PECAN TREE PEDIATRICS

Pediatric New Patient Intake Form

Date: _____

Patient Information

Last Name: _____ First Name: _____ Date of Birth: _____

Primary Phone: _____ Alternate Phone: _____

Primary Address _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Pharmacy's Address: _____

Parent/Guardian Information

#1 Last Name: _____ First Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____ Type: ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Deceased

Phone: _____ E-mail: _____

☐ Address Same as Patient

Address _____ City: _____ State: _____ Zip: _____

Does patient reside with this parent/guardian? ☐Yes ☐No Rights to patient: ☐ Exclusive Custody ☐ Joint Custody ☐ Other _____

**Please provide court documents (for patient medical records files) pertaining to the patient's medical rights/restrictions if necessary*

#2 Last Name: _____ First Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____ Type: ☐ Biological ☐ Step-parent ☐ Adoptive ☐ Deceased

Phone: _____ E-mail: _____

☐ Address Same as Patient

Address _____ City: _____ State: _____ Zip: _____

Does patient reside with this parent/guardian? ☐Yes ☐No Rights to patient: ☐ Exclusive Custody ☐ Joint Custody ☐ Other _____

**Please provide court documents (for patient medical records files) pertaining to the patient's medical rights/restrictions if necessary*

Medical Insurance

Primary Insurance Payor: _____ Subscriber ID: _____ Group #: _____

Policy Holder/Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Payor: _____ Subscriber ID: _____ Group #: _____

Policy Holder/Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Authorized Individuals for Patient Care and Accompaniment/Consent for Treatment

Please provide the names of any individuals (such as grandparents, babysitters, family friends, or other caregivers) whom you authorize to bring your child to medical appointments, receive medical information and/or prescriptions, and consent to routine medical care or immunizations on your behalf when you are unable to attend.

Authorized Individual Full Name	Relationship to Patient	Phone

Parent/Legal Guardian Authorization:

I acknowledge that the information provided on this intake form is accurate and complete to the best of my knowledge. I consent to the provision of routine medical care and treatment for my child and understand that I am responsible for notifying the practice of any changes to the information provided.

I further authorize the individuals listed in the section "Authorized Individuals for Patient Care and Accompaniment/Consent for Treatment" to accompany my child to appointments, receive relevant medical information and prescriptions, and consent to routine medical care and immunizations on my behalf when I am unable to attend.

By signing below, I acknowledge and agree to these terms. I certify that I am the parent or legal guardian of the patient listed above.

Parent or Legal Guardian Name (Print): _____ Relationship to Patient: _____

Parent or Legal Guardian Signature: _____ Date: _____

Last Name: _____ First Name: _____ DOB: _____

Patient's Medical and Social History

Birth History

Is the patient adopted? ☐ Yes ☐ No If yes, is patient aware that he or she is adopted? ☐ Yes ☐ No

Birth weight: _____ Weeks of gestation at birth: _____ Delivery: ☐ C-Section ☐ Vaginal Delivery ☐ Vacuum ☐ Forceps

If C-Section, why? _____

Group B Strep (GBS)+: ☐ Yes ☐ No ☐ Unknown

Was patient placed in NICU or Special Care Nursery: ☐ Yes ☐ No If "Yes", please give details: _____

During pregnancy, did the biological mother use: ☐ Tobacco ☐ Alcohol ☐ Illicit drugs ☐ Prenatal vitamins

Please describe any health problems the mother or patient experienced during pregnancy, during labor, during delivery or after birth: _____

Medical History

Does the patient have any allergies to medications or other substances (pets, plants, food, etc.)? ☐ Yes ☐ No

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).

Allergy	Reaction		Allergy	Reaction

Please list ALL current medications, including over-the-counter supplements and herbs.

Medication Name/Strength	Dose		Medication Name/Strength	Dose

Please list any past surgeries and hospitalizations and the approximate date.

Surgeries/Procedure/Hospitalization	Date	Reason	Complications

Last Name: _____ First Name: _____ DOB: _____

Patient's Medical and Social History (Continued)

Has the patient EVER had any of the following?

