636 S. Peek Rd. Katy, TX 77450
Ph: 832-437-7239 Fax:832-787-1185

PATIENT INFORMATION

Patient Name: **Patient Name:**	**Gender: M/F Date of Birth: ____/____/____** **Gender: M/F Date of Birth: ___/____/____**
Address: **Apartment #:**	**Mobile Phone #:** **Alternative Phone #:**
City/State/Zip Code:	**Email Address:**
Referred By:	**Pharmacy Name, Address and Phone Number:**
Name of Mother or Legal Guardian: **Date of Birth:**	**Name of Father or Legal Guardian:** **Date of Birth:**
Insurance Co. Name: **Policy/ID #:** **Group #:**	**Secondary Insurance Co. Name:** **Policy/ID #:** **Group #:**

Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file to insurance as a COURTESY: however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans. **It is your responsibility to:**
   - **Bring your insurance card and photo ID to every visit.**
   - **Pay your co-pay and/or deductible at each visit.**
   - Pay in full for any medical care/services that are not covered by your insurance.
2. If your child has insurance that we do not accept, or your child does not have insurance, payment is due in full at the time of service provided. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service.
3. If your insurance plan is an HMO or POS policy, it may require you to choose a PCP or PCM (Primary Care Provider or Primary Care Manager). You will need to select Dr. Syed Haider as your child(s) PCP or PCM. If your insurance card lists another physician's name, we will see your child, but you will be notified to update the PCP or PCM.
4. *Secondary Insurance*: **It is your responsibility to update the COB with your primary and secondary insurance.**
5. **You are financially responsible for any amount not covered by your child's insurance**.
6. If you have questions about your insurance, you may contact our office. However, specific benefit(s) questions should be directed to your insurance provider. If the payment is denied, it is the parent(s) responsibility to contact the insurance provider.
7. **If you fail to make a payment in full for services that are rendered, your outstanding balance will be sent to a third-party collection agency.** Accounts are considered past due after 90 days. You will be responsible for any fees associated with your collection of outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
8. To protect your child's records, we ask you to provide our office with a valid driver's license or other photo ID. Annually, or as changes occur, we will ask to sign our financial policy and update your registration information. We will check these documents prior to release your child(s) records.
9. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child(s) account.

Late Arrival/No-Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back into the schedule later. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you do not show up to three times, we reserve the right to discharge your child from the practice. Appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time there will be a **No-Show fee of $50.00.**

ADVANCED BENEFICARY NOTICE: These services may NOT be covered by your insurance provider. The purpose of this list is to help you make an informed choice about whether you choose for your child to receive certain services. The face that your insurance provider does not cover a service does not mean that you should not receive that service, it means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance provider, you will be financially responsible for the balance on your account.

We will not provide medical care to children whose parents/guarantors refuse to sign and comply with our financial policy. Signature of Understanding: I have read and understand the above stated financial policy.

Child's Name	Date of Birth	Child's Name	Date of Birth

Patient or Parent/Guardian if Patient is under 18 years of age.

CONSENT TO TREAT

I, _____ the parent and legal guardian of

_____hereby give my consent for and authorize the administration and performance of all medical care, treatment, and diagnostic procedures which in the judgement of the licensed physicians, nurses and health care professionals of Kingsland Pediatrics are believed to be medically necessary. I understand that all services will be provided according to generally accepted standards of pediatric medical care and in accordance with applicable state law.

Included among the medical care services provided will be the administration of immunizations as required by law and generally recommended by the American Academy of Pediatrics and Center for Disease Control (CDC).

I acknowledge that I may revoke or change this Consent in writing addressed to Kingsland Pediatrics.

PRIVACY PRACTIVE AND OFFICE PROTOCOL ACKNOWLEDGEMENT

1. I hereby acknowledge that I have been presented with a copy of Kingsland Pediatrics Notice of Privacy Practices.

2. I hereby acknowledge that I have been presented with a copy of Kingsland Pediatrics Office Policies and understand my responsibilities.

Parent /Guardian Name: _____

Parent/Guardian Signature: _____

Date Signed: _____

Kingsland Pediatrics
Address: 636 South Peek Road Katy, Tx 77450
Phone: (832)437-7239
Fax: (832)787-1185

RELEASE OF MEDICAL RECORDS TO KINGSLAND PEDIATRICS

Patient's Name: _____ *Date of Birth:* _____

Persons or class of persons authorized to make the use or disclosure: Kingsland Pediatrics

_____
Above information released FROM (Name of Clinic/Doctor, Hospital, Insurance Company, Self, etc.)

Address of facility: _____

Phone Number of facility: _____ Fax Number: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient, which is call "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the follow purposes:

__ Changing Physicians __ Insurance Application __ Billing __ Other: _____

Specific information to be used or disclosed: Date(s) of service:

__ All Medical Records (Including VACCINE RECORDS & GROWTH CHARTS)
__ Vaccine Records __ Growth Charts __ Lab Reports __ Radiology Reports
__ Specialist(s) Notes __ Other _____

_____ _____
Print Name of Parent or Guardian **Signature of Patient or Guardian**

_____ _____
Relation to parent **DATE**

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). ImmTrac2 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. For more information, see Texas Health and Safety Code § 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 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; 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 DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
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 § 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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **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
Immunization Section

Stock No. C-7
Revised 02/2024

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

REGISTRO DE INMUNIZACIÓN DE TEXAS (ImmTrac2)
Consentimiento para menores de edad

Si el cliente es menor de 18 años, uno de los padres, el tutor legal o el titular de la custodia debe firmar este formulario.

