REGISTRATION FORMS

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INSTRUCTIONS

1. Open "Fill & Sign"
2. Add signature and initials to sign boxes (these will be erased after you sign your file).
3. Give form to front desk clerk for review and witness signatures.

Thank you!

Patient Registration Form (Please fill in all fields completely)

Patient Information			
Child's Full Legal Name (Last, First Middle)	Date of Birth	Sex	Preferred Name
Other Children in family:			
Child's Street Address **City, State, Zip**	Telephone # where child lives	Parent/Guardian's Email: Mom Dad	Second Parent/Guardian Email: MomDad

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian and other Pacific Islander White

Ethnic Group: Hispanic Non-Hispanic

Patient's Primary Language: English ____ Spanish ____ Other ____________________

Parent's/Legal Guardian's Primary Language: English ____ Spanish ____ Other ________________
School/Daycare: Previous Schools:

It is VERY important for your child's health that we be able to reach you. Please fill out next section as completely as possible and let us know if you number changes!

Contacts - Alternate contacts should be people whose phone number never changes. We will not share health information without your permission.			
Mother's Name (Last, First Middle)	Cell #	Work Place: Phone:	Home/Friend/ Grandparent #
Home Address (City, State, Zip Code) (copy/paste from above if same as child. Field must be filled.)			
Father's Name (Last, First Middle)	Cell #	Work Place: Phone:	Home/Friend/ Grandparent #
Home Address (City, State, Zip Code) (copy/paste from above if same as child. Field must be filled.)			
Additional Contact (Last, First Middle)	Phone 1	Phone 2	Address
Social Media account where we may contact you if we are unable to reach you another way. (Platform: Profile)			Any notes about above:
Who may we thank for referring you to our practice?			**Birth Hospital**

Guarantor Information (Person financially responsible)			
Name	Relationship to Patient		Emancipated Minor? Yes No
Street Address (If not listed above)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)		
Insurance Name	Subscriber/Member ID	Group Number
Stop here for Medicaid	Continue for private insurance:	Patient relationship to subscriber (if not listed above)
Subscriber's Name		Date of Birth of Subscriber
Subscriber Address (if not listed above)		Subscriber Employer (if not listed above)

MINDFUL PEDIATRICS PEDIATRÍA CONSCIENTE

Patient Name:______________________
DOB:_______________
Date:_______________

Allergies: (Include name of medication or food, reaction, and age of onset)
____
____

Current Problems:
____
____

History:
____
____

Birth History:

Birth Length: _________Birth Weight:_________
Discharge Weight: _____________
Gestational Age at Birth (weeks):_______
Complications? __________________
Twin/Multiple Birth? Yes No

Hearing Screening: Pass Fail Re-testing

Birth Head Circumference:_______________
Delivery Method: Vaginal / C-section
If C-section, why? ________________________

Infant Feeding: Breast Bottle Both
Formula name: ___________________________

Heart disease screening: Pass Fail

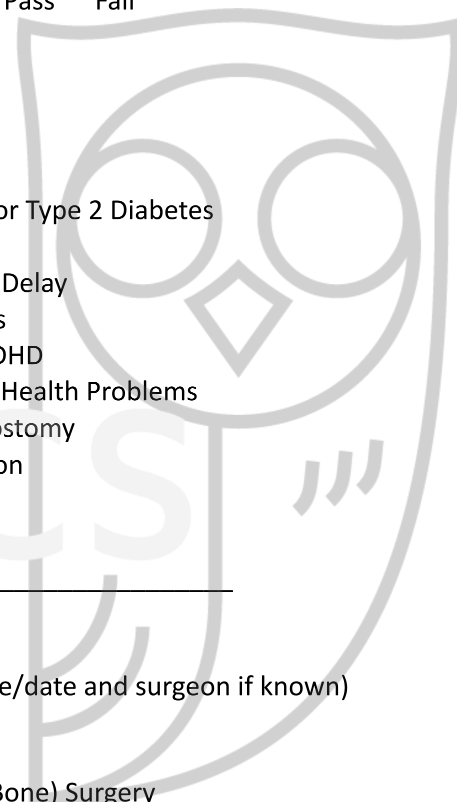
Medical History: (Check any that have been diagnosed and comment below)

