Shining Star
PEDIATRICS

No Show and Missed Appointment Policy

When our office schedules your appointment, we are reserving a dedicated room and time slot just for you. Our policy is that if you must reschedule your appointment that you must provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved Time slot to another patient in need.

Our policy is that possible dismissal from the practice may result after three (3) no show/ missed appointments

Repeated cancellations or missed appointments will result in loss of future appointment privileges for all new patient appointments

Every patient in our practice received a unique reservation. When your appointment is made, a time is reserved, possible vaccines are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, Of course, would appreciate the same courtesy from you.

_____ I understand that I should fail to attend three (3) appointments. I will be subject to possible dismissal.

I have read the above Appointment Policy and have initialed in order to ensure my understanding of this policy

_____

Guardian Signature Date

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Patient Information

Patient Name:_____ Nicknames:_____

Date of Birth:_____ Race:_____ Sex: Male / Female

Address:_____ Apartment #:_____

City: _____ State:_____ Zip Code:_____

Email Address:_____

Secondary Email Address:_____

Primary Phone:_____(Father, Mother, Other:_____)

Secondary Phone:_____(Father, Mother, Other:_____)

Email and Text confirmations: yes / no

Parent Information

Father's Name:_____ Mothers name:_____

Date of Birth:_____ Date of Birth:_____

Father's Occupation:_____ Mother's Occupation:_____

Insurance Information:

	Primary Insurance	Secondary Insurance
Insurance Company		
Policy / Identification Number		
Group Number		
Name of Policy Holder		

Allergies: (Food, Medication, etc.)

Allergy	Reaction

Current Medications:

Medication	Dosage	Frequency	Reason

Surgeries / Hospitalization: **Date:**

Other Medical Providers:

Type and place	Name
Ear, Nose, and Throat-	
Allergist-	
Orthopedics-	
Other-	

Preferred Pharmacy:_____

How did you hear from us?_____

Previous Pediatrics:

Facility Name:
Provider Name:
Location:
Phone:

Medical Problems:

☐ ADHD	☐ Allergic Rhinitis	☐ Asthma	☐ Chronic Constipation
☐ Developmental Delay	☐ Diabetes	☐ Eczema	☐ Hearing Loss
☐ Heart Conditions	☐ Kidney/Renal Disorders	☐ Mental Health Problems	☐ Migraines
☐ Seizures	☐ Thyroid Conditions	☐ Other	

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 55	High Blood Pressure	High Cholesterol/ Triglycerides
Sickle Cell Disease	Other	

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 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 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

• 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 may be 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.

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2304 Judson Road Suite D
Longview, Tx 75605

P (903) 212 6060
F (903) 212 4466

shiningstarpedsclinic@gmail.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.

_____

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

Consent to Treatment and Other Acknowledgements

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), physic or any healthcare professional assigned to my care by my attending physician(s), andI 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 to, surgical assistants, physical therapists, and consulting vets of Shining Star 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 ION 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 I 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 a 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 v 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, but inside or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these he 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 read and understand its contents, 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 o any health care rendered to patient: and (2) in the event of a dispute, any lawsuit. action 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:_____ Date:_____

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shiningstarpedsclinic@gmail.com

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:

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
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shiningstarpedsclinic@gmail.com

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize _____

(Name of 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 the 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 inin the 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.

Patients Name:_____ Date of Birth:_____

Print Name (Patient, Parent, Guardian):_____ Date:_____

Signature:_____ Relationship to Patient:_____