Coppell Pediatric Associates, P.A
1705 E. Belt Line Rd., Coppell, TX 75019
Phone: 972-393-8687 Fax: 972-393-4975
www.coppellpedi.com

Tammi L. Schlichtemeier, MD, FAAP

Welcome to COPPELL PEDIATRICS. We are glad that you have chosen us to provide your child's primary care, and we are looking forward to working with your family.

Enclosed you will find our **"New Patient Information."** Please complete and submit each of the following documents to our office staff prior to or at the time of your first visit:

Required

- **Family demographic form**: This form provides your address and phone number, emergency contacts, and insurance information.
- **Health history form:** Provides information about your child's past medical history.
- **HIPPA form**
- **Release of records**: It is important that we obtain copies of your child's previous medical records from those who have treated your child in the past. Please complete a separate release form for each doctor your child has seen.
- **Financial Policy:** Please sign and return this form to the office staff.

Optional

- **"Consent to Treat a Minor" form**: Complete and submit if you anticipate that your child will be accompanied to his or her appointments by someone other than a parent or legal guardian.

It is also important that you contact your insurance company and alert them which Pediatrician will be serving as your child's primary care physician. Also, please be sure to bring your insurance card(s) and required co-Payment or deductible payment (if any) to the appointment.

Enclosed you will also find the practice brochure. This brochure provides you with information on how to schedule appointments, billing, refill requests, and more.

Once again, welcome to Coppell Pediatrics. Should you have any questions, please do not hesitate to contact us at (972) 393-8687

Sincerely,

Tammi L. Schlichtemeier, M.D., FAAP

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New Patient Registration

Last Name _____ First Name _____ Middle Name _____

Home Address _____ City, State, Zip Code _____ Home Phone # _____

Date of Birth __/__/__ Who referred you to Coppell Pediatrics? _____

Preferred Pharmacy _____ Address/Location of Pharmacy _____

PATIENT RACE/ETHNICITY (REQUIRED FOR INSURANCE STATISTICS ONLY):

☐ American Indian or Alaskan ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Island ☐ Latino-Hispanic ☐ White ☐ Other

MIGRANT FARM WORKER ☐ YES ☐ NO

Father's Information

Last Name _____ First Name _____ Middle Name _____

Home Address _____ City, State, Zip Code _____ Home Phone # _____

Date of Birth __/__/__ Social Security Number _____ Driver's License # _____

Employer _____ (___) Work Number _____ (___) Cell Number _____

Mother's Information

Last Name _____ First Name _____ Middle Name _____

Home Address _____ City, State, Zip Code _____ Home Phone # _____

Date of Birth __/__/__ Social Security Number _____ Driver's License # _____

Employer _____ (___) Work Number _____ (___) Cell Number _____

Insurance Information

Insurance Name _____ Claims Address _____ (___) Phone Number _____

Policyholder Name _____ Member ID # _____ Group # _____

Person completing forms _____ Relationship to patient _____ Date _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I request that the health information regarding the patient's care and treatment be released as set forth on this form.

_____ _____/_____/_____
PATIENTôS LAST NAME FIRST MIDDLE DATE OF BIRTH

PREVIOUS MD OR HOSPITAL OR ENTITY TO RELEASE THIS INFORMATION:

_____
NAME ADDRESS FAX

THIS INFORMATION WILL BE SENT TO:

COPPELL PEDIATRIC ASSOCIATES, P.A.
DR. TAMMI L. SCHLICHTEMEIER
1705 E. BELT LINE RD., COPPELL, TX 75019

SPECIFIC INFORMATION TO BE RELEASED:

☐ **Entire Medical Record**, including patient histories, growth chart, vaccine records, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults and records sent to you by other health care providers.