ADD/ADHD	☐ Yes ☐ No		Endocrinology/Growth disorder/problems	☐ Yes ☐ No
Allergies (seasonal)	☐ Yes ☐ No		Gastrointestinal (stomach/bowel/liver) problems	☐ Yes ☐ No
Anemia/Bleeding tendency	☐ Yes ☐ No		Genitourinary (Kidney & Bladder) disorder	☐ Yes ☐ No
Asthma/Breathing Problems	☐ Yes ☐ No		Immune Deficiency	☐ Yes ☐ No
Autism	☐ Yes ☐ No		Neurological (seizure or epilepsy)	☐ Yes ☐ No
Bed-wetting	☐ Yes ☐ No		Orthopedic problems (fractures, etc)	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		Psychiatric problems (depression, anxiety, etc)	☐ Yes ☐ No
Cardiovascular/Heart disorders/problems	☐ Yes ☐ No		Rheumatological (muscle, bones, joints, tendons, etc) disease/disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No		Thyroid disorder	☐ Yes ☐ No
Ears/Nose/Throat problems	☐ Yes ☐ No		OTHER:	☐ Yes ☐ No
Eczema/Skin disorder	☐ Yes ☐ No		OTHER:	☐ Yes ☐ No
Eye disorder/Vision Impairment	☐ Yes ☐ No		OTHER:	

Please list any other medical illnesses or problems not listed above and provide details for any of the above conditions: _____

_____

_____

For females only: Have you started menstruating? ☐ Yes ☐ No If yes, at what age did you start? _____

Social History

Please provide details of siblings and other individuals in the household:

Name	DOB	Gender	Relationship to Patient	Type (if sibling)	Lives with Patient (FT): Full-time, (PT) Part-time
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody
				☐ Biological ☐ Half-biological ☐ Step ☐ Adopted	☐ FT ☐ PT/Shared Custody

Custody/Household Status:

Parents/Guardians: ☐ Together ☐ Separated ☐ Divorced ☐ Never Married ☐ Other: _____

Custody arrangement: ☐ 50/50 shared custody ☐ Primary w/Mother ☐ Primary w/Father ☐ Other: _____

Does the patient regularly live in two households? ☐ Yes ☐ No

If yes, please list siblings/other children present in each household:

Household 1: _____ Household 2: _____

Please describe the patient's current living/custody arrangement, including all households in which the patient regularly resides: _____

_____

Exposure History

Does patient attend daycare? ☐ Yes ☐ No Does anyone who lives in same home as patient smoke? ☐ Yes ☐ No If yes, who? _____

Do you have any pets? ☐ Yes ☐ No If yes, how many? _____ What type(s)? _____

If guns in home: **Pecan Tree Pediatrics recommends that guns be locked up and kept separate from ammunition**

Pool/Bodies of Water: If your home has a pool or body of water nearby, is it/are they surrounded by a 4-sided fence or other precaution to keep your child safe from accidental drowning? ☐ Yes ☐ No ☐ We do not have a pool or body of water near our home. **Pecan Tree Pediatrics recommend that bodies of water near the home be surrounded by a 4-sided fence and direct supervision of children around these bodies of water/pool areas. **

Family Medical History

Please indicate any major conditions/illnesses that the patient's immediate family members have had.

M-mom, **D**-dad, **B**-brother, **S**-sister
MGM-mom's mom, **MGF**-mom's dad, **MA**-mom's sister, **MU**-mom's brother
PGM-dad's mom, **PGF**-dad's dad, **PA**-dad's sister, **PU**-dad's brother

	Family Member – Explain/Condition			Family Member – Explain/Condition
Alcohol/Drug Abuse/Addiction			Growth disorder	
Anemia/Bleeding tendency			Heart disease/disorder/defect	
Asthma/Breathing problems			High Blood Pressure	
Behavioral problems (ex: ADHD, ADD, ODD)			High Cholesterol	
Birth Defects			HIV/AIDS	
Blood disorder (other than anemia)			Kidney/Bladder disease/disorder	
Cancer			Lung disease (other than Asthma)	
Cystic Fibrosis			Migraines	
Dermatologic/Skin issues/disorder			Muscle or Orthopedic Issues – Bone Joint disease	
Developmental disorder (ex: Autism)			Neurologic Issues (other than seizure; ex: Cerebral Palsy)	
Diabetes			Psychiatric issues	
Ear disorders/Hearing Impairment			Rheumatologic issues	
Endocrinology			Seizure or Epilepsy	
Eye disorder/Vision Impairment			Thyroid disorder ☐ hypo- ☐ hyper- ☐ cancer	
Gastrointestinal/Bowel/Stomach disorder/problems			OTHER:	
Genetic disorder (specify)			OTHER:	

If there have been deaths in family members prior to age 50, please list family member relationship, age reason:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform the providers office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Parent or Legal Guardian Name (Print): _____ Relationship to Patient: _____

Parent or Legal Guardian Signature: _____ Date: _____

PECAN TREE PEDIATRICS

FINANCIAL POLICY

We are committed to providing your child(ren) with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

We will file primary insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD(REN)'S CHARGES.

