New Patient/New Born Packet

First Name:_____ Middle Name: _____ Last Name: _____

Birth Date: ____/____/____ Gender: _____ (M) (F) SS #_____-_____-_____

Address: _____ City/State _____ Zip Code _____

Race: _____ Ethnicity: _____ Resides with: Mom, Dad or Both (Circle One)

Preferred Contact Method: Home, Cell, Work (Circle one) Email: _____

Mother (Genetic Y or N): _____ Date of Birth: ____/____/____

SS # _____-_____-_____

Home # _____-_____-_____ Cell Phone #_____-_____-_____ Work # _____-_____-_____

Father (Genetic Y or N): _____ Date of Birth: ____/____/____

SS # _____-_____-_____

Home #_____-_____-_____ Cell Phone # _____-_____-_____ Work #_____-_____-_____

- **Insurance Information:**

Primary Insurance: _____ Policy Number: _____

Group #: _____ Subscriber Name: _____

Relationship to patient: _____ Subscriber Name: _____

SS # _____-_____-_____ Address: _____

Secondary Insurance (If any): _____ Policy Number: _____

Group #: _____ Subscriber Name: _____

SS # _____-_____-_____ Address: _____

- **Third Party Consent:**

I authorize Tots & Teens, P.A. to communicate with my insurance company to coordinate treatment, to facilitate quality of treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at the time of service.
Initial: _____
I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify the information provided is true and correct. I will notify Tots & Teens, P.A. of any changes in the above information, in a timely manner. **Initial:** _____

- **Privacy Practice**

I acknowledged that I have been provided access of Tots & Teens notice of privacy practices, and can obtain a copy from the front staff at any time requested. **Initial** _____

- **Authorization to Release Information**

I hereby authorize Tots & Teens, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing application for the financial benefit. **Initial:** _____

Parent's Signature: _____ **Date:** _____

General Office Policies

- Parents are responsible for accurate and up to date insurance information and immunization records. Please bring your insurance information for each visit.
- Please notify our staff of changes to address, telephone work or cell phone number.
- Please alert our staff on arrival of temperature > 103, difficulty breathing/wheezing or suspected chicken pox.
- We may ask you to arrive on time for your appointment. Please be aware that your appointment time may not reflect the actual time you are seen by the doctor.
- Patients that arrive more than 10 mins late to a sick or follow up appointments may be rescheduled.
- We do not allow grace periods for new patients, physicals, and ADD/ADHD visits. Please arrive 10-15 mins before scheduled time. If late to your scheduled appointment time, we will need to reschedule your appointment.
- Aggressive, confrontational behavior or the use of foul language(cursing) in our office will not be tolerated and is subject for dismissal from our practice.
- For security purposes a copy of photo ID for either parents or guardians are required.
- Additional fee or $10 will be charged for any paperwork requiring a provider's signature outside of a scheduled appointment. We do ask for 24 to 48 hours to have paperwork completed.
- Parent request to fax patient information such as shot records, physical exams, etc. will require written consent for security purposes.
- WE FIRMLY BELIEVE THAT ALL CHILDREN AND YOUNG ADULTS SHOULD RECEIVE ALL THE RECOMMENED VACCINES ACCORDING TO THE SCHEDULE PULISHED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND THE ACADEMY OF THE AMERICAN ACADEMY OF PEDIATRICS. IF YOU SHOULD ABSOLUTELY REFUSE TO VACCINATE YOUR CHILD DESPITE ALL OUR EFFORTS, WE WILL ASK YOU TO FIND ANOTHER HEALTH CARE PROVIDER WHO SHARE YOUR VIEWS.

NO SHOWS/ CANCELLATION PROCESS

- A NO SHOW is defined as missing a scheduled appointment without calling in advance to cancel.
- A patient who no shows three times within a six-month period is subject to dismissal from the practice.
- After the third no show, a letter will be mailed requesting that the patient finds a new primary care physician.
- We understand that the situations occasionally arise when an appointment cannot be kept, and adequate notice is not possible. These situations will be considered on a case-to-case basis.

Patient Name: _____ **DOB:** _____

Parent Signature: _____ **Date:** _____

PLEASE UNDERSTAND THAT THE INTENT OF THESE POLICIES IS TO AID US IN OFFERING A HIGH STANDARD OF CARE TO OUR PATIENTS. THEY ARE NOT MEANT TO BE A BURDEN. WE ALSO PLEDGE TO DO OUT PART TO KEEP OUR SCHEDULE MOVING AS EFFICIENTLY AS WE POSSIBLY CAN.