Up to date on vaccines? Yes No (if no, please see our vaccination policy)

____Hospitalizations?
____Asthma
____Allergic Rhinitis
____Eczema
____Wheezing
____Food Allergies
____Murmur
____Congenital Heart Disease
____Prematurity

____GE Reflux
____Constipation
____Anemia
____Recurrent Ear infections
____Recurrent Strep
____Urinary Tract Infection (UTI)
____Vesicoureteral Reflux (VUR)

____Type 1 or Type 2 Diabetes
____Autism
____Speech Delay
____Seizures
____ADD/ADHD
____Mental Health Problems
____Tracheostomy
____ G-button



MINDFUL PEDIATRICS
PEDIATRÍA CONSCIENTE

Other Medical History:
____
____

Surgical History: ______**No Surgeries** (Check any past surgeries and complete age/date and surgeon if known)

Procedure Date or Age Surgeon

________Tonsils & Adenoids removed
________Apendix Removed
________Ear Tubes Placed
________Nissen Fundoplication
________G-Tube Placed
________Heart Surgery
________Hernia Repair

__________Orthopedic (Bone) Surgery
__________Orchiopexy (Undescended testicle surgery)
__________Trach Placed
__________VP Shunt
Other Surgical History: _________________________
____
____

Patient Name:_____________________
DOB:______________
Date:______________

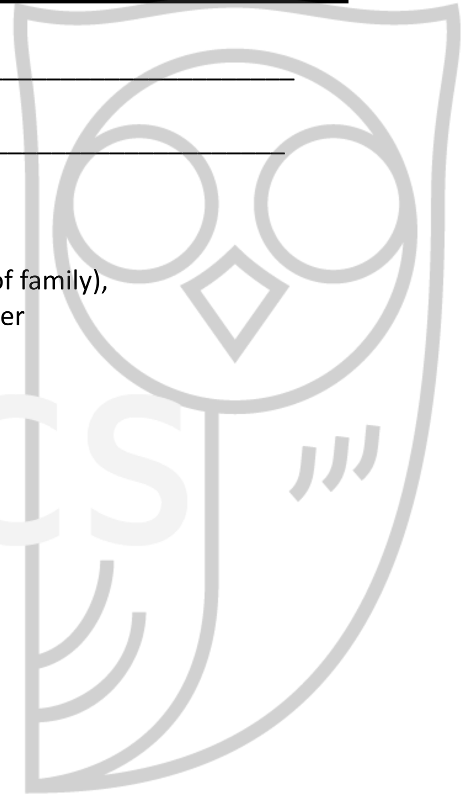
Family History: (Check any known problems in the family – please complete *at least* for parents and siblings)

Relationship to CHILD		Name	Alive?	No Known Problems	Asthma	Food/Med. Allergies	ADHD/ADD	Autism	Learning Problems	Cancer	Hearing or Vision Loss	Blood Disorders	Abnormal Heart	GI Disease	Kidney Disease	Depression/Anxiety	Schizophrenia/Bipolar	Migraines	Seizures	Diabetes Type 1 & 2	Skin Conditions	Autoimmune Disease
Parents	Mother		○Y○N																			
	Father		○Y○N																			
Siblings	○Bro○Sis		○Y○N																			
	○Bro○Sis		○Y○N																			
	○Bro○Sis		○Y○N																			
	○Bro○Sis		○Y○N																			
	○Bro○Sis		○Y○N																			
Grandparents	MGM		○Y○N																			
	MGF		○Y○N																			
	MGF		○Y○N																			
	MGF		○Y○N																			