1. Our office participates in a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card and photo I.D. *at every visit.*
   - Pay your Co-Payment and/or any deductibles *at each visit.*
   - Pay in full for any medical care or services that are not covered by your insurance plan.

2. If your child(ren) has insurance that we do not participate with, or your child(ren) does not have insurance, payment in full is expected at the time of service. Your child(ren) will be a "Private Pay" patient in our office. We offer a discount to "Private Pay" patients if the charges are paid at the time of service.

3. If your insurance plan is a HMO or POS policy, it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice prior to making any appointments to be seen with us. We will be unable to see your child(ren) until this change is made.

4. You are responsible for filing secondary insurance claims for federal and state sponsored health insurance carriers.

5. You are financially responsible for any amount not covered by your child(ren)'s plan.

6. You are financially responsible for all charges incurred in your child(ren)'s care and treatment.

7. If your check is returned for non-sufficient funds or any other reason, your account will be charged a *$25 Returned Check Fee*. If one check is returned to us for any reason, your account will be marked to not allow further payments to be made by check.

8. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.

9. In an effort to maintain our patients' accounts in good standing for outstanding balances that are greater than 90 days old, payments must be made to maintain account balances that are less than $100. If a large amount is due, then we may allow you to pay 10% of the balance if a payment plan for the remaining balance is agreed upon.

   If you fail to make payment for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.

10. To protect your child(ren)'s records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Family Information Form. We will scan your insurance card, ID, and Family Information Form, into your child(ren)'s electronic medical chart. We will check these documents prior to releasing your child's records.

11. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child(ren) 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(ren)'s account.

12. Payments may be requested by and returned to Pecan Tree Pediatrics, P.A.

ADVANCED BENEFICIARY NOTICE

We have developed a list of services that may **NOT** be covered by your insurance carrier, or the charges will be applied to your deductible. The purpose of this list is to help you make an informed choice about whether or not you choose for your child(ren) to receive certain services. The fact that your insurance carrier does not cover a service does not mean that you should not receive that service, it just means that you have a choice as to whether your child(ren) receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance carrier, you will be financially responsible for the balance on your account.

SERVICE	CPT CODE
Pure Tone Hearing Test	92551
OAE	92558
Visual Acuity Screen (vision test-chart)	99173
Auto Vision (machine with print out)	99177
Fluoride Treatment	99188
Spotfire Testing (Respiratory Panel) 3-5 panel/12-15 panel	87631/87633
Cepheid Xpress Testing (Combo – RSV, Flu, SARS-COVID or SARS-COVID)	87637/87635
Preventative Medicine Risk Management (Counseling for delayed vaccine schedule)	99401/99402
30 Month checkup (Established/New) (This is recommended by the AAP but may not be covered by all insurance plans)	99392 established/99382 new patient
*Well Checkups over the age of 18 years	99395 established/99385 new patient

***When being seen for a well child check over the age of 18 years, please call your insurance carrier and verify they will pay for services provided by a pediatrician.**

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to Pecan Tree Pediatrics, P.A. for any services furnished by my child(ren) by the practice. I also authorize you to release to my child(ren)'s insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child(ren). This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

WELL CHILD CHECKUP CHRONIC ISSUES or ACUTE ISSUES:

Please be advised that if your child is treated for an illness or injury, or there are changes in chronic illness management during a Well Child Check-up, we are required to bill an Encounter Code visit in conjunction with the well visit, per AMA guidelines.

It is the policy of this office that the provider will bill for an Encounter Code in conjunction with your child's Well Visit Code. Your insurance will process the Encounter Code according to your plan guidelines, applying copay, coinsurance, and/or deductible as applicable. If this happens, you will be responsible for any amount insurance deems your responsibility, and you will receive a bill for these additional services. Any copay applied by your insurance carrier for an acute illness or injury and changes to chronic management during a well-child check will be billed to you on your next statement.

Self-pay patients will be charged an additional $50 for acute illness or injury and changes to chronic management during a Well Child Check-up; this amount will be billed to the guarantor.