TOTS & TEENS MEDICAL CONSENT & EMERGENCY CONTACT

Emergency Contact

First Name:_____Last Name:_____

Relationship to patient:_____Phone# (____)_____-_____

Authorized Individual:

Please list individuals other then parent/guardian authorized to bring patient in for medical treatment

(1) First Name:_____ Last Name:_____

Relation:_____ Phone# (____)_____-_____

(2) First Name:_____ Last Name:_____

Relation:_____ Phone# (____)_____-_____

(3) First Name:_____ Last Name:_____

Relation:_____ Phone# (____)_____-_____

(4) First Name:_____ Last Name:_____

Relation:_____ Phone#(____)_____-_____

Please be aware only those names listed on the consent can bring your child to an appointment. If an individual other then those listed above brings in the child, we will reschedule the appointment unless a written consent is sent in and signed by parent/guardian.

I_____, authorize the above individual(s) to bring my child to any doctor's appointments and make medical decisions on my behalf.

Regarding Minor Patients

A parent or legal guardian **MUST** accompany all minor patients under the age of 18 years to each visit.

Patient Name:_____ Birth Date:_____/_____/_____

Parent Signature:_____ 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). 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

Stock No. C-7
Revised 02/2022

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

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____ (Last Name / First Name / MI)
2. Child's Date of Birth: ____/____/____ (MM DD YYYY)
3. Parent, Guardian, or Individual of Record: _____ (Last Name / First Name / MI)
4. Primary Provider's Name: _____ (Last Name / First Name / MI)
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Tots & Teens
PEDIATRICS

Edward Borchard, M.D-F.A.A.P
Camilla Gupta, M.D-F.A.A.P
Vivan Lopez, FNP-C

Christine Rivera, M.D.-F.A.A.P
Velma Borchard, FNP BC
Cynthia Garica, FNP

6434 Saratoga Blvd, Corpus Christi, TX 78414
Phone: 361-991-1885 Fax: 361-991-1839
Website: www.tots-teenspediatrics.com

Authorization to Release Healthcare Information

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

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

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

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

I, _____, request and authorize: _____
(previous doctor's name)

Phone: _____ Fax: _____

To release health care information of the patient(s) named above to: **Tots & Teens Pediatrics**
6434 Saratoga Blvd
Corpus Christi, Tx 78414

This request and authorization applies to: ALL Healthcare Information/Medical Records

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this order to assure treatment. I understand that any disclosure of information carries with the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Dept. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

Parent/Guardian Signature: _____ **Date:** _____

For Office Use Only:

Date Faxed: _____ Employee Signature: _____ Date: _____

Tots & Teens
PEDIATRICS

TOTS AND TEENS VACCINE POLICY STATEMENT

- WE FIRMLY BELIEVE ON THE EFFECTIVENESS OF VACCINES TO PREVENT SERIOUS ILLNESS AND TO SAVE LIVES.
- WE FIRMLY BELIEVE IN THE SAFECTY OF OUR VACCINES.
- WE FIMLY BELIEVE THAT ALL CHILDREN AMD YOUNG ADULTS SHOULD RECEIVE ALL THE RECOMMENEDED VACCINES ACCORDING TO THE SCHEDULE PUBLISHED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND THE AMERICAN ACADEMY OF PEDIATRICS.
- WE FIRMLY BELIEVE, BASED ON ALL AVAILABLE LITERATURE, EVIDENCE, AND CURRENT STUDIES, THAT VACCINES DO NOT CAUSE AUTISM OR OTHER DEVELOPMENTAL DISABILITES.
- WE FIRMLY BELIEVE THAT VACCINATING CHILDREN AND YOUNG ADULTS MAY BE THE SINGLE MOST IMPORTANT HEALTH-PROMOTING INTERVENTION WE PERFORM AS HEALTH CARE PROVIDERS, AND THAT YOU CAN PERFORM AS PARENTS/CAREGIVERS. THE RECOMMENDED VACCINES AND THEIR SCHEDULE GIVEN ARE THE RESULTS OF YEARS AND YEARS OF SCIENTIFIC STUDY AND DATA GATHERING ON MILLIONS OF CHILDREN BY THOUSANDS OF OUR BRIGHTEST SCIENTISTS AND PHYSICANS.

