

## REGISTRATION / CONSENT FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Female / Male

Address: \_\_\_\_\_

City: \_\_\_\_\_, Texas Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Member ID: \_\_\_\_\_

Pharmacy & Address: \_\_\_\_\_

1.) May we phone, email and/or send a text to you to confirm appointments?

- Yes
- No

2.) I voluntarily authorize and consent to the medical care, treatment, and diagnostics tests including televisits that the providers of Hummingbird Pediatrics and their designated associates or assistants believe are necessary.

- Yes
- No

3.) I hereby authorize and give permission to the following individual/s in my absence to bring my child when I am unable to: (Please type name of person, date of birth and relationship).

---



---



---

### **Immunization Policy Statement**

At Hummingbird Pediatrics we believe vaccines prevent serious illness and save lives. For this reason, we require all our patients to be vaccinated, following the vaccine schedule recommended by the Centers for Disease Control and the American Academy of Pediatrics. Based on all available literature and current studies, vaccines do not cause autism or other developmental disabilities. Thimerosal, a preservative that had been in vaccines for decades but is no longer in any vaccine we administer, does not cause autism or other developmental disabilities. Please be advised that delaying or breaking up the vaccines to give one or two at a time goes against expert recommendations. This can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Hummingbird Pediatrics. **I hereby acknowledge that I have read, understand and agree with the Immunization Policy for Hummingbird Pediatrics and will vaccinate my child as per schedule. By my signature below, I grant consent for Immtrac registration. I wish to include my child's information in the Texas immunization registry.**

X \_\_\_\_\_ Date: \_\_\_\_\_

If you decide not to vaccinate your child despite all our efforts based on medical, religious and conscientious reasons, we require you to sign a vaccine refusal form which will be sent to the state and your insurance.

## **Financial Policy**

We would like to thank you for choosing Hummingbird Pediatrics as your child's health care provider. Please review the payment policies for our office. Responsibility for Payment - It is expected that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. Due to the National Insurance Documentation Requirements and Coding Guidelines, any preventive office visit which includes other reasons; sick, medicine refill, follow up, etc. will be charged as two office visits. Co Pays, Deductibles and coinsurance may apply depending on your insurance benefits. Acceptance of your health insurance - We accept most insurance plans and Medicaid. Please check with the office to confirm that we accept your insurance. Co payments and any prior patient balance are due when your child checks in to be seen in the office. Hummingbird Pediatrics is not a party to any legal agreements between divorced or separated parents. The parent/guardian accompanying a minor to an appointment is responsible for payment. Self Pay Patients - If you do not have health insurance or we do not accept your health insurance, payment in full is due at the time of your visit. PPO/HMO Insurance Plans - All managed care co-payment amounts are due at the time of service. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan. HMO - Your insurance plan may require you to identify a Primary Care Physician (PCP) for your child. If this notification is not on file with your insurance plan, payment for services may be denied. Please notify your insurance company if you change PCPs or insurance.

**I have read the Financial Policy and agree to abide by its terms, as well as authorize my insurance company to forward related payment and benefits directly to the physician's office.**

X \_\_\_\_\_ Date: \_\_\_\_\_

## **Hummingbird Pediatrics Office Policies**

1. *Same Day Appointments* - If you would like a same day appointment please text us at (281) 628-7442 between 9am-11am asking for a same day appointment. We do not take walkins.
2. *No Show Policy* - If unable to make your appointment please call to cancel before 24 hours of your scheduled time so that we may accommodate other patients. If you fail to show up to your appointment more than three times without a cancelation, you will be terminated.
3. *Insurance/PhotoID Card Policy* - We require that you present your insurance card and photo identification at every visit for the protection of our patients.
4. *Immunization Record* - It is the parent's responsibility to bring the patient's shot record for any well or nurse visits. There will be a \$5 fee collected at the time of service if the parent requests a copy of the short record due to loss.
5. *Primary Care provider (PCP)* - We require that we are the PCP the day of the visit. It is the parents' responsibility to ensure that this is completed prior to the visit. Insurance should be active.
6. *Answering Services* - The doctor on call will handle emergency calls only. These calls should be limited to urgent problems that cannot reasonably await regular office hours. Please be advised that Medicaid also has its own nurse line: the Medicaid Nurse First Advice line is a toll-free, round the clock number found on your medicaid card.
7. *Termination From Practice* - We practice the right to remove a patient from our office in the following situations - gross misconduct (yelling, not being courteous of others, disrespect, any form of

physical misconduct), illegal or fraudulent acts, profanity, and verbal abuse either over the phone or in person. Your insurance company will be notified of this change.

8. *Patient Portal* - It is mandatory to set up a patient portal account per Cares Act.

9. *Results/Referrals* - Please text the clinic (281) 628-7442 after 48 hours.

10. *Paperwork/Refills* - For paperwork and refills, please give 48 hour notice and the patient has to have been seen in the last 3 months and up to date on their wellness check up, if not please schedule an appointment.

11. *New Patient Policy* - Patients must come with a parent at first visit, no exceptions.

**I hereby acknowledge that I have read the Hummingbird Pediatrics Office Policy and had the opportunity to ask questions.**

X \_\_\_\_\_ Date: \_\_\_\_\_

### **HIPAA Compliance Policy**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. Use And Disclosure of Your PH by Hummingbird Pediatrics.

Hummingbird Pediatrics may use or disclose your PHI without your written authorization for the following reasons: Treatment. Hummingbird Pediatrics may disclose PHI to physicians, nurses, technicians, hospitals, ambulance, insurance, medical students or other personnel who are involved with the administration of your care at Hummingbird Pediatrics or other locations.

As Required By Law. We will disclose PHI when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. Hummingbird Pediatrics may also disclose PHI to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

Emergency Situations when your authorization cannot be reasonably obtained, including for disaster relief purposes;

To business associates (outside vendors or consultants that perform services on behalf of Hummingbird Pediatrics and are contractually required to appropriately safeguard your information);

To report abuse, neglect, or domestic violence as required by state of federal law;

For public health and health oversight activities, such as preventing or controlling disease or investigations;

We will retain our records of the care provided to you as required by law.

**I hereby acknowledge that I have read the Hummingbird Pediatrics Notice of Privacy Practices/HIPAA policy. Our HIPAA policy is on our website.**

X \_\_\_\_\_ Date: \_\_\_\_\_