Include: (Indicate by Initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____HIV-Related Information

☐ Other: _____

Authorization to Discuss Health Information

☐ **By initialing here** _____ I authorize _____ to discuss my health information with
(Name of Previous MD)
Dr. Tammi L. Schlichtemeier or her Associates

Reason for release of information: ☐ TRANSFER OF MD ☐ OTHER _____

I understand that the information released is for the specific purpose as designated above. I understand that this consent expires in 120 days after the date of my signature.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.
I may revoke this authorization by notifying **COPPELL PEDIATRIC ASSOCIATES, PA** in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

_____ _____ Ĭ Parent Ĭ Foster Parent Ĭ Legal Guardian
Signature of **parent or guardian** for minor child Date

_____ _____ _____
Signature of **patient** if 18 years of age or older Date SSN or Date of Birth

OFFICE USE ONLY:

Date of Fax#1 _____/_____ Fax#2 _____/_____ Fax#3 _____/_____
Initial Initial Initial
Date Records Received _____ Chart reviewed by _____

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CONSENT FOR MEDICAL TREATMENT OF MINOR

Name of Minor Child _____DOB:_____/_____/_____ Age: _____

CONSENT BY PARENT/MANAGING CONSERVATOR/GUARDIAN OR OTHER ADULT

Printed Name of Parent(s) if known _____

Printed Name of Person authorized to consent for child if parent not available. _____
_____

(Check one) ☐ Grandparent ☐ Babysitter/Nanny ☐ Neighbor ☐ Managing Conservator
☐ Stepparent ☐ other_____

The above named adult has my consent to medical treatment for the above minor (given in writing by the parent or legal guardian of _____)
Child's Name

As per Texas Family Code Chapter 32.001, I consent for medical treatment of the above named minor.
My child has _____ drug allergies.
My child is taking _____ medications.

Please **CHECK** which you are allowing the above named adult to consent for any visit.

☐ Well child, exam only
☐ Well child, exam with vaccines and/or blood draws
☐ Vaccines & labs
☐ Sick visit, exam only
☐ Sick visit, with labs and/or injections

Date(s) of consent to treat form effective: _____ / _____ / _____ **to** _____ / _____ / _____
(Note: you may allow up to 1 year for this form to be effective, one day only for verbal consent)

I give permission for Coppell Pediatric Associates, PA to provide medical treatment to the minor named above.
The consent is effective for the dates listed above.
If consent is verbal, it is witnessed by 2 staff members, acknowledged by signatures below.

I declare under penalty of perjury that the above information is true and correct.

***Please note, we must have a signed consent for well child exams AND vaccines. The physician will need to see and speak with both patient and parent on day of well child exam, and parent must be at well child exam to give written consent for immunizations.**

_____ _____ _____
Printed Name of Person Giving Consent (Parent/Guardian) **Signature of Person Giving Consent** **Date**

_____
Relationship to child

Staff Members x2 have simultaneously, verbally witnessed consent of parent listed above.

_____ _____ _____ ____:____**AM/PM**
 # 1 Staff Signature **#2 Staff Signature** **Today's Date** **Time**

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Patient's Name: _____ **DOB:**____/____/_____ **Today's Date:** _____

YOUR CHILD'S GENETICS AND FAMILY HISTORY

How does family history currently influence your child's health?
Place a check mark beside the conditions and diseases of each family member. The more check marks you make, the greater your childôs risk is becoming overweight and developing the serious diseases associated with it.

	Mother	Father	Sibling #1	Sibling #2	Sibling #3
ADD/ADHD	☐	☐	☐	☐	☐
Alcoholism/Drug Use	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Cancer: Type/Location: _____	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Attack/Heart Murmur	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Obese/overweight	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Next, fill out a similar chart for your **child's grandparents**, not the parentsô grandparents. Which of the following conditions apply to your **child's grandfathers and grandmothers**?

