PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

GENDER	SOCIAL SECURITY #	MARITAL STATUS	DATE OF BIRTH	DRIVERS LICENSE #
☐ F ☐ M				

RACE	ETHNICITY
☐ prefer not to answer	☐ prefer not to answer

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE/ PREFERRED PHONE	CELL PHONE	E-MAIL ADDRESS	PREFERRED CONTACT

PARENT/ GUARDIAN INFORMATION (required for minor patients, < 18 years old)

MOTHER/ GUARDIAN NAME		
DATE OF BIRTH	SOCIAL SECURITY #	DRIVERS LICENSE #
ADDRESS ☐ check if same as patient's		
HOME PHONE	CELL PHONE	E-MAIL ADDRESS
EMPLOYER NAME/ OCCUPATION		WORK PHONE

FATHER/ GUARDIAN NAME		
DATE OF BIRTH	SOCIAL SECURITY #	DRIVERS LICENSE #
ADDRESS ☐ check if same as patient's		
HOME PHONE	CELL PHONE	E-MAIL ADDRESS
EMPLOYER NAME/ OCCUPATION		WORK PHONE

BILLING RESPONSIBILITY / GUARANTOR

NAME	RELATIONSHIP TO PATIENT
ADDRESS ☐ check if same as patient's	

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

INSURANCE INFORMATION

INSURANCE COMPANY		CUSTOMER SERVICE PHONE #	
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP
POLICY #	GROUP #	EFFECTIVE DATE	
NAME OF PRIMARY INSURED		RELATIONSHIP TO PATIENT	
PRIMARY INSURED DATE OF BIRTH	PRIMARY INSURED SOCIAL SECURITY #		

EMERGENCY CONTACT (other than parent/ guardian)

NAME		PHONE	
STREET ADDRESS	CITY	STATE	ZIP

PREFERRED PHARMACY INFORMATION

PHARMACY NAME		PHONE	
STREET ADDRESS/ INTERSECTION	CITY	STATE	ZIP

Authorization to Release Information and Assignment of Benefits

I certify that information I have reported about my insurance is correct. I authorize the release of any medical information necessary to process my insurance claims. I authorize my doctor to apply for benefits on my behalf for covered services rendered by him or her, or by his or her order. I request that payment be made directly to my doctor or to the party who accepts assignment. I acknowledge that any insurance billing done is at the discretion of my doctor. I understand that any co-pays, co-insurances and deductions deemed my responsibility are payable in full by me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing by either me or my insurance company.

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN DATE

PRINTED NAME

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

PEDIATRIC MEDICAL HISTORY FORM

(Please complete all pages.)

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details.

YOUR RELATIONSHIP TO CHILD: _____ **CHILD'S PREVIOUS DOCTOR:** _____

PRESENT HEALTH CONCERNS: _____

ALLERGIES or REACTIONS TO MEDICATIONS/ FOODS/ OTHER AGENTS:

Medication/ Allergen	Reaction or Side Effect

MEDICATIONS: List prescription / non-prescription medicines, vitamins, home remedies, birth control pills, herbs.

Medication	Dose	Times per day	Medication	Dose	Times per day

BIRTH HISTORY:

Where was your child born? _____ Is the child yours by: □birth □adoption □stepchild □other
Please indicate any medical problems during pregnancy: _____
Delivery by: □ vaginal birth □ caesarean-section (Reason for C-section: _____)
Birth weight: _____ Birth length: _____ APGAR score: 1 min _____ 5 min _____
Please indicate any medical problems during the newborn period: _____
_____
Other problems: _____

PAST MEDICAL HISTORY:

Are your child's immunizations up to date for their age? □No □Yes
Describe any major medical problems and their dates: _____
_____
_____
_____
Has your child had any of the following? □chicken pox □measles □mumps □meningitis □tuberculosis (TB)
Hospitalizations (list dates and reasons): _____
_____

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

SURGICAL HISTORY: Please list all prior operations and dates.

Operation	Date	Operation	Date

FAMILY HISTORY: Please indicate with a check mark any family members who have had any of the following conditions.