Comments (including *Other* responses): ____

____

____



MINDFUL
PEDIATRICS
PEDIATRÍA
CONSCIENTE

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather For example: MGM = Maternal Grandmother

Home Environment
Number of People at Home:_______________
Lives with biological parents?_______________
Foster Care? ____________
Care Givers (select all that apply):______________
Daycare (hours/day):________
Time at Relatives (hours/day):______
Pets? ______
Parents/ Daycare/ Relatives/
Others:______________________

Parent's Status: Married Divorced Single
Other__________

Mother's Occupation: _____________________
Father's Occupation: __________________________

PAYMENT POLICY

1. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim. Please bring your insurance card to every visit and notify us of any new changes.

2. All **co-payments, co-insurance and deductibles must be paid at time of service** as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. If you have a balance with us, we will keep your credit card on file and set up a payment plan with you.

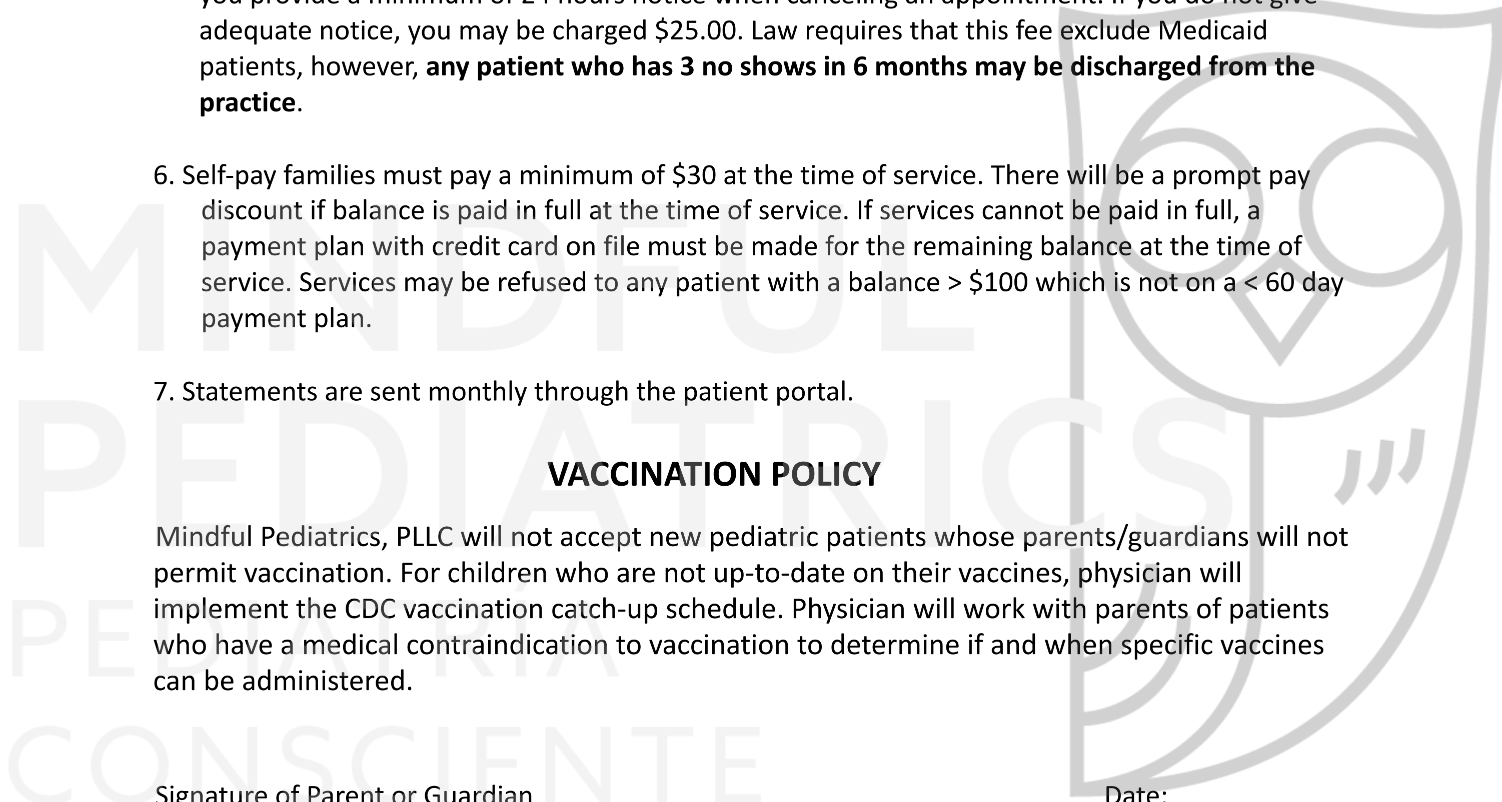
3. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days, we will require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.

