Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743

Patient Information

Patient's Name:_____ **DOB:**_____
Gender: ☐ Male ☐ Female
Race: ☐ African-American ☐ White/Hispanic ☐ Asian ☐ Other:_____
Preferred Contact Number: (___) _____

Address: _____
Street City State Zip Code

Preferred email _____

Name(s) of other siblings and Date of Birth *(Put* X if not living in the home with Patient)

_____

_____

_____

Parent(s) or Guardian(s) Information

Mother/Guardian Name: _____ Birth Date:_____
Relationship to Patient: _____
Primary Phone: (___)_____ Secondary Phone: (____) _____
Address if different from above:

_____
Employer:_____ Wk#:_____ Social Security#_____

Father/Guardian Name:_____ Birth Date: _____
Relationship to Patient:_____
Primary Phone: (___)_____ Secondary Phone: (___)_____
Address if different from above:

_____
Employer:_____ Wk#:_____ Social Security#_____

The person(s) listed below have my permission to seek medical attention for my child at Corridor Primary Care Pediatrics

Name	Relationship to Child	Phone Number:
Name	Relationship to child	Phone Number:
Name	Relationship to child	Phone Number :

The info1mation that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

Date:_____ Signature_____

Print Name_____ Referred to our office by:_____

Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743
www.corridorpd.com

Nurse Practitioner Consent

Date: _____

Patient: _____

Patient DOB: _____

I understand that Corridor Primary Care has Pediatric Nurse Practitioners on staff.

Pediatric Nurse practitioners are registered nurses with advanced academic and clinical education in pediatric health care, pharmacology, child development and family dynamics.

PNPs provide the following care:

Physical exams
Diagnose and treat common acute illnesses
Provide management and counseling
Serve as advocates

I understand that I may be offered appointments for sick or well care with a nurse practitioner. I understand that it is my responsibility to know if my appointment is with a physician or a nurse practitioner. I agree to have my child(ren) treated by a nurse practitioner if I schedule an appointment with one.

_____

Parent or guardian Date

Notice of Privacy Practices

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.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient DOB

Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Phone: (512) 392-1700 Fax: (512) 396-8743

Insurance Information

Patient: _____ Sex: _____ DOB: _____

Primary Insurance Information:
Insurance Company: _____ ID # _____
Group # _____ Effective Date: _____
Employer: _____ Work Phone: _____
Policyholder: _____ Sex: _____ DOB: _____
Policyholder Social Security #: _____
Policyholder Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____

Secondary Insurance Information:
Insurance Company: _____ ID # _____
Group # _____ Effective Date: _____
Employer: _____ Work Phone: _____
Policyholder: _____ Sex: _____ DOB: _____
Policyholder Social Security #: _____
Policyholder Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____

Date _____Signature _____

Authorization for Medical Treatment of Minors

I authorize Corridor Primary Care Pediatrics to provide medical care to my teenage child (15 years to 18 years) without an accompanying adult. If immunizations are to be given, I agree to be available by phone for a verbal consent

_____ _____ _____
Parent/Legal Guardian Relationship Date

_____ _____ _____
Parent/Legal Guardian Relationship Date

Corridor Primary Care Pediatrics
601B Leah Avenue
San Marcos, TX 78666
Ph (512) 392-1700 Fax (512) 396-8743

Financial Policy

I understand, accept, and acknowledge the following terms: (please initial each line)

_____ Payment for all services is my responsibility and is due and payable at the time services are rendered.

_____ If my health insurance carrier has accepted Corridor Primary Care (CPC) as a participating provider at the time of service, CPC will submit a claim to my insurance carrier.

_____ Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____ If my health insurance carrier HAS NOT accepted CPC as a participating provider at the time of service, I am responsible for full payment at the time of service unless prior arrangements have been made with CPC's billing department.

_____ Upon my request to CPC's billing department, documentation will be provided so that I may submit a claim for reimbursement of out-of-pocket expenses from my insurance carrier.

_____ Any contract for insurance coverage is made between my employer, the insurance company and myself. CPC has no influence over available benefits or the approval of claims.

_____ If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.

_____ I am responsible for requesting any necessary referrals prior to seeing any specialists, and prior to having any tests or procedures performed. When possible, these requests should be made 5 days prior to the appointment date with the specialist. It is up to the discretion of a CPC provider whether or not to issue a referral requested after the appointment or procedure date.

_____ Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.

_____ I am responsible for all co-payments and non-covered services at the time of service unless prior arrangements have been made with CPC's billing department.

_____ Any co-insurance, deductibles or rejected claims are to be paid in fill to CPC within 30 days of receipt of a bill.

_____ Any checks returned unpaid by your financial institution will be subject to a fee of $25.00.

_____ You understand if your account is submitted to a collection agency, the fact that you received treatment at our office may become a matter of public record.

_____ In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ Overpayments on accounts will be refunded at your request. If no such request is made, the overage will be applied as a credit to your account. If there is a patient due balance elsewhere on the account, the credit will be applied to the balance. You may use this credit for any services provided by our office.

Records Release: I hereby authorize the release of information, including medical and billing information, to my referring doctor, insurance company, the responsible party named above, and the immediate family. Assignment of Benefits: I hereby authorize payment of medical benefits to Corridor Primary Care for services rendered to myself and/or dependents.

Patient Name:_____ Date of Birth:_____

Date: _____ Signature: _____

Print Name: _____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

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

Child's Date of Birth (mm/dd/yyyy) ____/____/____ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone ____ - ____ - ____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name _____

Date _____ Signature _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac2 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.**