THESE THINGS BEING SAID, WE RECONGIZE THAT THERE HAS ALWAYS BEEN AND WILL LIKELY ALWAYS BE CONTROVERSY SURROUNDING VACCINATIONS. **VACCINES ARE EFFECTIVE AT PREVENTING DISEASES.** PARENTS CONTINUE TO HAVE THOUGHTS AND WHETHER OR NOT THEY SHOULD BE GIVEN. BECAUSE OF VACCINES, MANY PEOPLE HAVE NEVER SEEN A CHILD WITH POLIO, TETANUS, WHOOPING COUGH, BACTERIAL MENIGITIS, OR EVEN CHICKENPOX, OR KNOWN A FRIEND OR FAMILY MEMBER WHOSE CHILD DIED OF ONE OF THESE DISEASES. SUCH A SUCCESS CAN MAKE US UNCONCERNED ABOUT VACCINATING. THIS ATTITUDE, IF IT BECOMES WIDESPREAD CAN ONLY LEAD TO TRAGIC RESULTS!

AFTER PUBLICATION OF AN UNFOUNDED ACCUSATION (LATER RETRACTED) THAT MMR VACCINE CAUSE AUTISM IN 1998, MANY PEOPLE CHOSE TO NOT VACCINATE THEIR CHILDREN. AS A RESULT OF UNDERIMMUNZATION, THERE WERE LARGE OUTBREAK OF MEASLES, WITH SEVERAL DEATHS FROM COMPLICATIONS OF THE DISEASE. BY NOT VACCINATING YOUR CHILD, YOU ARE TAKING ADVANTAGE PF THOUSANDS OF OTHERS WHO DO VACCINATE THEIR CHILDREN, WHICH DECREASES THE LIKELIHOOD THAT YOUR CHILD WILL CONTRACT ONE OF THESE DISEASES. WE FEEL SUCH AN ATTITUDE IS UNACCEPTABLE.

WE ARE MAKING YOU AWARE THAT EMPHASIZING THE IMPORTANCE OF VACCINATING YOUR CHILD. VACCINATING ACCORDING TO THE SCHEDULE APPROVED BY THE CDC AND AAP IS THE RIGHT THING TO DO. PLEASE BE ADVISED, HOWEVER, THAT DELAYING OR "BREAKING UP THE VACCINE" TO GIVE ONE OR TWO AT A TIME OVER TWO OR MORE VISITS GOES AGAINST EXPERT RECOMMENDATIONS, CAN PUT YOUR CHILD AT RISK FOR SERIOUS ILLNESS (OR EVEN DEATH), AND GOES AGAINST OUR MEDICAL ADVICE AS PROVIDERS AT TOTS AND TEENS PEDIATRICS.

FINALLY, YOU SHOULD ABSOLUTELY REFUSE TO VACCINE YOUR CHILD DESPITE ALL OUR EFFORTS, WE WILL ASK YOU TO FIND ANOTHER HEALTH CARE PROVIDER WHO SHARES YOUR VIEWS. PLEASE RECONGIZE THAT BY NOT VACCINATING YOU ARE PUTTING YOUR CHILD AT UNNCESSARY RISK FOR LIFE THREATENING ILLNESS AND DISABILITY, AND EVEN DEATH. AS MEDICAL PROFESSIONALS; WE FELL STRONGLY THAT VACCINATING CHILDREN ON SCHEDULE WITH CURRENTLY AVAIABLE VACCINES IS ABSOLUTELY THE RIGHT THING TO DO FOR ALL CHILDREN AND YOUND ADULTS.

THANK YOU FOR YOUR TIME IN READING THIS POLICY AND PLEASE FEEL FREE TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE ABOUT VACCINES WITH ANY OF US. PLEASE VISIT WWW.IMMUNIZE.ORG FOR INFORMATION CONCERNING VACCINES AND UNPROTECTED PEOPLE REPORTS.

TOTS & TEENS PEDIATRICS

NOTICE OF PRIVACY PRACTICE

THIS IS NOTICE IS A SUMMARY THAT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE READ IT CAREFULLY.

USES & DISCLOSURE OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared without your authorization to providers to whom you are referred. Information may be shared by paper mail, fax, or other methods. For example, we may contact you by telephone or mail to provide appointment reminders.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, may give out health information without your authorization for public health purposes and is case of emergencies. We provide information when otherwise required by law, such as law enforcement in specific circumstances. In any other situation, we will ask for your written consent before disclosing any identifiable health information about you. If you sign an authorization to disclose any information, you can later revoke that authorization to stop any future uses and disclosures.

WE MAY CHANGE OUR POLICIES AT ANY TIME. WHEN WE MAKE A CHANGE, WE WILL POST THE NOTICE IN THE WAITING ROOM.

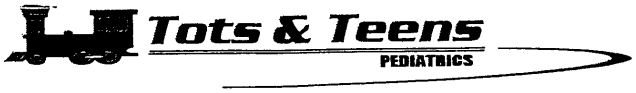
Subject to limitations outlined by law, you have the right to request restrictions on certain uses and disclosure. However, Tots & Teens is not obligated to agree to requested restrictions. You may also request, inspect, and a copy of your protected health information with some limited exceptions. If you believe that information in your record is incorrect or important information is missing, you have the right to request that we correct or add missing information.

