Patient Name____Date of Birth____________ SS#_____________________
(Nombre del paciente) (Fecha de Naciminto) (# de seguro social)

Address____ City:_________________ State_______ Zip Code_______________
(Direccion) (Ciudad) (Estado) (Codigo postal)

Home Phone__________________________________ Male______Female_____Email address:_____________________________
(Telefono) (Masculino) (Femenino) (Direccion electronica)

Father Name: ____ Cell#__________________________________
(Nombre de la Padre) (# la celula)

Mother Name____Cell#__________________________________
(Nombre de la Madre) (# la celula)

Person to contact in case of emergency other than parent:
(Contacto de emergencia)

Name____Relationship to patient________________________
(Nombre) (la relacion)

Address____Phone#_______________________________
(Direccion) (Telefono)

Insurance Information:
(informacion de seguro)

Policy Holder Name____Date of Birth______________SS#____________________
(nombre del titular politica) (Fecha de naciminto) (# del seguro social)

Relationship to Patient_____________________________Name of Employer____
(la relacion) (nombre del empleador)

Employer Address____City_______________State____________Zip_________
(direccion del empleador) (ciudad) (estado) (codigo postal)

ID#_____________________________________Group#____________________Insurance Phone#______________________________
(grupo #) (Telefono seguro)

Medicaid #____ Do you have any additional insurance?______Yes______No
(# el Medicaid)

Medications:

Compass Pediatrics prescribes medications electronically. This means all prescriptions are automatically sent to the pharmacy before the patient leaves the office. We must have consent on file from the patient's guardian stating that we can prescribe this way for you. Please Selct:________**YES**________**NO**, if YES please name a pharmacy that you choose for your medications to be filled at:____, If NO you will be given a paper prescription to take to the pharmacy of your choice. However, if there is a problem we will have no way of tracking your medications.

Insurance Authorizations:

I hereby authorize Compass Pediatrics to furnish information to Insurance carriers/medical facilities concerning treatments, and I hereby assign Compass Pediatrics all payments for medical services rendered. Please be aware that Medicaid is considered insurance.

La Medicacion

Compass Pediatrics prescribe medicamentos electronically. Esto significa que todas las recetas se envian automaticamente a la farmacia antes de que el paciente sale de la oficina. Debemos tener consentimiento de fle de guardian del paciente indicando que podemos prescriber esta manera para usted. Por Favor, seleccione: _______ **Si or** _______ **No,** en caso afirmativo por favor nombrar una farmacia que usted elige para que sus medicamentos a llenarse en.______________________________Si no se le dara una receta de peper para llevar a la farmacia, sin embargo, si hay un problema tendremos ninguna manera de rastrear su receta.

Autorizacion de seguro:

Me ahorize herby Compass Pediatrics que proporcione informaciones al servicios de transportistas/medical seguro con respect a traets y yo por la presente asignar Compass Pediatrics todos los pagos por los servicios medicos prestados. Los please tenga Medicaid se considera seguro.

Print Name:____DOB:_______________Relationship to patient:_____________________
(Nombre en imprenta) (Fecha de Naciminto) (relacion)

Address if different from patient:____
(Direccion si es distinto del paciente)

Signature:____Date:______________________
(la Firma) (la fecha)

Consent to Treatment:

I voluntarily consent for myself/my child to receive medical and health care services provided by Compass Pediatrics, PLLC, its nurse practitioner, employees and such associates, assistants, and other healthcare providers, as my practitioners deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I understand that no guarantee or warranty has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I seek services from Compass Pediatrics, PLLC, unless revoked by me in writing or amended by the refusal of treatment consent.

Consent to Disclosure of Protected Health Information:

Protected health information pertains to you/your child's diagnosis and/or treatment at Compass Pediatrics, PLLC, including but not limited to information concerning mental illness (except psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, radiology reports, medical history, treatment, progress or any other such related information.

Consent to Photograph:

I consent to have my/my child's photograph as per routine creation of the medical record through the Electronic Medical Record (EMR) in use by Compass Pediatrics, PLLC and as deemed necessary by the staff, employees or agents of Compass Pediatrics, PLLC to document pertinent medical conditions, reactions or other conditions requiring photograph.

Release of Liability:

I release and agree to hold harmless Compass Pediatrics, PLLC and its agents, representatives and employees from any and all liability associated with the release of confidential patient information in accordance with the authorization. I understand Compass Pediatrics, PLLC cannot be responsible for use or re-disclosure of information by third parties.

