



### Patient Information

Patient Name: \_\_\_\_\_ Goes by: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: Male / Female

Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ (Father, Mother, Other) Text Confirmations: Yes / No

Secondary Phone: \_\_\_\_\_ (Father, Mother, Other)

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Date of Birth: \_\_\_\_\_ Mother's Date of Birth: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

**Insurance Information:**

	Primary Insurance	Secondary Insurance
Insurance Company:		
Policy (ID) Number:		
Group Number:		
Name of Policy Holder:		

**Allergies: (Food, Medicine, etc.)**

Allergy	Reaction

**Current Medications:**

Medication	Dosage	Frequency	Reason

**Surgeries/Hospitalizations:****Date**


**Medical Problems: (Please indicate any chronic medical problem)**

<input type="checkbox"/> ADHD	<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Constipation
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Kidney/Renal Disorders	<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Migraines
<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid Conditions	<input type="checkbox"/> Other	

**Other Medical Providers:**

Type and Place	Name
ENT-	
Allergist-	
Orthopedics-	
Other-	

**Previous Pediatrician Information:**

<b>Provider Name:</b>	
<b>Practice/Clinic Name:</b>	
<b>Location:</b>	
<b>Phone Number:</b>	

Referred by: \_\_\_\_\_

**Family Medical History:**

**Please list any pertinent family members with a history of the following medical conditions**

Allergies	Anemia	Asthma
Birth Defects	Cancer	Diabetes
Seizure Disorder	Excessive Bleeding	Heart Disease
Heart Attack or Stroke under age 55	High Blood Pressure	High Cholesterol/ Triglycerides
Sickle Cell Disease	Other	

**Daycare/ School**

<b>Place</b>	<b>Grade Level</b>

**Pharmacy Name and Location:** \_\_\_\_\_



# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## Understanding Your Health Record/Information

This notice describes the practices of Shining Star Pediatrics with respect to your protected health information. Shining Star Pediatric physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, Shining Star Pediatrics and physicians may share medical information with each other for treatment, payment or healthcare operations described in this notice. We create a record of the care and services you receive at Shining Star Pediatrics. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care within Shining Star Pediatrics and will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

### *Your Health Information Rights*

Although your health record is the physical property of Shining Star Pediatrics, the information belongs to you. You have the right to:

- Inspect and request a copy of your health record as provided by law
- Request communications of your health information by alternative means
- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of certain disclosures of your health information as provided by law
- Obtain a paper copy of this notice of information practices upon request from the office Privacy Officer at 2304 Judson Road Suite D, Longview, Texas 75605. A copy is also available on the patient portal [www.YourHealthFile.com](http://www.YourHealthFile.com)

You may exercise your rights set forth in this notice, by providing a written request to the office manager at 2304 Judson Road Suite D, Longview, Texas 75605

*Our Responsibilities*

### *Our Responsibilities*

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you
- Abide by the terms of this notice

### *Notify you if we are unable to agree to a requested restriction on certain uses and disclosures*

- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at Shining Star Pediatrics and on the patient portal at [www.YourHealthFile.com](http://www.YourHealthFile.com)
- We will not use or disclose your health information without your written authorization, except as described in this notice or permitted by law.

Examples of Disclosures of Health Information for Treatment, Payment and Healthcare Operations and as Otherwise Allowed by Law. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories:

**TREATMENT:** For example, we may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you within Shining Star Pediatrics. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and X-rays. We may also provide your physician or a subsequent healthcare provider with copies of various reports to assist in your treatment.

**PAYMENT:** For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

### **HEALTHCARE OPERATIONS:**

For example, we may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare



and services we provide. Your health information will also be used as otherwise allowed by law. The following are some examples of how we may use and disclose medical information about you:

**BUSINESS ASSOCIATES:** There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests and copy services. To protect your health information, however, we require business associates to take the appropriate measures to safeguard your information.

**NOTIFICATION:** We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care of your location and general condition.

**RESEARCH:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**FUNERAL DIRECTORS:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**ORGAN PROCUREMENT ORGANIZATIONS:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

**COMMUNICATIONS FOR TREATMENT AND HEALTHCARE OPERATIONS:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that maybe of interest to you.

**FOOD AND DRUG ADMINISTRATION (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

**HEALTH OVERSIGHT ACTIVITIES:** We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government benefit programs and compliance with civil rights laws.

**WORKER'S COMPENSATION:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**PUBLIC HEALTH:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

**ABUSE, NEGLECT OR DOMESTIC VIOLENCE:** As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence.

**JUDICIAL, ADMINISTRATIVE AND LAW ENFORCEMENT PURPOSES:** Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes. This may include disclosures to avert a serious threat to your or a third party's health or safety as well as victims of crime or criminal conduct at the Covered Entity.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:** We may use and disclose your health information when we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

**NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES:** We may release your health information to authorized federal officials for lawful intelligence, counterintelligence and other national security activities authorized by law.

**PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS:** We may disclose your health information to authorized federal officials so they may provide protection to the president, other authorized persons or foreign heads of state or for the conduct of special investigations.

**REQUIRED OR ALLOWED BY LAW:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.

**OTHER USES OF YOUR HEALTH INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your medical information, you may cancel that permission, in writing, at any time. If you cancel your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM:**

If you have questions regarding your privacy rights and would like additional information, you may call the Shining Star Pediatrics Privacy Officer at (903) 212-6060. If you believe your privacy rights have been violated, you may file a written complaint with the Shining Star Pediatrics Privacy Officer, 2304 Judson Road Suite D. Longview, Texas, 75605, or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.





2304 Judson Road Suite D  
Longview, TX 75603

T (903) 212-6060  
F (903) 212-4466

[shiningstarpediatrics@yahoo.com](mailto:shiningstarpediatrics@yahoo.com)

<http://www.shiningstarpediatrics.com>

## Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I have received a copy and/or read the "Notice of Privacy Practices," which explains how my medical information will be used and disclosed. A copy is available upon request.

In effort to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your child's privacy according to your wishes when it comes to your family and friends.

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Patient

Name: \_\_\_\_\_

Relationship to

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, immunizations as requested, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** Shining Star Pediatrics may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited too, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Shining Star Pediatrics and are responsible for their own actions. I understand that Shining Star Pediatrics shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).
2. **VALUABLES:** Shining Star Pediatrics assumes no responsibility for, and I hereby release Shining Star Pediatrics from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.
3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS:** I hereby expressly authorize Shining Star Pediatrics and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payer) which may be responsible for paying for my care. I authorize and direct all payers to pay all benefits due for such care directly to Shining Star Pediatrics and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Shining Star Pediatrics and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
4. **PAYMENT FOR SERVICES:** I acknowledge that Shining Star Pediatrics accepts me as a private pay patient and that I am responsible for paying all services and that any form of Texas Medicaid will not be accepted or billed including Superior or Amerigroup. If the services I receive are covered by a third party payor, Shining Star Pediatrics may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.
5. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS:** I authorize and release Shining Star Pediatrics and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Shining Star Pediatrics may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
6. **NO GUARANTEE OF RESULTS:** Shining Star Pediatrics physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Shining Star Pediatrics, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Shining Star Pediatrics or its employees.
7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.
8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making. I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original.
9. I(we), the patient or patient's representative as well as the providers, employees, and agents of Shining Star Pediatrics, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/ district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient, Parent, or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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<http://www.shiningstarpediatrics.com>

### Authorization for Treatment of Minors

We recognize that parents may not always be able to be present during treatment of their young child or teen. This form addresses the situation when your child is accompanied by another adult.

I (parent/guardian): \_\_\_\_\_

Authorize my child: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

My child may be treated and their medical needs may be discussed with the following persons:

**Name:**

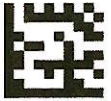
**Relation to patient:**

_____	_____ (must have Picture ID at visit)
_____	_____ (must have Picture ID at visit)
_____	_____ (must have Picture ID at visit)
_____	_____ (must have Picture ID at visit)





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) Ethnicity (select only one)
American Indian or Alaska Native Asian Black or African-American Hispanic or Latino
Native Hawaiian or Other Pacific Islander White Other Race Not Hispanic or Latino
Recipient Refused 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.

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.

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.

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.

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





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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize \_\_\_\_\_  
(Name of person or facility which has information)

**To release information to:** Shining Star Pediatrics  
2304 Judson Rd Suite D  
Longview TX 75605  
Ph: 903-212-6060 Fax: 903 - 212 - 4466

**The purpose of release is for:**

- Continuity of care or discharge planning
- At the request of the patient/patient representative

**Please specify the health information you authorize to be released:**

- Health Summary  Growth Chart  Other \_\_\_\_\_
- Immunization Record  Sub-specialist Notes  Labs/Radiology Results

**The following information will not be released unless you specifically authorize it:**

- Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. 2.34 and 2.35).
- Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code 5328, et seq.)
- Release of HIV/AIDS test results (Health and Safety Code 120980(g)).
- Release of genetic testing information (Health and Safety Code 124980(j)).

**Expiration Of Authorization**

Unless otherwise revoked, this Authorization expires \_\_\_\_\_. If no date is indicated the Authorization will expire 12 months after date of my signing this form.

**Your Rights**

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative and delivered to: Shining Star Pediatrics, 2304 Judson Rd., Suite D, Longview, TX 75605. The revocation will take effect when received except to the extent Shining Star Pediatrics or others have already relied on it. You are entitled to receive a copy of this Authorization.

\_\_\_\_\_  
Print Patient Name DOB

\_\_\_\_\_  
Signature (Patient, Parent, Guardian) Print Name

\_\_\_\_\_  
Date Relationship to Patient