4. Please be aware that some of the services you receive may not be covered by your insurance company. You will be responsible for payment of all charges for services not covered by your insurance company.

5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when canceling an appointment. If you do not give adequate notice, you may be charged $25.00. Law requires that this fee exclude Medicaid patients, however, **any patient who has 3 no shows in 6 months may be discharged from the practice**.

6. Self-pay families must pay a minimum of $30 at the time of service. There will be a prompt pay discount if balance is paid in full at the time of service. If services cannot be paid in full, a payment plan with credit card on file must be made for the remaining balance at the time of service. Services may be refused to any patient with a balance > $100 which is not on a < 60 day payment plan.

7. Statements are sent monthly through the patient portal.



VACCINATION POLICY

Mindful Pediatrics, PLLC will not accept new pediatric patients whose parents/guardians will not permit vaccination. For children who are not up-to-date on their vaccines, physician will implement the CDC vaccination catch-up schedule. Physician will work with parents of patients who have a medical contraindication to vaccination to determine if and when specific vaccines can be administered.

Signature of Parent or Guardian____ Date:___________

Patient Name: ____

I have voluntarily presented for medical care and consent to such medical care and treatment from Mindful Pediatrics, PLLC including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education.

I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means:
_______________________________ (name of patient).

Electronic Medical Record

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical record system, they may have access to your medical record. If you do not want medical records shared with other providers please request and complete a Health Information Exchange Opt-out form.

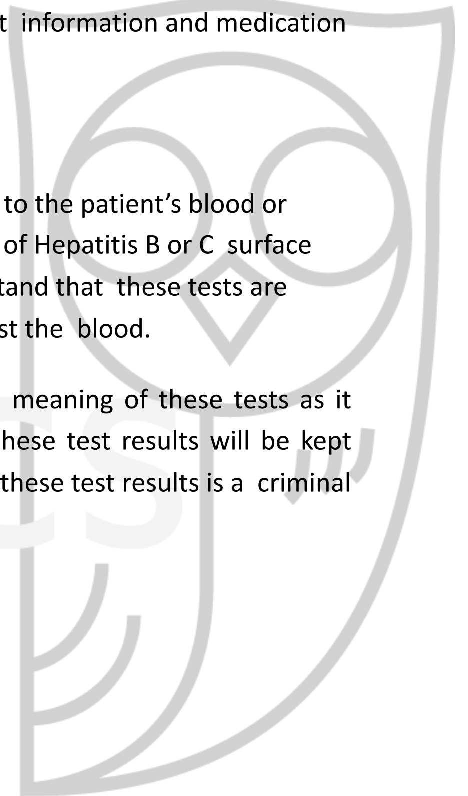
Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

Testing in Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to the patient's blood or bodily fluids, I will be required to have blood tested to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing a small amount of blood and using substances to test the blood.

I understand that if any test is positive, I will receive counseling about the meaning of these tests as it relates to the herein-named patient's healthcare. I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized disribution of these test results is a criminal offiense under state law.



MINDFUL PEDIATRICS
PEDIATRÍA CONSCIENTE

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain patient and physician anonymity.

