REGISTRATION FORM

Thank you for choosing our office. All information will be kept strictly confidential.

Childs Last Name: _____

Childs First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Father: _____ DOB: _____ email: _____

Address: _____ Phone: _____ Cell: _____

Mother: _____ DOB: _____ email: _____

Address: _____ Phone: _____ Cell: _____

Emergency Contact: _____ Phone: _____

INSURANCE AND BILLING INFORMATION

Guarantor: O Father O Mother O Guardian O Self Name: _____ Social Security No. : _____

Address: _____ Phone: _____ Cell: _____

Primary Insurance Company: _____ ID #:_____ Group #: _____

Secondary Insurance Company: _____ ID #:_____ Group #: _____

Please inform us of any changes in patient name, insurance, address, phone number to avoid delays during the visit.

- We will bill your insurance company as a courtesy to you; however payment of your medical bill is your responsibility and should be settled between you and your insurance company. It is your responsibility to know the coverage of your individual insurance policy. Your insurance policy is a contact between you, your employer, and your insurance company. You are responsible for services rendered that your insurance policy does not cover.
- ALL COPAYS AND DEDUCTIBLES ARE DUE AT VISIT. We are required by your insurance to collect all deductibles and co-payment at each visit as set forth by the contract YOU hold with YOUR insurance company and will be collected prior to seeing the doctor. Co-insurance is due immediately upon receipt of the explanation of benefits generated by your insurance company. If we have not received payment from your insurance company and you have an outstanding balance of more than 60 days from the date-of-service, you will be billed directly for payment. We will provide you with the necessary information in order for you to be directly reimbursed by your insurance company. In event of returned checks regardless of the cause there will be a charge of $30.00 plus the fee of the check collection services. In the event that there is an overpayment we will reimburse you thirty (30) days following the end of the month in which payment from your insurance company was received in order to clear our accounting system.
- If you have more than one insurance company we will bill only your primary insurance company. If your primary insurance company denies payment you will be responsible for payment. We will provide you with the necessary information for you to file for payment direct to you from your secondary insurance company.
- In the event that you need copies of your child's medical records we might charge $25. We only release the record with the legal parent/ legal guardian written consent.
- All minor patients must be accompanied by a parent or legal guardian. In case parent/ guardian cannot accompany the child, a written consent from the parent/ guardian is required.

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby voluntarily consent to the medical care, treatment and diagnostic test that Dr. M. Ramchandra, her associates, assistants, or their health care providers believe are necessary for above named child as long as Dr. Ramchandra is the above child's pediatrician. I hereby irrevocably assign to Mahalakshmi Ramchandra MD PA, Bay Colony Pediatrics any interest in benefits payable for all treatment provided by Dr. M. Ramchandra, her staff and/or associates, whether in his office or at a hospital facility. I herby agree to be responsible for the payment of the charges that result from the care provided to the patient. I also understand and agree that I will be responsible for all charges not covered by insurance. I further authorize the release of medical information about me or my child that maybe necessary for the completion of any insurance claims by my insurance carrier.
My signature below is evidence that I understand and that I am giving legal authorization for medical treatment and that I agree with the terms and conditions on this form relating to the continuing treatment of me/my child.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. By signing this form I giving consent to MAHALAKSHMI RAMCHANDRA MD PA's use and disclosure of my and/or my child's Protected Health Information (PHI) to carry out treatment, payment and healthcare operations.

Responsible Party Name: _____

Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT US (CIRCLE ALL THAT APPLY)

	INSURANCE		MEDICAID		ANOTHER CHILD		FRIEND		HOSPITAL		YELLOW PAGES
	WALK IN		INTERNET		MAIL		MAGAZINE		PHYSICIAN		OTHER

IMMUNIZATION CONSENTS

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC) PATIENT ELIGIBILITY SCREENING RECORD

Child's Last Name: _____ **First** Name: _____ Middle Initial: _____ Birth Date: _____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one)*:

	is enrolled in Medicaid, or		is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness), or
	does not have health insurance, or		is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
	is an American Indian,		is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
	or is an Alaskan Native, or		**None of the above, not eligible for TVFC vaccine**

Parent/Guardian/ Name: _____

Signature: _____ Date: _____

CONSENT FOR IMMUNIZATIONS

I give permission for my above named child to receive immunizations as scheduled during visits to the clinic.

If I choose NOT to allow the above child to receive immunizations, it will be my responsibility to inform the nurse or the physician and I will also sign the REFUSAL TO VACCINATE form and I will obtain waivers from the State of Texas.

You will receive a copy of the Vaccine Information Statement (VIS) for the vaccine to be administered. The VIS will have information on the benefits and risks of the vaccine. You will be given a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.