LATE ARRIVALS / NO SHOW POLICY

Appointments are scheduled specifically for each patient. Please arrive 15 minutes prior to your scheduled appointment for the completion of any paperwork or account issues that could cause a delay for check-in. If you arrive late for your appointment or arrive without the pre-registration process being completed, you may be asked to reschedule it for another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child(ren) from the practice.

EACH WELL VISIT AND/OR ADHD EVALUATION APPOINTMENT THAT IS MISSED AND NOT CANCELLED PRIOR TO 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME WILL BE ASSESSED A $50 FEE TO THE PATIENT'S ACCOUNT.

EACH SICK VISIT THAT IS MISSED: "NO SHOW" WILL BE ASSESSED & A $25 FEE TO THE PATIENT'S ACCOUNT.

Signature of Understanding: I have read and understand the above-stated financial policy.

_____ _____

Patient or Parent/Guardian if Patient(s) is under 18 years of age Date

For questions regarding your Pecan Tree Pediatrics, P.A. account, please contact one of our Billing Specialists, at 972-772-3100 or 972-429-4800.

PECAN TREE PEDIATRICS

PRIVACY PRACTICE POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

Adhere to the standards set forth in the Notice of Privacy Practices.

Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose PHI to remind patients of their appointments unless they instruct us not to.

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.

Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--

- Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.

All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

PECAN TREE PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me with a more complete description of the uses and disclosures of certain health information. I understand Pecan Tree Pediatrics reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling the office or requesting a copy in person at *my* appointment.

Patient's Printed Name _____ Date of Birth _____

Patient/Legal Representative Signature _____ Date _____

Relationship to Patient _____

Witness _____ Date _____

CONSENT FOR AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize employees and agents of Pecan Tree Pediatrics (including physicians and other staff members) to administer such care and treatment as is medically necessary and as is set forth in the development plan of treatment.

I also authorize Pecan Tree Pediatrics to release any medical information acquired in the course of *my* examination or treatment, to any facility (including other physicians, laboratory, hospital or ancillary providers) to which I may need to be referred.

I further authorize Pecan Tree Pediatrics to release any medical information determined in the course of *my* examination or treatment required to process medical claims, to my insurance carrier.

I, _____, give permission for:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Authorization to bring my child _____, for his/her appointments and obtain any information and/or prescriptions that may be needed for recommended care.

In case of an emergency, I can be reached at: _____

Signature of Patient/Legal Representative _____ Date _____

IF THE PATIENT REFUSES TO SIGN THIS ACKNOWLEDGEMENT, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

Patient refused to sign this acknowledgement.

Employee Printed Name: _____

Employee Signature: _____ Date/Time: _____

PECAN TREE PEDIATRICS

EMAIL/VOICEMAIL CONSENT
AUTHORIZATION TO LEAVE A VOICEMAIL and/or SEND AN EMAIL with PROTECTED HEALTH INFORAMTION (PHI)

Print Patient Name: _____**Chart #**: _____

The HIPAA Privacy Rule permits Pecan Tree Pediatrics (PTP) providers and staff to communicate with parents/guardians regarding their child's health care. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the Rule does not prohibit PTP providers and staff from leaving/sending messages for patients on their voicemails/emails.

Messages that contain protected health information (PHI) require the parent/guardian to sign an authorization form to receive messages by voicemail/email. For example, messages that contain PHI would be test results, medication information, payment information, and treatment plans.

The goal of this authorization is to decrease the call volume and delay in communication between patients, staff and providers. However, to reasonably safeguard patient privacy, PTP providers and staff may limit the amount of information disclosed on the message.

This authorization is in effect until cancelled in writing.

I understand my HIPAA rights and I request that Pecan Tree Pediatrics leave messages, including those containing PHI, for me by voicemail/email at the number/email noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information. This authorization is in effect until cancelled in writing.

Voicemail Messages - □ Decline □ Approve
My preferred phone number is: _____ Initial _____

Email Messages - □ Decline □ Approve
My preferred email is: _____ Initial _____

Parent/Guardian Name (Print): _____ **Date**:_____

Signature: _____ **Relationship to Patient**: _____

201 I-30 East
Suite 100
Rockwall TX 75087
972-772-3100

2300 W FM 544
Suite 245
Wylie TX 75098
972-429-4800

6301 Gaston Ave
Suite 750
Dallas TX 75214
214-214-3100

FAX 469-757-4890 (All Locations)

