Patient Name____Date of Birth__________ SS#____________________
(Nombre del paciente) (Fecha de Nacimiento) (# 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 nacimiento) (# 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 Nacimiento) (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:

<u>I understand that after 3 No call No show appointments I/My child will be sent a letter and dismissed from the practice,</u> 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)

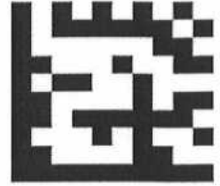
Medication Condition the medication is for
_____________ ____________________
_____________ ____________________
_____________ ____________________

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**

REGISTRO DE INMUNIZACIÓN (ImmTrac2) FORMULARIO DE CONSENTIMIENTO PARA MENORES



(Favor de escribir claramente con letra de molde)

Apellido del Niño(a)

Nombre del Niño(a) **Segundo Nombre del Niño(a)**

__/__/____ *Solamente niños menores de 18 años. **Género:** ☐ **Masculino** ☐ **Femenino**

Fecha de Nacimiento del Niño(a)

Dirección del Niño(a), Calle **Apartamento #** **Teléfono** ___-___-____

Ciudad **Estado** **Código Postal** **Condado**

Nombre de la Madre **Apellido de Soltera de la Madre**

ImmTrac2, el registro de inmunización de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud de Texas (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 ImmTrac2. 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 ("ImmTrac2"). Una vez que la información del menor esté en ImmTrac2, 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 ImmTrac2 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.texas.gov* 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) 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.**

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

Programa de Vacunas para los Niños de Texas

Registro de la determinación de elegibilidad del paciente

En el consultorio del proveedor de servicios de salud debe mantenerse, durante un mínimo de cinco (5) años, un registro de todos los niños de 18 años de edad o menores que reciban inmunizaciones por medio del Programa de Vacunas para los Niños de Texas (TVFC). Dicho registro lo puede rellenar el padre o la madre, el tutor, el individuo cuyo nombre aparece en el registro, o el proveedor de servicios de salud. En cada visita para inmunización debe determinarse y documentarse el estado de elegibilidad para el TVFC a fin de asegurar que el menor es elegible para el programa. Aunque no se requiere la verificación de las respuestas, es necesario conservar este registro, o uno similar, para cada niño que reciba vacunas bajo el Programa TVFC.

1. Nombre del menor: ____________________
   Apellido   Primer nombre   Inicial del 2.o nombre
2. Fecha de nacimiento del menor: ____/____/____
   mm   dd   aaaa
3. Padre, tutor o individuo del registro: ____________________
   Apellido   Primer nombre   Inicial del 2.o nombre
4. Nombre del proveedor primario: ____________________
   Apellido   Primer nombre   Inicial del 2.o nombre
5. Para determinar si un menor (de 0 a 18 años de edad) es elegible para recibir vacunas federales por medio del Programa TVFC, en cada cita o visita para inmunización anote la fecha y marque la categoría de elegibilidad apropiada. Si marca una columna de la A a la F, el menor es elegible para el Programa TVFC. Si marca la columna G, el menor no es elegible para las vacunas federales VFC.

Fecha	Elegible para las vacunas VFC				Elegible con programa estatal		No elegible
	A	B	C	D	E	F	G
	Inscrito en Medicaid	No tiene seguro médico	Indoamericano o nativo de Alaska	* Con seguro insuficiente, recibe atención de un FQHC, una RHC, o un proveedor delegado	** Otras situaciones de seguro insuficiente	*** Inscrito en el CHIP	Tiene seguro médico que cubre vacunas

** El seguro insuficiente incluye a los niños cuyo seguro médico no incluye vacunas o solo cubre ciertos tipos específicos de vacunas. Los niños solo son elegibles para recibir vacunas que no están cubiertas por el seguro. Además, para recibir las vacunas de VFC, los niños con seguro insuficiente deben ser vacunados en un Centro de Salud Federalmente Acreditado (FQHC), en una Clínica de Salud Rural (RHC), o por un proveedor delegado autorizado. El proveedor delegado debe tener un contrato por escrito con un FQHC o una RHC y con el programa de inmunización estatal, local o territorial para poder vacunar a los niños con seguro insuficiente.*

*** Otros niños con seguro insuficiente son aquellos que, aunque están insuficientemente asegurados, no son elegibles para recibir las vacunas federales por medio del Programa TVFC porque el proveedor o centro no es un FQHC, o una RHC, o un proveedor delegado. Sin embargo, estos niños pueden ser atendidos si las vacunas son proporcionadas por el programa estatal para dar cobertura a los niños que no son elegibles para el TVFC.*

**** Niños inscritos en el programa estatal separado CHIP (Children's Health Insurance Program). Estos niños se consideran asegurados y no son elegibles para recibir vacunas mediante el Programa VFC. Cada estado proporciona orientación específica sobre cómo se adquieren y administran las vacunas del CHIP a través de los proveedores participantes.*

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