

Elias Ezike, MD, PA

87 Interstate 10 N, Suite 221 • Beaumont, TX 77707 • (409) 838-9944

Patient Information

Appointment Date: _____

Patient's Name: _____ Male Female

Patient's Date of Birth: _____

Mailing Address: _____

City/State/Zip: _____

Home Phone: () _____ Cell: () _____ Email: _____

Father/Guardian: _____ Phone: _____ DOB: _____

S.S.# _____

Employer _____ Work Phone: () _____

Mother/Guardian: _____ Phone: _____ DOB: _____

S.S.#: _____

Employer _____ Work Phone: () _____

Child's Previous Doctor: _____

Preferred Pharmacy: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino Undetermined Race: _____

Language: English Spanish Other _____

Primary Insurance

Insurance Company: _____ Policy# _____ Group# _____

Insured Name: _____ Insured DOB: _____

Address: _____ City/State/Zip _____

Phone: () _____ Relation to Patient: _____ Insured S.S.# _____

Insured Employer: _____ Employer Address: _____

Secondary Insurance

Insurance Company: _____ Policy# _____ Group# _____

Insured Name: (if different) _____ Insured DOB: _____

Address: _____ City/State/Zip _____

Phone: () _____ Relation to Patient: _____ Insured S.S.# _____

Insured Employer: _____ Employer Address: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: () _____ Cell: () _____ Work: () _____

Referred By: _____

Assignment of Benefits/Consent for Treatment

I hereby agree to pay in full for medical services unless contractually or statutorily prohibited. I am aware that I will be financially responsible for any charges not paid by my insurer, employer or other third party. I also agree that any payment due from me will be made at the time services are rendered or promptly upon billing. We aspire to deliver the best medical care to every client but no guarantee is made as to the outcome of treatments or testing.

I authorize Elias Ezike, MD PA to release to my insurance companies all medical and confidential information necessary to process my insurance claims.

Parent/Patient Signature

Date

PATIENT NAME: _____ **DATE:** ____/____/____

MEDICAL HISTORY:

Birth Weight: _____ Length: _____ Hospital: _____

Problems during pregnancy/labor/delivery: _____

Problems as newborn: _____

Development:

Normal: _____ Delayed: _____

Held head up: _____ Sat up: _____ Crawl: _____ Walk: _____ Say words: _____

Potty train: _____ Ride Bike: _____

Accidents/Illness: _____

Surgery/Broken bones: _____

Hospitalization: _____

Drug Allergy: _____

Other Allergies: _____

Medications your child is on: _____

Past Medical History:

Family History: If Yes, List how related to the child.

Cancer Yes No _____

Heart Problems Yes No _____

Diabetes Yes No _____

Inherited Anemia Yes No _____

Other Yes No _____

Please circle the following if you feel a problem exists and then explain:

Head - Chronic nasal problems - Hearing - Ear Infections - Vision - Teeth - Headaches - Sore Throats
Other _____

Lungs - Cough - Wheezing - Chest Pain - Numerous Infections

Heart - Chest Pain - Rapid Heart Beat - Heart Murmurs

Genital/Urinary - Problems w/urine - Blood - Problems w/stream Urine - Infections - Pain
Unusual lump in genital area

Abdomen - Pain - Chronic Vomiting - Constipation Diarrhea - Blood in Stool - Food Intolerance
Other _____

Skin - Chronic Rash - Unusual Moles - Birth Marks

Explain circled problems: _____

Are immunizations up to date: Yes No

Previous reactions to vaccines: _____

Other problems not listed above: _____

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Beaumont, TX 77707. (409)838-9944

POLICY

No show and Cancellation Policy: It is important that you keep your appointment. If for any reason you could not keep your appointment, call at least 2 hours ahead of time to reschedule. We try to call one day before your appointment as a courtesy, however, you are responsible for keeping your appointment even if we cannot reach you. If NO SHOW FOR 3 APPOINTMENTS in a year, a warning letter will be sent. Any subsequent NO SHOW within one year of receiving a warning letter will be followed by a dismissal letter.

The office sees patients between the **ages of 0-21years** provided the **patient does not have a child of his/her own and is not pregnant.**

Immunization Policy: Our office does not accept families who are unwilling to vaccinate their children because we strongly believe in the importance of immunization as one of the most high quality preventive medicine. Families who have question on immunization can discuss their concern with the physician at the visit.

Prescription Refill Policy: Refills cannot be obtained after hours or on the weekends as the Doctor on call may not have access to your medical record.

Late Arrival Policy: Clients arriving more than 20 minutes late to their appointment time will be asked to reschedule to any available appointment.

Early Arrival Policy: If you arrive earlier for your appointment, you still have to respect your appointment time.

Change of Contact/ Insurance Information: You are encouraged to inform our office of any change of address, phone number or insurance so that we can update your profile.