I acknowledge that I have received a Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact the Privacy Office at (956)545-1327.

Assignment of Benefits

I hereby assign Mindful Pediatrics, PLLC all right, title, and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to Mindful Pediatrics, PLLC and I will be responsible for all co-pays, deductibles, co-insurance and non-covered services.

This agreement remains in effect until revoked in writing.

Patient's Name: ____________________________________

Patient's Date of birth (MM/DD/YYYY): __________________________

Name of Patient's Representative, if patient under 18 (Printed):

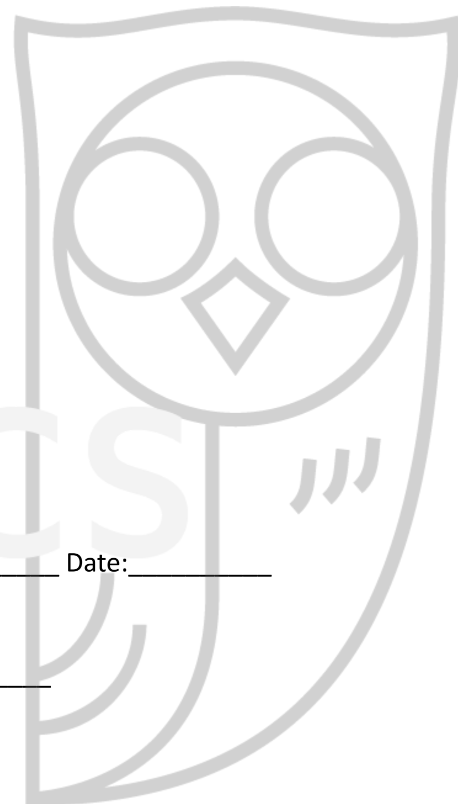
____

Relationship of Patient's Representative if patient under 18:

____

Signature of Patient or Patient's Representative: ________________________________ Date:__________

Signature of Witness: ____



MINDFUL PEDIATRICS
PEDIATRÍA CONSCIENTE

DELEGATION OF CONSENT FORM

(To give others permission to consent for care for the patient)

Patient's Name:	
Patient's Date of Birth:	
Mother / Legal Guardian's Name, Address, and Phone Number:	
Father / Legal Guardian's Name, Address, and Phone Number:	