Medical Condition	Mom	Dad	Sibling	Gma	Gpa	Medical Condition	Mom	Dad	Sibling	Gma	Gpa
Alcoholism						Genetic diseases					
Anemia						Glaucoma					
Anesthesia problem						Hay fever/ allergies					
Arthritis						Hearing problems					
Asthma						Heart disease					
Birth defects						High cholesterol					
Bleeding problem						Hypertension					
Cancer, breast						Kidney disease					
Cancer, colon						Lupus					
Cancer, lung						Mental retardation					
Cancer, melanoma						Migraine headache					
Cancer, ovary						Mitral valve prolapse					
Cancer, prostate						Osteoarthritis					
Cancer (not noted)						Osteoporosis					
Depression						Psychiatric diseases					
Diabetes, type 1 (child onset)						Rheumatoid arthritis					
Diabetes, type 2 (adult onset)						Stroke					
Eczema						Thyroid disorders					
Epilepsy (seizures)						Tuberculosis					

Other Medical Conditions: _____

_____

SOCIAL HISTORY:

PARENT INFO:

Marital status: □single □married □separated □divorced □widowed □other: _____

If divorced or separated, when? _____

Mother's Occupation: _____

Mother's Employer: _____

Father's Occupation: _____

Father's Employer: _____

WHO LIVES AT HOME?

Name Age Relationship

_____

_____

_____

_____

_____

_____

EXPOSURE/HABITS:

Any concerns about lead exposure? □No □Yes

(old home,plumbing, peeling paint)

Do any household members smoke? □No □Yes

TV- hours per day _____

Computers- hours per day _____

Video games- hours per day _____

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

SCHOOL HISTORY:

Does your child attend daycare? □No □Yes
Does your child attend preschool/ school? □No □Yes
Current grade level: _____
Name of school: _____
Any concerns about school performance? □No □Yes

Any concerns about relationship with:
Teachers? □No □Yes
Peers? □No □Yes
If more than 4 yrs old,
does your child have a best friend? □No □Yes

SPORTS/ EXERCISE/ HOBBIES:

Type of exercise: _____
List hobbies: _____

How often? _____ How long? _____
Any concerns? □No □Yes

SAFETY:

Do you use carseats/ seatbelts consistently? □No □Yes
Does your child use a bike helmet regularly? □No □Yes
Is violence at home a concern? □No □Yes

Do you have a gun in your home? □No □Yes
Other concerns? _____
_____

REVIEW OF SYSTEMS:

Nutrition/ Feeding: Was your child breastfed? □No □Yes If so, how long? _____
Milk intake now: □whole milk □2% milk □1% milk □skim milk □soy milk □rice milk Avg ounces/day: _____
Has your child had any unusual feeding/ dietary problems? □No □Yes (specify: _____)

Sleep: Hours per night _____ Naps (number and length) _____ Any sleep problems? _____

Dental History:
Has your child been seen by a dentist? □No □Yes If so, how often? _____ Date of last visit: _____

Development:
At what age did your child, Sit alone: _____ Walk alone: _____ Say words: _____ Toilet train: _____
Girls only- Age at first menstrual period: _____ Date of last menstrual period: _____

Please check any current problems your child has on the list below.

Constitutional
- ☐ Fever/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/ weakness
- ☐ Excessive thirst/ urination

Eyes
- ☐ Squinting/ crossed eyes

Ears/ Nose/ Throat/ Mouth
- ☐ Difficulty hearing
- ☐ Mouth breathing/ snoring
- ☐ Problems with teeth/gums
- ☐ Hay fever/ allergies
- ☐ Bad breath

Cardiovascular
- ☐ Chest pain/ discomfort
- ☐ Tires easily with exertion
- ☐ Palpitations

Chest (breast)
- ☐ Breast lump/ discharge

Respiratory
- ☐ Cough/ wheeze
- ☐ Difficulty breathing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

Genitourinary
- ☐ Bedwetting
- ☐ Pain with urination
- ☐ Discharge: penis or vagina

Blood/ Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/ bleeding

Musculoskeletal
- ☐ Muscle/ joint pain

Skin
- ☐ Rash or mole change

Neurological
- ☐ Headaches
- ☐ Dizziness/ light-headedness
- ☐ Weakness
- ☐ Loss of coordination
- ☐ Developmental delay

Psychiatric/ Emotional
- ☐ Anxiety/ stress
- ☐ Problems with sleep
- ☐ Speech problems
- ☐ Depression
- ☐ Nail biting/ thumb sucking
- ☐ Aggressive behavior
- ☐ Alcohol/ tobacco/ drug use

Other (please specify) _____
_____

8380 Warren Parkway Suite 305 Frisco, Texas 75034
(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

8380 Warren Parkway Suite 305 Frisco, Texas 75034
(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES
Specialists in Adult and Pediatric Medicine

NOTICE OF PRIVACY PRACTICES

In Accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Effective 1/1/2015

This notice describes how your personal healthcare information may be disclosed or used by this office and how you can get access to this information. Please read this notice carefully. If you have any questions, please contact our Privacy Officer. After reviewing this document, you will be asked to sign that you have received this notice.