	Maternal		Paternal	
	Grandmother	Grandfather	Grandmother	Grandfather
ADD/ADHD	☐	☐	☐	☐
Alcoholism/Drug Use	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer: Type/Location: _____	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Attack/Heart Murmur	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Obese/overweight	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

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FINANCIAL AND OFFICE POLICY

Patient Name _____ **Date of Birth:** _____/_____/_____

PAYMENT- Payment is due at the time of service. If you have Insurance, your co-pay, deductible or coinsurance is due at the time of service. We accept Visa, Master Card & Discover or debit cards, cash, and checks. Please note: The parent or guardian who brings child to visit is responsible for payment at time of service, including the divorced, separated, or unmarried parent.

Initials ____

INSURANCE - If we are your Insurance's preferred provider, you must first meet your deductible and any part your Insurance does not pay. Most misunderstanding about Insurance can be avoided if you understand what your policy provides. If your Insurance Company chooses not to pay Coppell Pediatrics for whatever reason or they choose to delay payment, **YOU** will be responsible for payment. **If payment is not received within 60 days from your Insurance Company, you will be charged.** Payment is expected within one week of receipt of your invoice. The invoice will accrue a 0.5% interest fee per month on delinquent accounts. The stated policies regarding payment must be implemented because Insurance companies have become more cavalier in the prompt processing of claims by physician's office.

Initials ____

INSURANCE REFERRALS - As your primary care physician, we will send a referral to your preferred Specialist upon your request via fax.

- **It is your responsibility to find out if referrals are required by your Insurance.**
- **If a referral is not requested before you see your specialist, you will be responsible for any payment that you are billed.**
- **You may be asked to reschedule your appointment if ample time was not given.**

If referrals are required, please make sure to call us two to three days before your appointment. We want to have ample time to call your Insurance and/or specialist and do any paper work if needed. Referrals are done in the order received or by appointment date.

Initials ____

DELINQUENT ACCOUNTS - Delinquent account will be reported to our collection service after 90 days. Please let us know if your payment will be late arriving at the office.

Initials ____

COLLECTION SERVICE -1 understand if I have an unpaid balance to Coppell Pediatric Associates, PA, and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

Patient Name _____ **Date of Birth:**___/___/_____

In order for Coppell Pediatric Associates, PA, or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Coppell Pediatric Associates, PA, and the designated external collection agency are authorized to

(i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me,

(ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and

(iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Initials____

RETURNED CHECKS - There will be a $30.00 charge for all returned check. After a check has been returned for NON-SUFFIENT FUNDS, all further payment will need to be **CASH, CREDIT CARD OR DEBIT CARD.**

Initials____

OFFICE PROCEDURE/SURGERY ï When office procedure are schedule; you must call your insurance prior to your visit and verify that the procedure that you are requesting is covered under your plan. We will gladly file the claim for you. However, if payment is denied, **YOU** will be responsible for any balance due.

Initials____

PRESCRIPTIONS - There will be a $15.00 charge for all duplication or replacement of written prescriptions. If you would like your prescriptions called into your pharmacy, please provide pharmacy phone number to receptionist, and we will gladly do it for you. All routine medication refill requests must be made during regular business hours.

My preferred pharmacy is _____ _____

Name Location

Initials____

LABS, HEARING/VISION SCREENING/VACCINES OR X-RAYS - Patients are financially responsible for any labs, hearing/vision screening/vaccines or x-ray ordered by your physician. Please contact your Insurance Company to verify your benefits before you do any procedure.

Initials____

PHONE CALLS - We ask that all non-emergency calls are made during regular business hours. We will return all calls after 4:30 pm the same day in the order they are received. No labs or test results will be discussed over the phone unless it is medically necessary. Lab and test results that are normal will be mailed out 7 to 14 days after they are done. All abnormal results; our office will contact you within 3 to 5 days after they are completed to schedule a follow up appointment with your child's physician. In that visit your child's physician will go over all results and discuss treatment if needed.