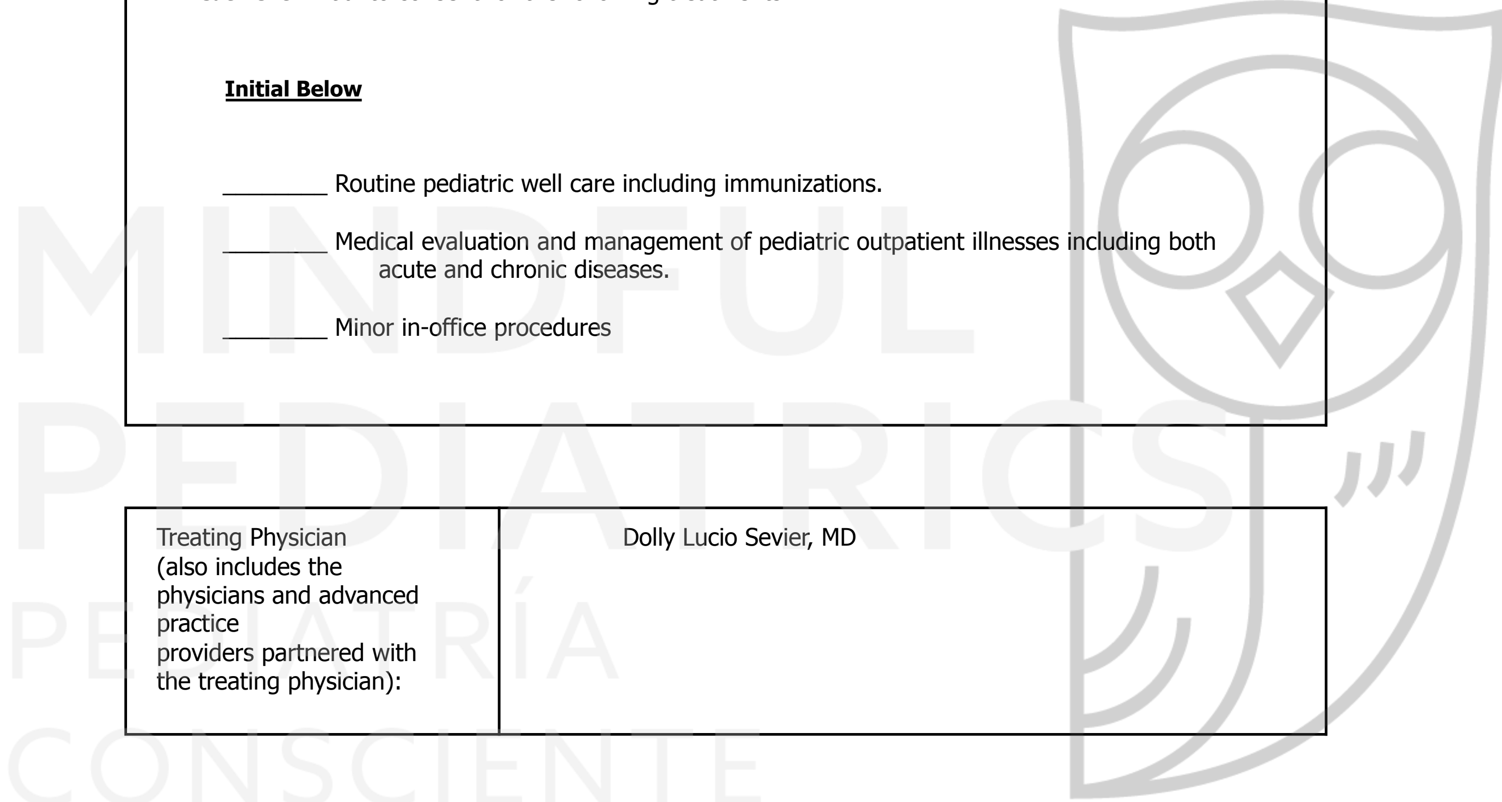
Statement of Medical Treatments and Procedures to be Given and Purpose of Treatment. Initial to consent for the following treatments.

Initial Below

_________ Routine pediatric well care including immunizations.

_________ Medical evaluation and management of pediatric outpatient illnesses including both acute and chronic diseases.

_________ Minor in-office procedures



Treating Physician (also includes the physicians and advanced practice providers partnered with the treating physician):	Dolly Lucio Sevier, MD

