Kerrville Pediatrics Patient Registration

Child 1:

Last Name:_____ First Name:_____ MI: ____

Sex: M / F Primary Language: _____ Social Security Number: _____

Ethnicity: *Hispanic / Not Hispanic* ***Race:*** *Native American / Indian / Alaskan Asian or Pacific Islander / African American / White or Declined to Specify*

Child 2:

Last Name:_____ First Name:_____ MI: ____

Sex: M / F Primary Language: _____ Social Security Number: _____

Ethnicity: *Hispanic / Not Hispanic* ***Race:*** *Native American / Indian / Alaskan Asian or Pacific Islander / African American / White or Declined to Specify*

Child 3:

Last Name:_____ First Name:_____ MI: ____

Sex: M / F Primary Language: _____ Social Security Number: _____

Ethnicity: *Hispanic / Not Hispanic* ***Race:*** *Native American / Indian / Alaskan Asian or Pacific Islander / African American / White or Declined to Specify*

Mailing Address

_____

(Street or PO Box) (City) (Zip Code)

Home Phone: _____ **Cell Phone:** _____

Who lives in this Household?_____

Parent 1:

Full Name: _____ Relation: _____

DOB: _____ Social Security Number: _____

Email Address: _____

Cell Phone: _____ Work Phone: _____

Parent 2:

Full Name: _____ Relation: _____

DOB: _____ Social Security Number: _____

Email Address: _____

Cell Phone: _____ Work Phone: _____

Kerrville Pediatrics Patient Registration

How would you like to be contacted regarding the following? (Circle One)

Medical Issues: Cell Phone / Home Phone / Work Phone / Email
Appointment Reminders: Cell Phone / Home Phone / Work Phone / Email
Recall Notices: Cell Phone / Home Phone / Work Phone / Email
Billing Statements: Cell Phone / Home Phone / Work Phone / Email
Patient Portal: Cell Phone / Home Phone / Work Phone / Email

Emergency Contacts NOT Parents:

1._____ Relationship:_____ Phone Number: _____
2._____ Relationship:_____ Phone Number: _____
3._____ Relationship:_____ Phone Number: _____

Insurance

Primary Policy;

Policy Holders Name:_____ **DOB:**_____
Social Security Number:_____ **Sex: Male or Female**
Insurance Carrier:_____ **ID #** _____

Secondary Policy;

Policy Holders Name:_____ **DOB:**_____
Social Security Number:_____ **Sex: Male or Female**
Insurance Carrier:_____ **ID #** _____

Who should receive billing statements? _____

Preferred Pharmacy:_____
Preferred Primary Care Provider: _____

Divorced or Separated Parents Only

Who has Custody? _____

Are there any legal restrictions that would restrict the Non-Custodial Parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, Please provide a copy of any legal paperwork that supports this restriction.

Kerrville Pediatrics Patient Registration

J. Christopher Meriwether, M.D, FAAP
Carena Sears, MSN, RN, CPNP-PC
Jacquelyn Pena, MD
Macalah Jenschke, DNP, RN,CPNP-PC

1331 Bandera Hwy, Suite 10
Kerrville, TX 78028
(830) 257-1440

General Consent for Treatment

I, the undersigned parent or guardian of _____, knowing that the child is suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care into such medical, surgical, or other services under the general and specific instructions of either J. Christopher Meriwether, M.D., or Jacquelyn Pena, MD, or Carena Sears, CPNP, or Macalah Jenschke, CPNP, or their assistants, or their designate as is necessary in their judgement.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me, as a result of treatments or examination by either J. Christopher Meriwether, M.D., or Jacquelyn Pena, MD, or Carena Sears, CPNP, or Macalah Jenschke, CPNP.

Insurance Assignment and Release

I, the undersigned, do hereby authorize J. Christopher Meriwether, M.D., and/or Jaquelyn Pena, MD, and/or Carena Sears, CPNP, and/or Macalah Jenschke, CPNP to release to my insurance company any and all medical information, of whatever nature, now in their possession or later acquired, from whatever source, which pertains to or relates to my child's medical care. This authorization in consent is granted for the sole and limited purpose of facilitating the quality of medical care conducted by J. Christopher Meriwether, M.D., and/or Jacqulyn Pena, MD, and/or Carena Sears, CPNP, and/or Macalah Jenschke, CPNP. I am releasing those rights and claims of confidentiality and privilege concerning the information I described which may otherwise exist, when used for the purposes I described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the office of Kerrville Pediatrics, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the office of the written notice of withdrawal.

Payment Policy

All professional services rendered or charged to the patient, the patient is responsible for payment regardless of insurance coverage. Full payment is expected at the time of each service unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurers.

Authorization of Payment

I authorize release of any medical information necessary to process a claim. I also request payment of benefits to either myself or to the party who accepts assignment.

_____ _____

Signature Date

J. Christopher Meriwether, MD, FAAP
Carena Sears, MSN, RN, CPNP-PC
Jacquelyn Pena, MD
Macalah Jenschke, DNP, RN, CPNP-PC

1331 Bandera Highway, Suite 10
Kerrville, TX 78028
(P) 830-257-1440, (F) 830-257-2542

HIPPA NOTICE OF PRIVACY PRACTICE

PATIENT CONSENT/ACKNOWLEDGE FORM

I hereby acknowledge receipt of the Notice of Privacy Practice.

With this consent, Kerrville Pediatrics may call and leave a message on voice mail or in person, mail, email to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment, Healthcare Operations, pertaining to my clinical care, including laboratory test results, or items such as appointment reminder cards and patient statements.

I have the right to request that Kerrville Pediatrics restrict how it uses or discloses my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Kerrville Pediatrics to use and disclose my Protected Health Information (PHI) to carry out Treatment, Payment, Healthcare Operations.

Restrictions:_____

Disclose my Protected Health Information (PHI) to:

_____ _____
Contact #1 Phone #

_____ _____
Contact #2 Phone #

Kerrville Pediatrics may leave a detailed message: YES NO (circle one)

_____
Signature of Patient/Guardian

_____ _____
Print Name of Patient Date

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

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

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Gender: ☐ Male ☐ Female Telephone ____ - ____ - ____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply)			Ethnicity (select only one)
☐ American Indian or Alaska Native	☐ Asian	☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ White	☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused			☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.
☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ Signature _____ Date _____

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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunization Section

Stock No. C-7
Revised 02/2024