Ancor Health Center PA
Raising the Bar in Healthcare

818 N. Fourth St. Longview, TX 75601 P: (903) 236- 8600

PEDIATRIC PATIENT REGISTRATION-ENGLISH

Please Print Today's Date:

Patient Information

First and last name		Preferred language	
Address		City, State Zip Code	Social Security Number
Telephone (Home)	Telephone (Cell)	Telephone (Work)	Email address:
Date of Birth	Age	Sex ☐ Male ☐ Female ☐ Other : ____	

Contact preference:

☐ Telephone (Home) ☐ Telephone (Cell) ☐ Telephone (Work) ☐ E-mail address

Your selection gives us permission to contact

Name of school or employer

Emergency Contact Name	Relation	Telephone (cell)

How did you find out about our office?

Siblings

Name	Date of Birth	Sex(M/F/Other)	Relevant Health Issue
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		

Financial Responsibility

Person responsible for the account		Relation to patient	
Address (if different)		City, State Zip Code	Driver's License Number
Telephone (Home)	Telephone(Cell)	Telephone(Work)	Place of employment
Date of Birth	Social Security Number	Sex ☐ Male ☐ Female	

Legal Guardians (Parent's) Information		
Name	Relation to Patient	
Address (if different)	City, State Zip Code	Driver's License Number
Telephone (Home)	Telephone (Cell)	Telephone (Work)
Place of employment	Social Security Number	Sex: ☐ Male ☐ Female

Primary Insurance: HMO or PPO or Medicare or Medicaid **(circle one)**		
Insurance name	Phone number of Insurance	
Address of Insurance	City, State Zip Code	Driver's License Number
Name of Insured	Identification Number	Group number
Relation to Patient	Date of Birth	Social Security Number

Secondary Insurance: HMO or PPO or Medicare or Medicaid **(circle one)**		
Insurance name	Phone number of Insurance	
Address of Insurance	City, State Zip Code	Driver's License Number
Name of Insured	Identification Number	Group Number
Relation to Patient	Date of Birth	Social Security Number

Consent to Treatment

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign and date this form.

☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other Relationship: _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

_____

Name Date Relationship

I, _____, give permission for _____ to seek medical treatment for my child in my absence.

Witness: _____ Date: _____

Reason(s) for today's visit:

Medical History

Allergies (Medicine, Food, Etc.):

Notable Surgeries/Hospitalizations/Injuries/Illness	Date

Immunization History

Diphtheria/Tetanus	Flu Vaccine	Pneumonia Vaccine

Current medicines:

Medicine	First Dosage	Dosage	The reason

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PATIENT MEDICAL HISTORY

Parent Information	
Mother(s) Age :	Occupation :
Father(s) Age :	Occupation :

Family Medical History: Please list who in your family has a history with, if any, of the following medical conditions.	
Alcoholism	Epilepsy/Seizure Fits
Allergies	Excessive Bleeding or Bruising
Anemia	Family Violence and/or Child Abuse
Asthma	Heart Disease
Birth Defects	Heart Attack or Stroke under age 55 years
Cancer	High Blood Pressure
Cystic Fibrosis	High Cholesterol and/or Triglycerides
Diabetes	Sickle Cell Disease
Drug Abuse	Other
Emotional Problems	

Developmental Health	
Is the child often around someone who smokes, in or outside of the house?	Y / N
Does your water have fluoride?	Y / N
Crawled at _____ months	
Walked independently at _____ months	
Rolled over at _____ months	
Sat up independently at ____ months	
Clearly spoken words at _____ months	
Sentences at ____ months	

Dry at night at _____ months
Grade Level in School :
School Performance : Good / Fair / Poor

Birth History
Pregnancy #_____ of _____ total. Any multiple births?
Mother's problems/illness during pregnancy, if any:
Full Term / Premature (at _____ weeks)
Normal Delivery? Y / N
Hospital :
Weight :
Length :
Blood Type :
In Hospital _____ days.
Circumcised? Y / N
Birth/Pregnancy Complications? Y / N

Feeding History
Breast Fed? Every _____ hours for _____ minutes.
Formula? Name _____ given _____ ounces ever _____ hours
Frequent formula changes? Y / N
Whole milk given at _____ months _____ounces per day
Milk used (please circle): Whole 2% 1% ½ Skim
Foods added at _____ months
Appetite (please circle): Good Fair Poor Picky
Likes (please circle): Meats Vegetables Fruits Cereals
Rejects (please circle): Meats Vegetables Fruits Cereals

ANCOR HEALTH CENTER, PA

FINANCIAL POLICY

Thank you for choosing Ancor Health as your health care provider. A patient information sheet and current insurance information is required before seeing the provider. You will be required to follow all registration procedures, which including updating or verifying personal information, presenting verification of current insurance and pay any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as self-pay patient. As a self-pay patient, Ancor Health's fee is expected to be paid in full at the time of service.

