**Medical Records Request**

| Patient Name (Please Print) | Patients Date of Birth (mm/dd/yyyy) |
|---|---|
| | |

**Previous Doctor Seen**

**I Authorize:**_____

**Name of Doctor/Clinic**_____

**Address:**_____

**City, State, Zip Code**_____

**Phone Number:**_____ **Fax Number:**_____

**To Release To:**
**Dino Pediatrics, PLLC**
**ATTN: Medical Records**
**1613 NE Big Bend Trl Suite C**
**Glen Rose, TX 76043**
**Phone:254-635-6236**
**Fax: 833-972-1617**

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I request and authorize the release of my health information noted below: (please check all that apply)

- All Healthcare Information
- Lab Report(s) Date(s)
- X-Ray Report(s) Date(s)
- Pharmacy Report(s) Date(s)
- Other

*I understand that I am entitled to receive a copy of this authorization.
*I understand that I may withdraw this authorization in writing at any time.
*Unless otherwise specified field below. I understand that this authorization will expire 90 days from the request date. I request this expire on (Specify date) _____

_____ _____ _____
Signature of Parent/Guardian Date Phone Number

**Authorization to Photograph**

I, the undersigned, do hereby grant my permission for my child's healthcare provider to photograph and/or make digital images of my child which will be placed in his or her medical record for the purpose of treatment and ongoing patient care. Also for the use of promotion. I release all rights to all images created and prepared, and release Christie Ramirez, DNP, APRN, CPNP-PC from any claims or liabilities resulting from their use.

_____

Patient's Name (please print) Date of Birth

_____

Signature of Parent/Guardian Relationship

_____

Witness Date

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## HIPAA Privacy Disclosure

I understand that I have the right to restrict how my Health information (defined below) is used or disclosed by Dino Pediatrics and its affiliated companies) hereinafter collectively referred to as "Dino Pediatrics") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions in writing, however, 1 understand that Dino Pediatrics is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical services at Dino Pediatrics.

RELEASE OF INFORMATION: I consent and authorize Dino Pediatrics and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at Dino Pediatrics or by practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B, C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory test results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, Its agents, representatives, attorneys or independent contractors, Medicare Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my Dino Pediatrics bill or conducting utilization management/review and financial medical audits;
2. To any person entity affiliated with or representing Dino Pediatrics and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuum of care to induce prospective or current home health company, to referring facility health care staff or to Dino Pediatrics.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. 1 have read or will read the Privacy Notice and ask Dino Pediatrics W I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my child's Health information as described in the Privacy Notice.

Moreover, I understand 1hat the Privacy Notice may be amended byDino Pediatrics from time to time and that I may obtain an amended Privacy Notice at any time by contacting Dino Pediatrics registration/front office personnel.

I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to release Health Information in writing at any time, unless action has already been taken In reliance there upon; in which case, I may revoke this Consent for Mure communications.

I give my permission to Dino Pediatrics and its agents, employees and representatives to use the contact information, inducing cell phone numbers, I have provided to contact me for payment (including but not limited to autodialed or prerecorded collection calls), treatment or any other health care purposes.

MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare."

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS: I hereby irrevocably assign, transfer and convey to Dino Pediatrics and any practitioner providing care and treatment to my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive form

## HIPAA Privacy Disclosure Cont.

Dino Pediatrics. I agree to assist Dino Pediatrics in processing claims for such benefits including providing all necessary information to Dino Pediatrics or the payor in a timely manner. If my child's treatment was caused by events which result in legal action, I assign to Dino Pediatrics an interest in any claims my child may have arising from or in connection with the delivery service by Dino Pediatrics to my child. I understand that Dino Pediatrics's charges for the services rendered or products received are set out in Dino Pediatrics's Charge Master and I hereby promise to pay the full billed charges for all of the services rendered to my child less any applicable contractual discounts. In cases where no insurance policy is applicable or my insurance considers Dino Pediatrics out--Of;network, I understand that I may be responsible for the full billed charges. I understand I am responsible for all health insurance copayments and deductibles and any other amounts property payable by me as permitted by law or contract, Charity care may be available if Dino Pediatrics eligible criteria are met.

DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint Dino Pediatrics (and its agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description: (2) pursue a benefit claim: (3) appeal and adverse benefit determination; and/or (4) file a legaVequMble action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by my child at Dino Pediatrics, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to Dino Pediatrics.

MEDICAID PATIENTS ONLY: I understand that the amount owed to Dino Pediatrics for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be billed by Dino Pediatrics for Medicaid covered services. I further understand that the services or Items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my child's care. I understand that the TExas Health and Human Services Commission or its health insurance agent determines the medical necessity of the services or items that are received. I also understand that I am responsible for payment of the services or items I receive if their services or items are determined not to be reasonable and medically necessary for my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply.

I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order).

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF THE Dino Pediatrics NOTICE OF PRIVACY PRACTICES.**

Patient's Name Printed _____

Date of Birth _____

_____

Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative Relationship Witness

Time of Signing: Month_____Day _____Year _____ _____ Hour _____ a.m / p.m.