This office is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change our privacy practices at any time and will apply the revisions to protected health information maintained at that time. The revised notice will be posted in our office. You may request a revised copy of this notice by also calling our office.

OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (ie- protected health information or PHI) and has taken reasonable steps to safeguard the privacy and confidentiality of your PHI. The staff of this office will only use your health information for the intended patient care purposes. Conversations among staff members that reference your information will be conducted on a confidential and professional manner.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

This office will need to access your protected health information for purposes of treatment, payment and operations (TPO) in accordance with State and Federal Law. Please be aware that information in your health record may include information relating to sexually transmitted diseases (STDs), human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), behavioral or mental health services, and treatment for alcohol and drug abuse.

- ***Using & Disclosing Information for Treatment Purposes***

  To maintain high quality healthcare, it will be necessary to share protected health information with all members of your treatment team. This can include employees in this office, laboratory personnel, pharmacists, as well as other medical providers and physicians. In addition, our practice will use and disclose your PHI to inform you of potential treatment options or alternatives.

- ***Using & Disclosing Information for Payment Purposes***

  Our practice will use and disclose your PHI in order to bill and collect payment for the services you receive from us. Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to, eligibility, benefit determination, and utilization review. Such information may be released to insurance companies, HMOs, PPOs, managed care organizations, IPAs, Medicare, Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities. Moreover, it will also be necessary for our internal billing personnel to have access to protected health information to carry out their job functions.

- ***Using & Disclosing Information for Operations Purposes***

  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, appointment reminders, business planning activities, and compliance with all State and Federal laws.

SPECIFIC AUTHORIZATION REQUIRED FOR OTHER USES AND DISCLOSURES:

Other uses and disclosures of your protected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form. Some examples include but are not limited to: some marketing activities, the use or disclosure of psychotherapy records in our possession, and in some instances for research purposes.

OTHER USES AND DISCLOSURES WITHOUT YOUR AUTHORIZATION:

The following are situations where this office may use or disclose your protected health information without your consent or authorization:

- Uses and disclosures of PHI as required by law, court orders, a legal process, or government agencies.
- Uses and disclosures of PHI for matters of public health for the purpose of controlling disease as dictated by law.
- Uses and disclosures to government oversight agencies for the purpose of health and privacy audits or investigations.
- Uses and disclosures may be made to public health authorities in situations of suspected abuse or neglect.
- Uses and disclosures to Institutional Review Boards for the purpose of medical research.

PATIENT PRIVACY RIGHTS EFFECTIVE APRIL 14, 2003:

In general, you will have the right to review and copy your protected health information as well as amend your record. Some exceptions include, but are not limited to: psychotherapy notes, information compiled for use in a civil, criminal or administrative proceeding.

You have the right to request a restriction of the disclosure of your protected health information for treatment, payment, or operation. This office is not required to agree to the request, but will do so at our discretion.

You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests.

You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment, or operations.

PRIVACY OFFICER AND COMPLAINTS:

Should you have any concerns you may contact our Privacy Officer who is responsible for the privacy and confidentiality of your information in accordance with State and Federal law. Any complaints or issues you have regarding the privacy or confidentiality of your information should be directed to the privacy officer.

YOUR RIGHTS:

You have the right to revoke your authorization at any time. You will need to inform the office, in writing, of any changes to your directives. Please be aware that any revocation will not apply to your insurance company when the law provides your insurer with the right to contest a claim under your policy. Authorizing the disclosure of this health information is voluntary. You can refuse to sign this authorization and need not sign this form in order to assure treatment. Without disclosure, you will be responsible for payment of services when they are rendered and will need to file your insurance claims directly to your insurance company. You may inspect or copy the information to be used or disclosed. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

FINANCIAL/ OFFICE POLICY

(revised 2/1/2018)

Thank you for choosing us as your primary care physicians. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it, ask us any questions that you may have, and sign the attached consent page. Other than for true medical emergencies, agreement with this policy is required for all medical care.