COMPLAINTS

For more information about our privacy practices, and if you believe we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You may also make a complaint to the Secretary for the Department of Health & Human Services. No individual will be retaliated against for filing a complaint.

OUR LEGAL POLICY

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this office.



TOTS AND TEENS PEDIATRICS

CORPUS CHRISTI TOTS & TEENS IS DEVOTED TO HELPING YOU WITH YOUR CHILD'S HEALTH NEEDS, WHETHER IT IS MAINTAING GOOD HEALTH OR IN THE EVENT OF ILLNESS. IT IS CUSTOMARY TO PAY FOR MEDICAL SERVICES AT THE TIME OF THE VISIT. THE FOLLOWING IS STATEMENT OF OUR FINANICAL IS OUR FINANCIAL POLICY THAT WE REQUIRE YOU TO READ AND SIGN PRIOR TO RECEIVING ANY TREATMENT. ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE YOUR APPOINTMENT.

FULL PAYMENTS IS DUE AT THE TIME OF SERVICES RENDERED. WE ACCEPT CASH, PERSONAL CHECKS, OR CREDIT CARDS.

REGARDING INSURANCES

WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY TO YOU. HOWEVER, PAYMENT OF YOUR MEDICAL BILL IS YOUR RESPONSIBILITY AND SHOULD BE SETTLED BETWEEN YOU AND YOUR INSURANCE COMPANY. IT IS YOUR RESPONSILIBTY TO KNOW THE COVERAGE OF YOUR INDIVIDUAL INSURANCE POLICY. YOUR INSURANCE POLICY IS CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR SERVICES RENDERED THAT YOUR INSURANCE DOES NOT COVER.

REGARDING OUTSTANDING BALANCE

IF WE HAVE NOT RECEIVED PAYMENT FORM YOUR INSURANCE COMPANY AND YOU HAVE AN OUTSTANDING BALANCE OF MORE THAN 90 DAYS FROM THE DATE OF SERVICE, YOU WILL BE DIRECTLY FOR PAYMENT. WE WILL PROVIDE YOU WITH NECESSARY INFORMATION IN ORDER FOR YOU TO BE DIRECTLY REIMBURSED BY YOUR INSURANCE COMPANY. IN THE EVENT THAT THERE IS AN OVERPAYMENT, WE WILL REIMBURSE YOU WITHIN 30 TO 60 DAYS. THIS IS AN APPROXIMATE AMOUNT OF TIME IN WHICH PAYMENT FROM YOUR INSURANCE COMPANY WOULD HAVE BEEN RECEIVED. UNLESS ARRANGEMENTS ARE MADE PRIOR TO THE DUE DATE, ANY BALANCE OLDER THAN 120 DAYS WILL BE SENT TO A COLLECTION AGENCY.

REGARDING SECONDARY INSURANCE

IF YOU HAVE MORE THEN ONE INSURANCE COMPANY, WE WILL BILL ONLY YOUR PRIMARY INSURANCE. IF YOUR PRIMARY INSURANCE COMPANY DENIES PAYMENT, YOU WILL BE THE RESPONSIBLE PARTY. WE WILL PROVIDE YOU WITH THE NECESSARY INFORMATION FOR YOUR FILE FOR DIRECT PAYMENT FROM YOUR SECONDARY INSURANCE COMPANY.

REGARDING MEDICAL RECORDS

IN THE EVENT THAT YOU NEED COPIES OF YOUR CHILDS MEDICAL RECORDS OR REPLACEMENT OF A LOST IMMUNIZATION CARD, THERE WILL BE AN ADMINISTRATIVE FEE OF $25.00 FOR THE RECORDS FOR THE 1ST 25 PAGES, THEN 50 CENTS EACH PAGE THERE AFTER AND $7.50 FOR THE IMMUNIZATION CARDS. OUR OFFICE DOES ASK FOR A 24-48 HOUR NOTICE ON IMMUNIZATION RECORDS, AND IF MEDICAL RECODS ARE REQUESTED WE ASK TO GIVE US TIME NEEDED DEPENDING ON FILE SIZE. YOU WILL ALSO BE REQUIRED TO SING AN AUTHORIZATION FORM FOR THE COPIES REQUESTED.

REGARDING MINOR PATIENTS

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY ALL MINOR PATIENTS UNDER THE AGE OF 18 YEARS TO EACH VISIT.