The following are Ancor Health's requirements for payment of medical services:

Regarding Self Pay for Service Patients

Ancor Health requires self-pay patients to pay the payment in full for the services provided to patients with no insurance payments can be made by cash, check, money order, or credit card.

Regarding Insurance

Ancor Health will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office, and any changes must be brought to our office. If your policy has a deductible or patient responsibility of a co-pay, then you will be required to make the payment at the time of service. Failure to provide our office with current insurance information leads to non-payments from the insurance company and will result in the balance being transferred to patient responsibility.

Regarding Non-Covered Services

Please be aware that Medicaid and some insurance companies consider certain services as non-covered services, therefore, you will be expected to pay for these services.

Regarding Insurance Plans Where We Are a Participating Provider

All co-pays and deductibles are due prior to treatment.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we change what is usual and customary for our area.

I have read and agree to abide by the terms of this financial policy

_____ _____

Signatures of Parent/Responsible Party

Date

NON-SUFFICIENT FUNDS (NSF)

Ancor Health Center will charge a minimum of $30.00 for any payment that has been returned as a non-sufficient funds (NSF). Ancor Health Center will notify the responsible party of the non-sufficient fund check by mail. The responsible party has seven business days to pay the non-sufficient fee of $30.00 to Ancor Health Center. If the non-sufficient fee has not been paid it will be applied to the responsible parties' balance. If a non-sufficient fund has occurred, Ancor Health Center will no longer accept checks from the responsible party.

Print Responsible Party Name _____ Date _____

Signature of Responsible Party Name _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, _____ acknowledge that I have read and understand
Guardian Name

The Notivce of Privacy Practices as given to me this ____ day of _____ , 20 _____.

Signature: _____

Printed Name: _____

Witness : _____

Patient Name: _____

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PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO FRIENDS AND FAMILY

If you desire to have certain family members or other specific people receive your personal protected health information on your behalf, you should provide their information below. We value your privacy and ask that you help us identify the individuals with whom you would like us to discuss your treatment.

Please identify anyone you wish Ancor Health Center to discuss your relevant health information with:

☐ I GIVE PERMISSION for Ancor Health Center to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below:

Name: _____ Name: _____
Relation: _____ Relation: _____

Name: _____ Name: _____
Relation: _____ Relation: _____

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

* Patient is a minor (_____years of age)* OR is unable to give permission because:

Signature of individual signing on behalf of patient: _____ Date: _____

Legal authority to act on the patient's behalf: _____

********* Office Use Only ***********

Reviewed by: _____

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize:

Previous Doctors Office or Clinic: _____

Address:_____

Phone: _____

Fax: _____

To release information to:

Ancor Health Center, PA
818 N. Fourth St.
Longview, TX 75601
(903) 236-8600
Fax (903) 236-8605

_____ _____
Patient Name (Please Print) Social Security #

_____ _____
Date Date of Birth

Circle: Male or Female

Information to be released:

_____ Initial Examination _____ Discharge Summary

_____ Follow-up Care Progress Notes _____ Office Visit Note

_____ Special Procedure Results _____ All Records

The above information is released for the following purpose and that purpose only, and other use is forbidden: Establish Care with ANCOR HEALTH CENTER. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parent Signature: _____

Relationship to Patient: _____

Telephone: _____ Date: _____

PROTECTED MEDICAL INFORMATION

The above information is release for the following purpose and that purpose only, and other use is forbidden: Establish Care with Ancor Health Care Center. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parent's Signature: _____

Relationship to Patient _____

Address: _____

Telephone: _____

Date: _____ Witness: _____

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HIPAA AUTHORIZATION FOR CONSENT/USE OF PHOTOGRAPHS

Ancor Health Center, PA (Ancor) is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received with us. Sharing your story can help others who are interested in knowing more about the patient services provided by Ancor and can help Ancor promote its mission to provide excellent healthcare.

Ancor respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Ancor seeks your permission to allow us to take and use photographic material of you in Ancor's internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as newspapers and magazines).

To ensure that Ancor is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Ancor will keep a copy of your written permission on file. .

- ❒I do give my permission for Ancor to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of Ancor, and consent to take and make use of my and/or my child's photographic images in publications produced by or on behalf of Ancor. This permission extends both to electronic versions on the Ancor websites and other internet/electronic applications as well as to printed.
- ❒I do give my permission for Ancor to release my or my child's name and details of his/her medical care to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to take images (digital or otherwise) of me or my child for purposes of illustrating my treatment and experience as a patient of Ancor.

You can request a copy of this authorization verbally with the Medical Records Department, and/or request to have it mailed to you. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and photographic material.

I am aware that my protected health information will exist forever in either printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Ancor Health Center at 818 N. Fourth Street Longview, TX 75601. I understand that Ancor, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Ancor's control that have not been previously published.

Patient Name: _____

Signature: _____

Address: _____

Phone: _____

Date: _____

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, 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 (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 • ImmTrac 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.**

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