PATIENT RESPONSIBILITIES:

Payment is required at the time services are provided unless other arrangements have been made *in advance*.

We participate in many insurance plans. We recommend that you become familiar with your insurance benefits- including eligibility, covered benefits, co-insurance and deductibles. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions you may have regarding your coverage. You are responsible for deductibles, co-pays, co-insurance, non-covered services, and items considered "not medically necessary" by your insurance company.

As a courtesy to our patients, our office will file claims on your behalf. Please be advised that, excluding Medicare, we do not file secondary insurance. You will be asked to present a current insurance card at every visit. If your insurance cannot be verified, payment for services is expected in full at the time of the visit. Please inform us of any changes to your address, contact information, insurance, or responsible party. Inaccurate demographic and insurance information may result in denial of your insurance claims. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim.

CO-PAYS/ CO-INSURANCE/ DEDUCTIBLES:

Pursuant to our participation with your insurance plan, we are required to collect co-pays, deductibles, and co-insurance at the time of service. For minor patients, payment will be collected and is expected from the parent/ guardian present at the visit. We accept cash, checks, debit cards, Mastercard, Visa, and Discover. We accept American Express for charges greater than $50.

PATIENT STATEMENTS/ ACCOUNT BALANCES:

Outstanding patient/ guarantor account balances will be e-mailed unless otherwise specified. Payment for outstanding account balances or arrangement of a payment plan is expected within 30 days of the statement billing date. Accounts more than 60 days past due will be assessed an administrative fee of $25 and forwarded to a collection agency. Should your account become delinquent, you will be responsible for any and all legal fees, court costs, and collection fees involved as a result of any collection activity.

RETURNED CHECKS:

Returned checks will incur a fee of $35. If more than one returned check is received on your account, we will require all future payments to be made by cash, cashier's check, or credit card.

APPOINTMENTS:

Patients are seen by appointment only. Please arrive on time for your appointment. If you are more than 15 minutes late, you may be asked to reschedule. Please notify us 24 hours in advance if you must cancel or change your appointment time. Appointments cancelled or missed without sufficient notification hinder us from seeing other patients who may be ill. All missed or no show appointments will be charged a $25 fee.

Well/ sick office visit: If you come in for a well child exam or check up and have "non-well" issues that need to be discussed and treated, your insurance will be billed for a consultation along with the check up visit. Your insurance may require you to pay a copay, deductible, or co-insurance in conjunction with this visit. Please remember, the total charge is the same as if you had to schedule a separate appointment without the inconvenience of having to come back a second time.

AFTER HOURS CALLS:

We ask that after hours calls be limited to urgent medical issues that cannot or should not wait until the office reopens. All pediatric after-hours telephone calls will be answered by a specially trained pediatric nurse. In addition, one of our pediatricians or call partner pediatricians is on-call

everyday and can be reached by the triage nurse for complex problems. An on-call internist is available for urgent medical issues for our adult patients. Calls handled by the pediatric nurse advice line are free to our patients. After-hours calls forwarded to and handled by a physician will incur a charge of $15 per call which is applied to the patient's account. Please allow 30 minutes for your call to be returned.

IMMUNIZATION RECORDS:

An updated shot record will be provided free of charge during every check up. Any additional copies requested will be subject to a $5 fee per immunization record. Immunization records can be faxed with a verbal request from the adult patient or parent/legal guardian of a minor patient.

PRESCRIPTIONS:

Antibiotics are not prescribed over the phone. Since there are many things that can be wrong, our physicians prefer to examine each patient for proper diagnosis.

Prescription refill requests are handled most efficiently by calling your pharmacy directly to request a refill. Refills can also be requested thru your patient portal account.

Refills on controlled substances, such as ADHD and some pain medications, require 2 business days to complete and you must pick up these prescriptions at our office. Please note that, by law, a prescription for a controlled substance must be filled within 21 days. Any prescription that needs to be reissued will incur a $5 fee.