## Non-parental consent to medical/surgical care and treatment

**I, _____ parent/ legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/ surgical procedures or treatment deemed necessary for the well being of my child(ren).**
**I am,by this document, representing that I have the authority to consent for all medical/ surgical care and treatment of said care**

_____ _____

**Signature** **Relationship to child(ren)** **Date**

**Child(ren)**

_____ _____

**Name** **Name**

_____ _____

**Name** **Name**

**Authorized person(s): (who can we talk to about your child)**

_____ _____

**Name** **Relationship to child(ren)**

_____ _____

**Name** **Relationship to child(ren)**

_____ _____

**Name** **Relationship to child(ren)**

_____ _____

**Name** **Relationship to child(ren)**

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**Permission to Release Information Specific to Voice Mail**

**In addition to the information contained within Dino Pediatrics Acknowledgment of Privacy Practices, I give permission for my physician's office personnel to leave a message on my home answering machine and or cell phone in regard to my child's routine and or NORMAL laboratory and or NORMAL radiology results. I realize that I might not be the only person to hear such a message about my child:**

**_____ YES, I give permission to leave messages on my home answering machine and or my cell phone for reasons stated above. (This permission is good until the office has received a written revocation from the parent/ guardian)**

**____ NO, do not leave a message about my child on my number listed within the file.**

**Please choose YES or NO above and complete the area below, including Signature**

Patient Name (please print) Date of Birth

Signature of patient's legally authorized representative Date

Printed name of authorized representative Relationship to patient

Witness Date

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**Medical Consent:** By signing this form, I am consenting to any exams, x-ray, laboratory procedures, tests, medication, medical treatment, pictures, videos, and other services determined advisable for the patient by the attending healthcare provider and or other healthcare providers. Other healthcare providers can include consulting doctors, technical assistants , nurses, or office staff.
This consent applies during the evaluation, diagnosis, and treatment of the patient being cared for by Christie Ramirez, DNP, APRN, CPNP-PC, dino pediatrics, and its affiliated.

I also consent to allow students (such as medical fellow, medical residents, medical students, nursing students, and other authorized individuals that are enrolled in profession training programs) and healthcare providers undergoing training to watch or join in the care provided as the treating healthcare provider deems appropriate and as allowed by Christie Ramirez, DNP, APRN, CPNP-PC, Dino Pediatrics policies.

**Healthcare Providers and Independent Contractors-** Each patient within Dino Pediatrics, is under the care of a healthcare provider. Healthcare providers are not always employees of Dino Pediatrics. Some healthcare providers may be independent contractors. All health care providers assume responsibility for the medical care they provide.

**Accidental Exposure to Healthcare Workers-** I understand that Texas healthcare law states that if any healthcare worker is exposed to a patient's blood or any other bodily fluid, the Dino Pediatrics may perform test(s) for HIV (the "Human Immunodeficiency Virus) on that patient's blood or bodily fluid. I give consent to test for other diseases too, including hepatitis, syphilis, and others. I understand that these test(s) are necessary to protect healthcare workers who are caring for dino pediatric patients.

**Money and Personal Valuables-** I understand that Dino Pediatrics will NOT be responsible for lost or damaged money or property.

**The person signing this consent form certifies that: 1) He/she is either the patient, parent or legal guardian of the patient: 2) Has read (or has been read) this form and understands what it says: 3) agrees to the terms of this consent form.**

Patients Name (Printed) _____ Date of Birth_____

Parent/ Legal Guardian (Print)_____ Signature_____

Relationship to patient_____ Date_____

Witness:_____ Date_____

# New Patient Information

**Patient Name**_____ **Nickname**_____

**Date of Birth(mm/dd/yyyy)**_____ **Sex M / F** **Social Security#-**_____

_____

**Address** **City** **State** **Zip**

**Primary Language Spoken**_____ **Race/Ethnicity** _____

**Preferred Pharamacy**_____ **Pharmacy Phone Number**_____

**Sibling Names**_____

## Parent Information

| | | |
|---|---|---|
| **Mothers Name** | **Mothers Phone Number** | **Mothers Email** |
| **Fathers Name** | **Fathers Phone Number** | **Fathers Email** |
| **Guardian Name** | **Guardian Phone Number** | **Guardian Email** |

****I give consent for the following emails to have access to a portal account for the above named patient**
**MUST CHECK AT LEAST 1!**** **( )Mother's Email** **( ) Father's Email** **( ) Guardian's Email**

## Financial Information

Person responsible for patient's account and relationship._____

Responsible persons Social Security Number.__ __ __-__ __- __ __ __ __ DOB_____

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**Insurance Information**

***Primary Insurance Name:_____ Policy #_____ Group#_____**

**Name of Policy Holder_____ DOB of policy holder_____**

**Secondary Insurance Name:_____ Policy #_____ Group#_____**

**Name of Policy Holder_____ DOB of policy holder_____**

**Please give your photo ID and any insurance card(s) to the receptionist with this form.**

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