DELEGATION OF CONSENT FORM

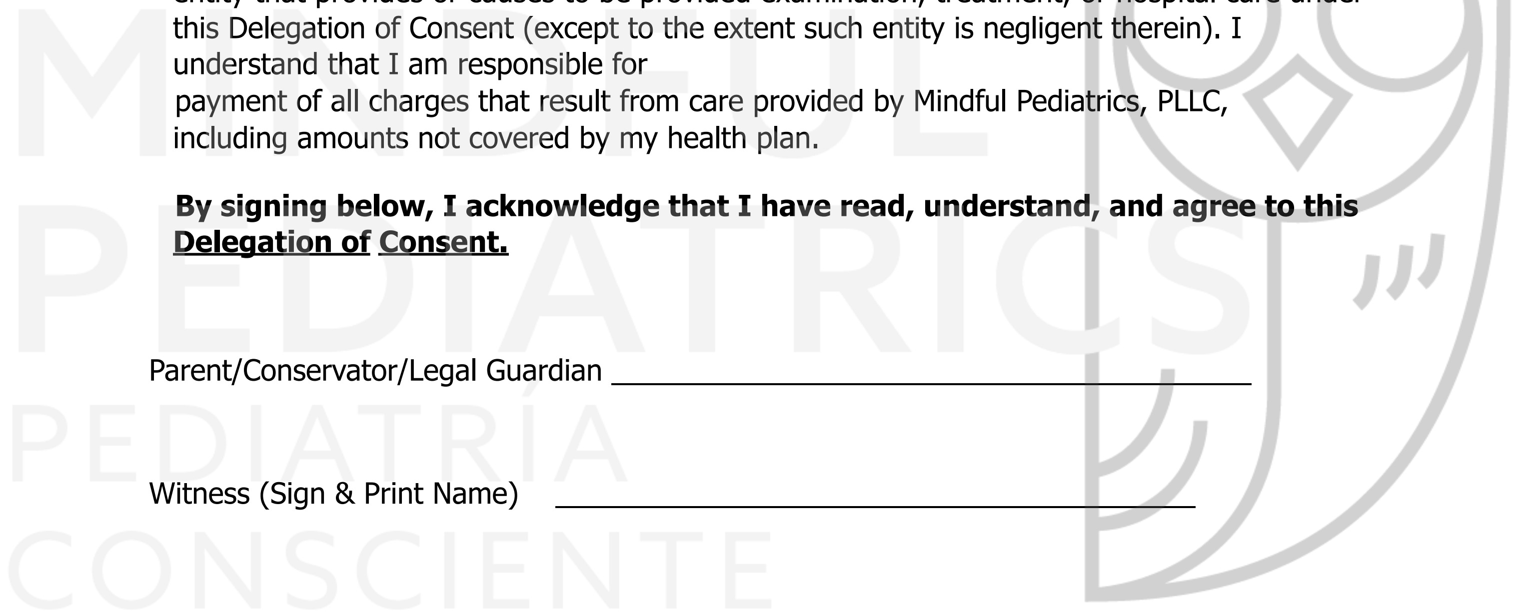
I, as the parent, conservator, or legal guardian of the minor child named above hereby appoint the individuals listed below in order of appearance to act on my behalf to consent to the above specified medical treatments and procedures when I am reasonably unavailable to grant such consent. If I choose to terminate this delegation I must contact my practice.

Name of Individual	Relation to Patient (Minor Child)	Phone Number

<u>Initial Below</u>

________ I understand that in the event that I am unavailable to grant consent on behalf of my minor child, the consent of the individual identified above, who I have granted authority to consent on behalf of my minor child too, will be considered sufficient for the specified medical treatments and procedures specified above.

________ I will indemnify and hold harmless, from any expense or claim of any nature, any entity that provides or causes to be provided examination, treatment, or hospital care under this Delegation of Consent (except to the extent such entity is negligent therein). I understand that I am responsible for payment of all charges that result from care provided by Mindful Pediatrics, PLLC, including amounts not covered by my health plan.



By signing below, I acknowledge that I have read, understand, and agree to this <u>Delegation of</u> <u>Consent.</u>

Parent/Conservator/Legal Guardian ____

Witness (Sign & Print Name) ____

MINDFUL PEDIATRICS
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Dolly Lucio Sevier, MD
BOARD CERTIFIED PEDITRICIAN
415 Palm Blvd Brownsville TX, 78520
www.Mindfulpeds.org
P: (956) 545 1327
F: (956) 545- 1326

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________________ Date of Birth:_____________

I request and authorize ____,
to release medical records of the patient named above to Mindful Pediatrics, PLLC
Dr. Dolly Sevier, MD.

Authorized Representative making request (if other than the patient):

____

☐ Parent of Minor Patient
☐ Guardian
☐ Health Care Power of Attorney

This request and authorization applies to:

☐ All Medical Records
☐ Other: ____

____ _________________
Authorized Representative Signature Date

Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Newborn Registration 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 ______

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). The Texas 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 the Texas Immunization Registry. 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 Sec. 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 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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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 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 Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. 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 Sec. 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 on Privacy Notification.(Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **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