7284 • www.ImmTrac.com
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