PECAN TREE PEDIATRICS

OFFICE PRACTICUM PATIENT PORTAL CONSENT AUTHORIZATION

Parent/Guardian Name: _____ Date: _____

Street Address: _____ City: _____ Zip code: _____

Email: _____ Cell Phone: _____

The Pecan Tree Pediatrics "Patient Portal" is a secure, confidential, easy to use website. It is administered and maintained by Office Practicum on behalf of Pecan Tree Pediatrics. Secure messages and information can only be viewed by someone entering the correct username and password to log into the Patient Portal site. I am requesting portal access for the following children:

1) Patient Name: _____

   Patient DOB: _____ Relationship to Patient: _____

(PTP Employee) Updated: (Print Name)_____ (Initial) _____ Date: _____ Chart#_____

2) Patient Name: _____

   Patient DOB: _____ Relationship to Patient: _____

(PTP Employee) Updated: (Print Name)_____ (Initial) _____ Date: _____ Chart#_____

3) Patient Name: _____

   Patient DOB: _____ Relationship to Patient: _____

(PTP Employee) Updated: (Print Name)_____ (Initial) _____ Date: _____ Chart#_____

4) Patient Name: _____

   Patient DOB: _____ Relationship to Patient: _____

(PTP Employee) Updated: (Print Name)_____ (Initial) _____ Date: _____ Chart#_____

Acknowledgement and Consent:

- I have provided an email address that belongs to me and is not shared by anyone else. I understand that Pecan Tree Pediatrics Portal will communicate with me through the email address used to create my login credentials and that Pecan Tree Pediatrics is not responsible for lost emails. I understand it is my responsibility to notify Pecan Tree Pediatrics of any changes to my email address.
- I consent to receive information, notifications, and other correspondence electronically to the email address I provided. Such correspondence may contain Personal Health and Information, billing information and other personally identifiable information. I accept all risks associated with the transmission of such information via those channels.
- I understand it is my responsibility to notify Pecan Tree Pediatrics of any changes to my information.

By signing below, I understand that I will be provided with registration information via email, and I consent to use the online portal in the manner prescribed.

Parent/Guardian Signature _____ Date _____

PECAN TREE PEDIATRICS

AUTHORIZATION FOR **RELEASE** OF **INCOMING** MEDICAL INFORMATION

I hereby authorize Pecan Tree Pediatrics to obtain my individually identifiable health information as authorized below. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that I may revoke this authorization at any time by notifying, in writing, Pecan Tree Pediatrics facility where this authorization is being signed and approved. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

Patient Name	Last 4 of Social Security Number	Date of Birth MM / DD YYYY	Chart # (Completed by Pecan Tree Staff)
Street Address City, State, Zip		Telephone Number	

Please release medical information for treatment dates: □ ALL Dates OR □ Specific Date Range: _____

I authorize release of information *from*:

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: □ Continued Care □ Legal □ Insurance □ Personal Use □ Other _____

Information to be released:

□ **COMPLETE Patient Chart** or Specific Information Only (please select below)

□ Well Child Summary □ Sick Encounter Summary □ Immunization Records

□ Diagnostic Results □ Growth Charts □ Phone Messages

□ Other: _____

Protected or Sensitive Information:

I understand that certain information cannot be released without specific authorization as required by law.
By initialing, I authorize release of the following protected information:

____Mental Health Information:
____Drug Abuse/Alcoholism Information
____AIDS/HIV Test results- including high risk behavior
____Other sexual information such as dysfunction or related diseases
____*Not Applicable*

The information will be **RELEASED TO:** ***Pecan Tree Pediatrics***

All Locations - ***Email:*** ***records@ptpeds.com*** *OR* ***Fax: 469-757-4890***

MAIL ALL RECORDS TO ROCKWALL LOCATION

Lakewood	***Rockwall***	***Wylie***
6301 Gaston Avenue, Suite 750	*201 I-30 East, Suite 100*	*2300 W FM 544, Suite 245*
Dallas, Texas 75214	*Rockwall, Texas 75087*	*Wylie, Texas 75098*
(214) 214-3100	*(972) 772-3100*	*(972) 429-4800*

By entering my name below, I certify that this information can be used for the purpose of processing my/my child's Authorization for Release of Information request. I consider this as my authorization signature for this request.

_____ _____
Signature of Patient/Legal Guardian/Representative Date

_____ _____ _____
Printed Name of Patient/Legal Guardian/Representative Relationship to Patient Valid Government ID # (DL, passport, etc)

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 Sex: ☐ 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 02/2026