Primer nombre del menor | Segundo nombre del menor | Apellido del menor

Fecha de nac. del menor (mm/dd/aaaa) / / | Sexo del menor: ☐ Femenino ☐ Masculino | Teléfono - - | Correo electrónico

Dirección del menor | Núm. de apartamento o edificio

Ciudad | Estado | Código postal | Condado

Nombre de la madre | Apellido de soltera

Raza (seleccione todos los que correspondan):

☐ Indio americano o nativo de Alaska
☐ Asiático
☐ Negro o afroamericano
☐ Nativo de Hawái o de otra isla del Pacífico
☐ Blanco
☐ Otro
☐ Se negó a contestar

Grupo étnico (seleccione solo una):

☐ Hispanic o latino
☐ No hispano o latino
☐ Otro

El Registro de Inmunización de Texas (ImmTrac2), es un servicio gratuito del Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida y guarda los registros de vacunación de su hijo/a (hasta los 18 años de edad). Con su autorización, la información de las vacunas que recibe su hijo/a se incluirá en el ImmTrac2. Médicos, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso a esta información para verificar que no falten vacunas importantes. Para más información consulte la § 161.007 (d) del Código de Salud y Seguridad de Texas en *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consentimiento para incluir en el registro a un menor y para divulgar sus datos a las entidades autorizadas

Entiendo que, al dar aquí mi consentimiento, autorizo la divulgación de mis datos de vacunación al DSHS, y entiendo además que el DSHS incluirá esta información en ImmTrac2. Una vez que los datos de las vacunas de mi hijo estén en ImmTrac2, las siguientes entidades tendrán, por ley, acceso a ella: un distrito de salud pública o departamento de salud local, por razones de salud pública, dentro de sus zonas de jurisdicción; un médico u otro proveedor de salud legalmente autorizado para aplicar vacunas, como parte del tratamiento al menor como su paciente; una dependencia estatal que tenga la custodia legal del niño; una escuela o guardería en la que el niño esté inscrito; un pagador autorizado por el Departamento de Seguros de Texas para operar en Texas lo relacionado con la cobertura del menor. Entiendo que puedo retirar este consentimiento en cualquier momento, llenando y enviando el formulario Withdrawal of Consent al ImmTrac2 del Texas DSHS.

La ley estatal permite la inclusión de los registros de vacunación de los socorristas y sus familiares directos en ImmTrac2.
Se define como "socorrista" al empleado de la seguridad pública o voluntario cuyas funciones incluyen el responder rápidamente a una emergencia médica. Se define como "familiar directo" a los padres, cónyuges, hijos o hermanos que viven en el mismo hogar que el socorrista. Para más información, consulte la § 161.00705 del Código de Salud y Seguridad de Texas. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Marque la casilla de abajo para indicar si su hijo/a es familiar directo de un socorrista.

☐ **Soy FAMILIAR DIRECTO de un socorrista.**

Con mi firma a continuación, DOY mi consentimiento para el registro. Deseo INCLUIR los datos de mi hijo en ImmTrac2.

El padre o madre, tutor legal o titular de la custodia:

Nombre escrito a mano | Firma | Fecha

Aviso de confidencialidad: Con ciertas excepciones, usted tiene derecho a solicitar y recibir información sobre los datos que el estado de Texas recabe sobre usted. Usted tiene derecho a recibir y revisar la información si así lo solicita. También tiene derecho a pedir que la dependencia estatal corrija cualquier información que se determine que es incorrecta. Consulte el sitio *http://www.dshs.texas.gov* para más información sobre el aviso de confidencialidad. (Fuente: Código gubernamental, § 552.021, 552.023, 559.003 y 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/*
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Immunization Section

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(Optional Service)

After-Hours Pediatric Care Agreement

Introduction

This agreement is between Kingsland Pediatrics ("Provider") and the undersigned patient or guardian ("Patient") for after-hours pediatric care.

Services Provided

- **Hours**: 5:00 pm to 11:00 pm, Monday through Sunday, including holidays.
- **Communication**: Care provided through text, phone, or virtual consultations with our healthcare team.

Fees and Payment

- **Membership**: $25/month for one child, $50/month for two or more.
- **Non-member Fee**: $25 per after-hours assistance.
- **Automatic Payments**: By signing this agreement, the Patient authorizes Kingsland Pediatrics to automatically charge the provided card on file every 3 months for the agreed membership fee.
- **Payment**: Payments are processed quarterly in advance. Non-payment may result in termination of services.

Exclusions

- No in-person care after hours.
- **Service area**: Texas residents only.

Insurance and Billing

Insurance may cover virtual visits, with co-pays applicable per the patient's insurance plan.

Termination

Either party may terminate with written notice. Payments made up to termination are non-refundable.

Agreement Acceptance

By signing, the Patient agrees to the terms and authorizes automatic payment as described.

Child name: _____

Patient/Guardian Signature: _____

Date: _____

Kingsland Pediatrics

Card Authorization

Card Type: Visa Mastercard AMEX Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____

Security Code: _____ **Expiration Date (MM/YY):** _____

Billing Zip Code : _____