Financial Responsibility and Assignment of Benefits:

In consideration for receiving medical or healthcare services, I hereby assign my right, title, and interest in all insurance. Medicaid/Medicare or other third-party payer benefits for medical or healthcare services otherwise payable to me to Compass Pediatrics, PLLC. I also authorize direct payments to be made to insurance, Medicaid/Medicare, or third-party payers, up to the total amount of my medical and healthcare charges, to Compass Pediatrics, PLLC practitioners. I certify that the information that I have provided in connection with any application for payment by insurance, Medicaid/Medicare, or third-party payers is correct. I understand that all co-pays, deductibles, and full payment (if applicable) for services rendered must be paid prior to the patient being seen. We except cash, check, debit/credit, we do not except travelers, temporary, pre- or post- dated checks. Valid ID must be shown with all check, debit and credit payments. I understand if my payment is declined another form of payment is expected before the patient can be seen. I also understand if my check is returned that I will be liable for a $30.00 return fee plus any other fees incurred by the bank and/or Compass Pediatrics, PLLC.

No-Show Policy:

I understand that after 3 No call No show appointments I/My child will be sent a letter and dismissed from the practice, you will have 30 days to transfer to another office. If during those 30 days your child needs medical attention, you may follow up with Compass Pediatrics, PLLC. We will provide all medical records upon request and signature of a HIPAA release.

Patient Portal:

Upon my request I will be granted rights to access my/my child's patient records through a secured patient portal via the internet. I will be given a temporary password which will need to be changed after the first log-in. I understand that if the information is lost or stolen it is my responsibility to contact Compass Pediatrics, PLLC to have my password reset. I understand that my log-in and password is for my use only and will not give the information out to the other parties. I understand this access can be revoked at any time by Compass Pediatrics, PLLC if deemed necessary. I understand I can terminate my portal usage at anytime upon a written request to Compass Pediatrics, PLLC signed by myself.

I certify that this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents.

Printed Name:____
(Nombre impreso)

Printed Name Parent/Guardian/Other Legally Authorized Person:______________________________
(Tutor nombre otra persona autorizada legalmente)

Signature:______________________________ Date:____________________
(La Firma) (La Fecha)

Witness:____
(El testigo)

_____________ DATE

CHILD HEALTH HISTORY

Name: ______________________ **DOB:** _________

Allergies: (circle) Medications Foods Latex

Allergy Reaction

_______________ _________________

_______________ _________________

____

Pregnancy and Birth

How many children do you have? _____

How old were you when the child was born? _____

Did you have prenatal care? __Yes __No ________Doctor

Where did you have your baby? (circle)

MCH ORMC Birthing Center Other ____

Was your baby in NICU? ____Yes ____No

Did your baby have problems breathing, have a heart murmur, infection or jaundice? __Yes __No

Birth: Weight______ Length______FOC _____

Was your delivery vaginal or c-section (circle)

Did your baby pass the hearing screen? __Yes ___No

Did your baby have a newborn screen? ___Yes ___No

Labs: PKU #1 _____ PKU#2______

Any problems with pregnancy, labor & delivery or nursery stay?
_____Yes _____No

Any infections while pregnant? ____Yes ____No

Any substance while pregnant? ____Yes ____No

Do you have any barriers to: (circle)

Communication Religion

Learning Cultural Other

Family History (circle)

Blood disorders High blood pressure

Diabetes Asthma

Allergies Seizures

Tuberculosis Hepatitis

HIV Sudden death before 40 y

Childhood hearing loss High cholesterol

Alcohol use Drug use

Tobacco use Genetic disease

Birth defects Other: ____________________

Developmental History

Does your child have any developmental delays or learning difficulties? _____Yes _____No

Did your baby :

Hold up head by 2 months? ___Yes ___No

Roll over by 4 months? ___Yes ___No

Sit up by 6 months? ___Yes ___No

Crawl by 9 months? ___Yes ___No

Walk by 13 months? ___Yes ___No

Potty train by 3 years old? ___Yes ___No

Activities/Habits

Does your child sleep all night? ___Yes ___No

Does your child nap? ___Yes ___No

Does your child wet the bed? ___Yes ___No

Is your child in sports, music or clubs? __Yes __No

Vaccines:

