ANCOR HEALTH CENTER

Patient Registration Form

Name:_____Date of Birth:_____/_____/_____

Phone Number:_____

Address:_____

City:_____State:_____Zip:_____

Parent's Information (Mother & Father)

Mother's Name:_____Date of Birth:_____/_____/_____

Phone Number:_____

Address:_____

Email:_____

Father's Name:_____Date of Birth:_____/_____/_____

Phone Number:_____

Address:_____

Email:_____

Emergency Contact

Name:_____Phone Number:_____

Relationship to Patient:_____

Insurance Information (Check One)

_____Medicaid _____Private Insurance _____Selfpay
Member ID:_____
Primary Subscriber Name:_____ Date of Birth:_____
Relationship to Patient:_____

Secondary Ins ID:_____
Secondary Subscriber Name:_____Date of Birth:_____
Relationship to Patient:_____

All insurance cards should be present at time of visit in order for Ancor Health Center to file to correct insurance company. I give permission for Ancor to file to my insurance company and I am also aware that if in any case insurance is not covered, I will be responsible for payment/balance.

Signature:_____Date:_____/_____/_____

HMO POLICIES - If Ancor Health Center or our providers are not listed as the Primary Care Provider, the claim can be denied by your insurance carrier. The balance will be the patient's responsibility. The patient is responsible for updating the Primary Care Provider.

ANCOR HEALTH CENTER

In the event that you are unable to bring your child to an appointment please list all contacts whom you give permission to be present in your child's healthcare and as an emergency contact:

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

All patients and guardians are able to view upcoming appointments, lab reports, demographic information and the ability to interact with our staff through messages. If you are interested in our "Patient Portal" please provide the following information:

Email:_____

Childs Name:_____ Date of Birth:_____

Childs Name:_____ Date of Birth:_____

Childs Name:_____ Date of Birth:_____

Please note: If there is a custody issue involving your child please be advised unless a court order is submitted to Ancor Health Center both parents will have rights to the child's healthcare records. All persons listed on this form will have to present their ID when accompanying the child to appointment. To avoid any information listed, a written request must be submitted to Ancor Health Center.

Signature:_____Date:_____/_____/_____

PRACTICE POLICY (Please Initial)

____**24 HR cancellation policy**: If you cannot keep your appointment please call 903-236-8600 to cancel or reschedule your appointment at least 24 hrs in advance.

____**Missed appointment policy**: After 3 no show scheduled appointments, I will be subject to possible dismissal from Ancor Health Center.

____**Appointment Payment:** Payment is due at the time of service. We will require ALL payment up front before a patient is seen by the provider. If Self-pay additional charges can be added depending on test/shots or blood collections and we will require the payment at check out.

____**Medication refills:** Please allow up to 48 hrs for refill prescriptions to be called into your pharmacy. Please note that our office is closed Friday afternoon through Sunday. Therefore refill requests left on Friday evening may not be filled until the next business day.

____**Referrals:** If the provider has made a referral to a specialist , their office will contact you to schedule an appointment at their earliest convenience. If you have not received a call from the specialist within a week, please contact our referral department.

____**Medical Records:** Please allow 15 business days for any medical records to be sent and or received. In need of a full medical records chart, there will be a $25 fee.

____**CONSENT TO TREATMENT OF A MINOR:** I the parent or guardian of the patient, a minor, authorize Ancor Pediatrics and all the agents who are similar to all the medical staff to treat the child for any diagnosis. This consent will be permanent until a written revocation is done by Ancor Health Center.

I have read and understood the above policies and fees. My signature indicates of and agreement to the office policies explained above.

Printed Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize:_____

Previous Doctors Office or Clinic:_____

Address:_____

Phone Number:_____Fax Number:_____

To release information to:

Ancor Health Center
818 N Fourth St
Longview Tx, 75601
Phone: 903-236-8600
Fax: 903-236-8605

Patient Name:_____ Date of Birth:_____/_____/_____
Social Security:_____

The information you may release subject to this signed release is as follows:

___ **ALL RECORDS**
___ Initial Examination
___ Discharge Summary
___ Office Visit Notes
___ Special Procedure Results
___ Follow-Up Care progress Notes

THE ABOVE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE AND THE PURPOSE ONLY, AND OTHER USE IF 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:

Signature of Patient/Guardian: _____

Printed Name of Guardian:_____

Date:_____/_____/_____ Relationship to Patient:_____

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)

☐ 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
☐ 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 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 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 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 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

Texas Department of State Health Services
Immunizations

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