For a particular vaccine, I hereby state that I know the risks of the disease the vaccine prevents; I know the benefits and risks of the vaccine; I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given; I know that the person named above will have the vaccine put in his/her body to prevent the disease vaccine prevents.

I am an adult who can legally consent for the person named above to get the vaccines. I freely and voluntarily give my signed permission for immunizations.

Parent/Guardian/ Name: _____

Signature: _____ Date: _____

TEXAS IMMUNIZATION REGISTRY (ImmTrac) CONSENT

ImmTrac, the Texas immunization registry is a free service of the Texas Department of State Health Services. 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.

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following: • public health district or local health department; • physician or health care provider; • insurance company, health maintenance organization or payor; • school or child care facility in which the child is enrolled and/or • state agency having legal custody of the child. I understand that I may withdraw the 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, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

Parent/Guardian/ Name: _____

Signature: _____ Date: _____

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)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, MAHALAKSHMI RAMCHANDRA, MD PA may use and disclose protected health information (PHI) about me and my minor child to carry out treatment, payment and healthcare operations (TPO). Please refer to MAHALAKSHMI RAMCHANDRA, MD PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MAHALAKSHMI RAMCHANDRA, MD PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to MAHALAKSHMI RAMCHANDRA, MD PA Privacy Officer at 2251 FM 646 West, Ste #155, Dickinson, Texas 77539.

With my consent, MAHALAKSHMI RAMCHANDRA, MD PA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my and/or my child's clinical care, including laboratory results among others.

With my consent, MAHALAKSHMI RAMCHANDRA, MD PA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that MAHALAKSHMI RAMCHANDRA, MD PA restrict how it uses or discloses my and/or my child's PHI to carry out TPO.

However, 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 MAHALAKSHMI RAMCHANDRA, MD PA's use and disclosure of my and/or my child's PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, MAHALAKSHMI RAMCHANDRA, MD PA may decline to provide treatment to me and/or my child.

Patient Last Name: _____ First Name: _____ Middle Initial: ____ Birth Date: _____
Parent or Legal Guardian: _____

Signature: _____ Date: _____

GENERAL INFORMATION ABOUT BAY COLONY PEDIATRICS

HOURS OF OPERATION: For your convenience, our office is open from 9:00 AM. until 6:00 P.M., Monday thru Friday, Patients are scheduled for appointments with a physician from 8:00 AM until 12:10 PM and from 1:00 P.M. until 5:20 P.M. Emergency appointments are scheduled as needed. We give SAME DAY appointments. **Our phone number is 281-614-2445.** We answer the phone 24 hours a day. Messages left in the morning for the doctor will be answered around lunch time and afternoon phone calls will be answered after 5 pm. In case an adult other than a parent is bringing the child to the clinic, we need a **written** authorization from the parent.

CHANGES IN PATIENT INFORMATION: Please inform our receptionist of any changes in patient name, address, phone number or insurance information as soon as possible.

APPOINTMENTS: We prefer to see patients by appointment. In case you are a 'walk-in' we will normally schedule an appointment to come back. **Please be on time for your appointment to avoid a wait.** In case you are late by over 15 minutes for your appointment, we could consider you as a 'walk-in' and reschedule your appointment.

INSURANCE FILING POLICY: All accounts are considered past due 45 days after your visit regardless of insurance delay. Your insurance contract is between you and your insurance carrier. This office will not enter into any disputes you have with your insurance company. We file with certain contracted insurance companies as a courtesy to you, our patient. We do request that you make sure all claims are processed within a timely manner. Any information requested from our office by your insurance company will be submitted in a timely manner. If this information is requested of you and not received within the same timely manner, the charges will become your responsibility. Should your insurance company, for any reason, fail to pay claims submitted the balance will become your responsibility.

MEDICAID COVERAGE: Current Medicaid cards **must** be presented at each visit, especially for a WELL CHECK visit. **Please ensure that Dr. M. Ramchandra is the Primary Care Provider (PCP) where applicable. Your appointment will be delayed or we might not be able provide care that day.**

MEDICAL RECORDS: As a courtesy we will forward a medical summary and shot record to another provider or individual once we receive a written consent signed by the parent or legal guardian as evidenced per our records. Please note that if you want complete medical records, please send $25 to Bay Colony Pediatrics and we will send complete records within 15 days of receipt of funds, as per Texas Administrative Code Title 22, Part 9 Rule 165.2.

REFERRALS: Please request referrals five (5) days prior to your visit with a specialist as this can be time consuming and requires authorization by your Primary Care Physician (PCP) and may require authorization by your insurance company.

PRESCRIPTION REFILLS: We do request that 24 hour notice be given on any prescription refills. This allows our office to get the refill written or called in to the pharmacy with no delay or missed dosage or to confirm it is our patient.