Do you vaccinate your child? ____Yes ____No

Are your child's vaccines up to date? __Yes ___No

Safety

Does your child wear seat belt or ride in car/booster seat? __Yes __No

Where does your child sleep? ____________________________

Child's Medical History

Ear infections Throat infections

Syndrome___________ Developmental delay(s)

Dental cavities Eczema

Blood disorders Seizures

Diabetes Asthma

Allergies Tuberculosis

Hepatitis HIV

Hearing loss High cholesterol

Genetic disease Birth defects

Other:________________________________

Has your child seen a dentist: __Y __N _______

____

Does your child see any specialists? __Yes __No

Doctor Condition seen for

_____________ ____________________

_____________ ____________________

_____________ ____________________

_____________ ____________________

____

Medication History

Does your child take any medications? __Yes __No

(Over the Counter or Prescribed)

Medication Condition the medication is for

_____________ ____________________

_____________ ____________________

_____________ ____________________

Has your child had any surgeries? ____Yes ___No

(surgery and date)_______________________________

____

Social/Environmental History

Parents (circle): married, separated, living together

Who lives with the child: __________________

____

Does your home have gas/heat/ac/water? __Yes __No

What year was your home built? ____________

Do parents work outside of the home? __Yes __No

School/Daycare/MDO: ____________________

Problems and home or school: ______________

Animals in the house? __Yes __No

Smokers in/out of the house? __Yes __No

Does child travel outside the United States? __Yes __No

Patient Tobacco History (older than 13 years old)

Never smoker __Yes ___No

Current smoker __Yes ___No

Former smoker __Yes ___No

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

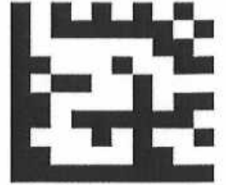
** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified 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 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, 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 • ImmTrac 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.**

Tamara Bavousett DNP, RN, C-PNP
6100 Eastridge Road
Odessa, TX 79762
432-332-2080 Fax – 866-298-7237

Patient Portal Consent

Upon my consent I will be granted rights to access my/my child's patient records through a secured patient portal via the internet. I will receive an invite email to sign up for the patient Portal. The invite email will come to the email I choose and provide to the front office at Compass Pediatrics, PLLC. I understand I will choose the secure password for my/my child's portal account. I understand if the information is lost or stolen it is my responsibility to reset my username and password on the log-in page of the patient portal. I understand that my log-in and password are for my use only and will not give the information out to other parties. I understand this access can be revoked at any time by Compass Pediatrics, PLLC if deemed necessary. I understand I can terminate my portal usage at any time upon a written request to Compass Pediatrics, PLLC signed by myself.

Parent/Guardian Name:____

Preferred Email Address:____

Relationship to Patient (s):____________________ **Phone Number:**_______________________

Mailing Address:____

City:_______________________ **State:**______ **Zip:**_________

1-Patient Name:_______________________________________ **DOB:**______________

2-Patient Name:_______________________________________ **DOB:**______________

3-Patient Name:_______________________________________ **DOB:**______________

4-Patient Name:_______________________________________ **DOB:**______________

5-Patient Name:_______________________________________ **DOB:**______________

6-Patient Name:_______________________________________ **DOB:**______________

5113 Wayland Drive
Odessa, TX 79762
432-332-2080 Fax: 866-298-7237

Cancellation Policy/ No Show Policy for Compass Pediatrics

1. **Cancellation/No Show Policy for Scheduled Appointment(s)**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

   If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee; this will not be covered by your insurance company. For appointments scheduled the same day, please notify our office within 2 hours of your appointment time to avoid the $25 fee.

2. **Scheduled Appointments**

   We understand that delays can happen, however we must try to keep other patients and doctors on time.

   If a patient arrives 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. **No Show Dismissal**

   Patients who do not show up for their appointment without a call to cancel an appointment will be considered a **NO SHOW**. Patients who No Show three (3) or more times in a 12 month period may be dismissed from the practice. They will be denied any future appointments.

4. **Account Balances**

   We will require that patients with self-pay balances pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the billing department to review their account and concerns. Patients with balances over $50 must make payment arrangements prior to future appointments being scheduled.

____________________ ____________________ ________

Print Patient Name **Signature Patient/Guardian** **Date**

____

Patient DOB