Initials____

CANCELLATIONS - If you cannot keep your appointment, we expect that you call us at least 4 hours prior to the appointment time. Failure to call or reschedule at least 4 hours prior will result in a $25 fee for the first time, a $50 fee for the second, and the third may result in being ask to leave the practice. Fee must be paid prior to or at the time of next scheduled appointment.

Initials _____

Patient Name _____ **Date of Birth:** ___/_____/_____

WALK-INS AND LATE ARRIVALS - Office visit from 8:00 am to 5:00 pm are by appointment only. We will do our best to get you in to see our physician the same day. Patients who are late for an appointment, by 15 minutes or more will be rescheduled. As a courtesy, we will notify you the day before to remind you of your child appointment via call, text, or email.

Initials ____

ASSIGNMENT OF BENEFITS -1 request that payment of authorized insurance benefits be made on my behalf to COPPELL PEDIATRIC ASSOCIATES, PA for any service furnished to me by that provider. I authorize the use of this signature on all my insurance submissions whether manual of electronic.

Initials ____

RELEASE OF INFORMATION - I authorize COPPELL PEDIATRIC ASSOCIATES, PA to release to my insurance carrier and its agents and/or my insurer any information needed to determine benefits or benefits payable. I understand that my child's health information is confidential, and therefore, will require periodic signatures of parent or guardian to release information. I also understand my child's records will not be faxed without a parent or guardian's authorized signature. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Initials ____

I ___ **DO** or ___ **DO NOT** desire to be contacted by postcard to **remind me of OVERDUE VACCINES OR OVERDUE WELL CHILD APPOINTMENTS.**

Because our #1 priority is patient care and satisfaction, please sign below that you have read and understand the **NEW POLICIES** that we have adopted. We would like to thank you for your understanding and cooperation if you have any question please feel free to ask.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

_____ _____

Signature of Person Financially Responsible Date Signed

_____

FULL NAME OF PERSON FINANCIALLY RESPONSIBLE

CONTACT INFORMATION OF PERSON FINANCIALLY RESPONSIBLE

_____ (_____) _____

Address, City, State, & Zip **Cell Phone Number**

_____**@**_____**. com** (_____) _____

Email Address **Home or Work Phone Number**

_____ _____ _____

Texas DL # **Social Security** **Relationship to Patient**

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PORTAL ACCESS AUTHORIZATION

Coppell Pediatrics is pleased to offer our patients access to our office via internet portal. The portal offers you the opportunity to do the following:

- **Make appointments on-line 24 hours a day**
- **Send email messages to your physician**
- **Print your child's vaccine records**
- **Check your child's lab results and print results**
- **Request refills on-line**
- **Update your child's health history on-line**

*This portal is **secure and encrypted**. No information on your child's health or medical history will be accessed by anyone other than you or your physician. No information will be used for sale or solicitation by any party. This portal authorization will be valid until your child's 18th birthday.*

You may access our portal via our website page www.coppellpedi.com by clicking on the portal button on the right side of our website page.

Please choose 1 of the following (Mark one with your initials):

_____ I DO want full access to the Coppell Pediatrics portal. My email address is

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

_____ I DO NOT want full access to the portal. I understand that I cannot make appointments on-line, I cannot access my child's chart on-line, and I cannot request refills or email MD since I decline portal access.

Patient Name_____ Date of Birth ____/____/____

Parent/Guardian Signature_____Date___/___/____

Date Staff entered _____ Staff initials _____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone ____-____-____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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, 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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.**

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NOTICE OF 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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used to disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclosed your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment**: means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.
- **Payment**: means such activities as obtaining reimbursement for services, confirmation coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations**: include the business aspects of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. As example would be in internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or an other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communication is protected health information from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **June 15, 2016** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file complaint: The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201
202-619-0257 or toll free 1-877-696-6775

_____ _____

Parent/Guardian Signature Date

Patient Name: _____ DOB:____/____/_____

_____ _____

Security Officer's Signature Date