All mail order prescriptions will be printed and given to the patient. It is the patient's responsibility to submit the prescriptions along with the necessary forms to the mail order pharmacy. Refills for mail order prescriptions are typically requested by the pharmacy via fax and will be handled directly by our office. "Lost prescriptions" will incur a $5 fee to reissue.

LAB/ RADIOLOGY/ STUDY RESULTS:

Most tests take 2-5 business days for results to be reported to our office. You will be contacted with results once we have them available. Afterwards, a copy of the results will be made available on your patient portal. Additional copies requested will be subject to a $5 fee per request.

FORMS (SPORTS/ SCHOOL/ CAMP/ FMLA/ ETC):

Please be advised that we complete these forms only if a complete check up or physical examination has been done in the past year. Due to the number of forms we receive, we require at least 2 business days for the completion of most forms.

FMLA forms, Disability Forms, Medical Certifications, and Medicare Medical Necessity Certification are subject to a $25 fee and may need up to 4 business days for completion.

REFERRALS:

If your insurance plan requires approval or authorization for referrals to a specialist, radiological imaging center, or other medical facility, please inform our office prior to referral. We require 2 business days notice to facilitate a referral request and cannot issue retroactive referrals.

MEDICAL RECORDS:

If you are moving or need a copy of your medical records for other purposes, please make your request at least 2 weeks in advance. Current Texas law allows up to 15 business days to release medical records. An Authorization to Release Medical Information Form must be signed prior to release and a $25 fee will be charged per record.

Because of privacy concerns, we will only fax medical records when requested by other physicians or medical facilities.

YEAR END/ SUMMARY STATEMENTS:

All requests for Summary Statements require 2 business days to complete. There is a $10 fee per family account per year. Please note that if you would like the statement faxed to you, you must provide written authorization per HIPAA.

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

AUTHORIZATION and CONSENT AGREEMENT

(One form may be completed for all minors in a single family.)

Thank you for reviewing our Notice of Privacy Practices and Office Financial Policies. Please sign in the spaces provided below to acknowledge receipt of this information, and enter your communication and contact preferences.

CONSENT TO TREAT

I hereby authorize the physicians and employees of Piga Primary Care Associates (PPCA) to render medical evaluations and care to the patient(s) indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient(s) will not be provided medical care except in case of emergency. Initial _____

HIPAA

I have reviewed a copy of the "Notice of Privacy Practices" from Piga Primary Care Associates, which explains how my child(ren)'s medical information will be used and disclosed. I understand that I can request a copy of this notice at anytime and that I have the right to review the notice prior to signing this consent. Initial _____

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian. For minor patients less than 17 years of age, all treatment and medical information will be discussed with both biological parents unless otherwise specified.

The following names are people I would like to be involved in or have access to my child(ren)'s protected health information on a routine basis. I give permission for PPCA to share my child(ren)'s protected health information with:

Contact Name	DOB	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL POLICY

I have read and understand the financial policies of PPCA and agree to abide by its guidelines. Initial _____

MEDICATION HISTORY CONSENT

e-Prescribing is a way for our physicians to send accurate, error-free, and understandable prescriptions electronically from our office to the pharmacy. It can also include formulary and benefit information as well as medication history data. The medication history information includes medications prescribed by our physicians as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, sexually transmitted diseases, substance abuse, and HIV/ AIDS. By signing this consent form, you are agreeing that your provider at PPCA may request and use your prescription medication history for treatment purposes. Initial _____

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

PATIENT PORTAL COMMUNICATION

Use of Electronic Communication from PPCA to the Patient

□ **YES**, I want PPCA to communicate my child(ren)'s information with me through a secure patient portal system that is designed to keep medical information safe. [You will be notified by email when there is secure information for you to review. The email will provide a link that will take you to your patient portal. After clicking the link, you will be required to log in and enter a password to access your information. You will need to make note of the password to access any future information.]

***** Please enter in the space below the email address you would like to use to be notified of secure messages *****

_____

Email Address (please print clearly)

In choosing your email address, please consider the privacy implications. For example, any other person that may have access to your email address, such as an employer, may have the right and/or ability to review any email you receive.

□ **NO**, I do not want PPCA to use electronic communication as a way to communicate my child(ren)'s information to me. I understand that copies of lab results, physician statements, and shot records I request to be printed, faxed, and/or mailed may incur a fee.