Conduct: Because ours is a pediatric office, we aspire to show good example to the children. Use of inappropriate language may result to dismissal.

Patient's Name

Date

Parent/Patient/Guardian Signature

Name of Parent/Guardian

HIPAA Notice of Privacy Practices

[Name of Practice]

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Elias Ezike MD - Pediatrics
87 Interstate 10 N, Suite 221
Beaumont, TX 77707
Fax 409-838-9086
409-838-9944

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____
Patient Parent/Guardian

Elias Ezike, MD, PA

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize _____
Name of Facility/Physician Phone Number Fax Number

to release medical information from the records of:

Patient Name: _____ D.O.B.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to be released:

- All Available Pertinent Information
- Records
- Consultation Records
- Immunization Record
- Radiology Reports
- Progress Notes
- Other _____

Purpose of Release (Please check appropriate box)

- Change of Primary Care Physician/Clinic
- Other (Specify) _____

Please initial below to include the following:

- _____ Alcohol/Drug Treatment
- _____ HIV Related Information
- _____ Mental Health Information
- _____ Genetic Testing

Information to be released to:

Recipient's Name: Dr. Elias Ezike

Street Address: 87 Interstate 10 N, Suite 221

City: Beaumont State: TX Zip Code: 77707

Phone Number: (409) 838-9944 Fax Number: (409) 838-9086

Conditions of Authorization:

I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization and that in any event this consent expires as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure to a third party such as the treating physician or insurance.

This authorization expires on: _____ or on the following event: _____
(If I fail to specify an expiration date or event, this authorization will expire 1 year from the date signed)

Signature of Parent/Patient/Legal Responsible Person

Date

Printed Name of Parent/Legal Responsible Person

Relationship

Phone Number

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Authorization - Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances. However, we must have written authorization allowing this person to accompany your child(ren). The person bringing your child(ren) will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, vaccinations, medication, certain procedures, and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child(ren) to Elias Ezike, MD, PA and to discuss and share medical information about my child(ren). I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of Elias Ezike, MD, PA.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

Name of Person (allowed to bring child) Relationship

Name of Person (allowed to bring child) Relationship

Name of Person (allowed to bring child) Relationship

Signature (Parent/Guardian) **Date**



Texas Immunization Registry (ImmTrac2)
Minor Consent Form



First Name Middle Name Last Name

Date of Birth (mm/dd/yyyy) Child's Sex: Male Female Telephone Email address

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 immunization records.

Consent for Registration of Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2. Once in ImmTrac2, my 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;

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.

Please mark the box below to indicate whether you are an immediate family member of a first responder.
I am 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 information in the Texas Immunization Registry. Individual (or individual's legally authorized representative):

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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Consent to Receive Text Message for Appointment Reminders

Patient(s) Name: _____

Patient's Date of Birth: _____

Parent/Guardian's Name (PRINT): _____

Our practice may be sending you text message to remind you of your appointment. However, the responsibility of keeping, and cancelling your appointment relies on you.

I hereby give my consent to Elias Ezike, MD, PA to send text message to my cell phone to remind me of my appointment. I understand that text message charges from my cell phone provider may apply.

Accept text messaging

Not Accept text messaging

Parent/ Guardian Cell Phone: (____) _____

Signature: _____ Today's date _____

I will keep the practice informed if there are any changes in my cell phone number to continue to receive text message for my appointment.

Appointment reminder by text message cannot be sent to you if you do not sign this form.

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Patient Financial Policy

Accepted Forms of Payment: Cash, Check, Visa, Discover, Mastercard, American Express, or Money Order.

Insurance: A current insurance card must be presented at every appointment. Claims are filed to all insurance companies we are contracted with. Your insurance policy is a contract between you and your insurance company. **You should be familiar with your insurance benefit as you are responsible for any non-covered charges.**

Assignment of Benefits: I hereby authorize my insurance benefits be paid directly to Elias Ezike, MD, PA and that I am responsible to pay all non-covered services and I hereby authorize release of pertinent medical information to insurance carriers and/or specialist referred by the physician.

Copayments: Copayments are due at the time of service by the person bringing the child to the office. **Copayment agreement is between you and your insurance company.**

Self-Pay: This means that the patient does not have insurance. Payment for all charges is expected at the time of service.

Returned Check: \$25.00 fee will be charged for a returned check due to insufficient funds in addition to the original bill.

Medical Record Copies: Fees are charged for copies of medical records. Please contact our office for current fee. There is no charge if records are sent directly to another physician's office.

I have read and understood Elias Ezike, MD, PA financial policy and agree to the terms and that the terms may be amended at any time by Elias Ezike, MD, PA.

Signature of Responsible Party /Guardian

Date

Name of Responsible Party/Guardian _____

Patient's Name _____