May we leave test results on your personal voicemail (home/cell)? □ YES □ NO
May we leave test results on your voicemail at work? □ YES □ NO

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Consent to Treat, Financial Policy, Medical History Consent, Patient Portal Communication, HIPAA Policy, and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require specific authorization prior to the disclosure of any personal health information.

PATIENT NAME / DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN

DATE

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

WAIVER FOR SERVICES PROVIDED BY PIGA PRIMARY CARE ASSOCIATES

(One form may be completed for all minors in a single family.)

We appreciate you selecting Piga Primary Care Associates for your family's health care needs. We are committed to quality health care and try to offer comprehensive services on site.

Piga Primary Care Associates may recommend services that may not be a benefit of or fully covered by your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, screening tests, immunizations, immunization administration, procedures, and laboratory tests, will be your responsibility and will be billed to you. These services may also be applied to your deductible or co-insurance. Our routine schedule of services follows the recommendations of the American Academy of Pediatrics and the American College of Physicians.

Patients always have the right to choose if they would like to have the procedures performed in our office. If a patient wishes to have the service performed elsewhere, the appropriate instructions, lab request or prescription will be given if needed. We ask that you familiarize yourself with your insurance benefits to minimize the possibility of misunderstanding any professional services not covered by your insurance plan.

The following is a list of some of these services and our fees if they are not covered:

Electrocardiogram (ECG)	$40	Photoscreening (vision test 1-5 yrs old)	$25
Fluoride varnish application	$25	Spirometry	$45
Hearing screen	$20	Vision screen	$5

Please be advised that well child check ups/annual exams cover preventive care only. Anything that is discussed outside of preventive care, including, but not limited to, the treatment of chronic conditions and acute illnesses may be billed to your insurance and assessed a co-pay, deductible or co-insurance. These fees are the responsibility of the patient.

We utilize your insurance plan's preferred laboratory and imaging facility for additional tests you may need. Please be advised that these facilities will bill your insurance directly. Please contact them directly for any billing questions that may arise.

By signing below, you acknowledge the above policies and are aware that services not fully covered by your insurance plan will be billed directly to you and are your financial responsibility.

PATIENT NAME / DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

PATIENT NAME/ DATE OF BIRTH

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN

DATE

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

8380 Warren Parkway Suite 305 Frisco, Texas 75034
(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

MEDICAL AUTHORIZATION FOR MINORS

(If needed, one form may be completed for all minors in a single family.)

The following authorization applies to the following minor patient(s) (< 17 years old):

NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	
NAME OF CHILD:		DATE OF BIRTH:	

I hereby authorize the following person(s) to authorize evaluation and medical treatment for the patient(s) identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the above patient(s). The duration of this consent is indefinite and continued until revoked in writing.

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

_____ Relationship to child(ren): _____

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN DATE

PRINTED NAME

8380 Warren Parkway Suite 305 Frisco, Texas 75034

(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

8380 Warren Parkway Suite 305 Frisco, Texas 75034
(214) 618-2222 • Fax: (972) 668-5831 • www.pigaprimarycare.com

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)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

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

Stock No. C-7
Revised 05/18/2012

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)

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

For Clinic/Office Use / Sólo para uso de la clínica/oficina

ImmTrac, 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 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)

Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac del DSHS o a un proveedor de salud inscrito.

¿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

Stock No. C-7
Revised 05/18/2012

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.

PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please **REQUEST** medical information **FROM**:

_____
_____
_____
_____
_____
_____

Please **SEND** medical information **TO**:

PIGA PRIMARY CARE ASSOCIATES
8380 Warren Parkway, Suite 305
Frisco, TX 75034
Main: 214-618-2222
Fax: 972-668-5831
Direct Msg: admin@pigaprimarycare.e-mdsdirect.com

Requesting only: (circle one)

All records
Immunization records
Insurance information
Labs/ Radiology
Physical form
Other: _____

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as requested above to Piga Primary Care Associates as I have indicated. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and/or drug abuse.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: **Initials: _____**

Release and/or disclose records and information regarding:

PATIENT'S FULL NAME		DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE/ PREFERRED PHONE	CELL PHONE	E-MAIL ADDRESS	

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose:

Reason for records release: _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

SIGNATURE OF PATIENT/ PARENT/ LEGAL GUARDIAN DATE

PRINTED NAME

****

The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that this information will be released within 15 business days of the receipt of request and that a fee for preparing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.