



LIVINGSTON/CLEVELAND PEDIATRICS

• Marlo Brawner, MD, FAAP*

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex: _____ Preferred Name: _____

Child's Address: _____
CITY STATE ZIP

Home Phone #: _____ Cell Phone #: _____

Primary Contact Number: HOME CELL Best time to call: Morning Afternoon

Parent's E-mail: _____

Who does child live with: () Mom Only () Dad Only () Parents () Relative () Legal Guardian () Other: _____

Patient's Primary Language: English Spanish Other: _____

Parent/Legal Guardian's Primary Language: English Spanish Other: _____

Does the parent/legal guardian require an interpreter? Yes No

GUARANTOR INFORMATION: (Person responsible for any bill)

Full Name (Last, First, Middle): _____

Relationship to Patient: _____ Emancipated Minor? YES NO

Street Address (if different than Patient's): _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State Issued: _____ Exp. Date: _____

Employer Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Work #: _____ Cell #: _____ Home #: _____

400 Ogletree Drive
Livingston, Texas 77351
#936-328-8812

Fax: 936-328-8815

203 N. College, Suite 1001
Cleveland, Texas 77327
#281-592-6000

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OTHER CHILDREN IN THE FAMILY THAT LIVE WITH THE PATIENT:

1. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
2. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
3. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
4. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
5. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO

ADDITIONAL ACCOUNT ACCESS AND/OR EMERGENCY CONTACTS:

Please list any person(s) who may bring the patient to their appointments or have access to the patient's health information.

1. Father's Name: _____ Phone #: _____
2. Mother's Name: _____ Phone #: _____
3. Legal Guardian's Name: _____ Phone #: _____
** LEGAL PAPERWORK NEEDED **
4. Legal Guardian's Name: _____ Phone #: _____
** LEGAL PAPERWORK NEEDED **
5. Authorized Name: _____ Phone #: _____
Relationship: _____
6. Authorized Name: _____ Phone #: _____
Relationship: _____

The individuals listed above are over 18 years of age and have my permission to seek and obtain medical care and discuss treatment of my child with Livingston/Cleveland pediatrics clinic and its employee's. This request may be revoked and/or changed at any time in writing, and expires one year from day of completion, whichever comes first. Written notification of the change must be given within 30 days of the effective date. No information will be released regarding your child via phone or at the clinic, if the individual is not listed on the authorization form. Unless court documents are on file with our clinic showing a revocation of mom's or dad's rights, they are automatically authorized by state law.

Any changes to this authorization must be received in writing within 30 days of effective date.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

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Consents & Policies

I have the legal right to consent to medical and/or surgical treatment because (a) I am the patient or (b) I am the parent/legal guardian of the patient.

All references to “patient,” “me” and “my” in this document is referring to _____

FULL NAME OF PATIENT (FIRST AND LAST NAME)

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Livingston/Cleveland Pediatrics and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurse practitioners, physician assistants, nurses and other health care providers in this medical office to provide treatment as long a physician/patient relationship exists, or until I withdraw my consent.

Sharing Records for Treatment

We may share medical records by mail, fax, portal or email with other health care providers to allow and promote continuity of care among providers. I hereby authorize Livingston/Cleveland Pediatrics to obtain and/or relate any medical information including, but not limited to, HIV test results, and financial information requested by a representative of local, state or federal agencies, insurance companies, legal guardian/parent, and/or organization or entities as may be required for payment of claim and treatment of patient. Any change in this authorization must be received in writing within 30 days of the effective date. Verification of release will be confirmed prior to releasing confidential information.

Voicemail, Text and Email Notifications

As a service to our patients, Livingston/Cleveland Pediatrics provides courtesy appointment reminders and other important calls and notifications. The information may include protected health information. By signing below, you consent to receiving such information by call including voicemail or text and or email. It is YOUR responsibility to keep us updated if you contact information changes.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize Livingston/Cleveland Pediatrics to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medication dispense history as long a physician/patient relationship exists, or until I withdraw my consent. I voluntarily authorize Livingston/Cleveland Pediatrics providers and staff to obtain my pharmacy history by phone, written or electronically.

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Livingston/Cleveland Pediatrics Notice of Privacy Practices (“Notice”). The Notice explains how Livingston/Cleveland Pediatrics may use and disclose the patient’s protected health information for treatment, payment and health care operations purpose. “Protected health information” means the patient’s personal health information found in the patient’s medical and billing records. *If you have questions about the Notice, please contact Livingston/Cleveland Pediatrics Privacy Officer.*

Unaccompanied Minors

Minors must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance for self. Please note that co-payments and/or deductibles are expected at the time of service.

Regarding Divorce

Livingston/Cleveland Pediatrics does not get involved in disputes between divorced parents regarding financial responsibility for their child’s medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

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Regarding Insurance

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require detailed descriptions of services, please have them request in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductible, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or “reasonable and customary” charges other than to supply the information as necessary. You are responsible for timely payment of your account. In the event my insurance company deems a service to be “non-covered,” I understand that I am personally responsible for payment. I agree to the release of all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release.

Contracted Managed Care Plans (HMO, PPO, POS, EPO)

Each time you make an appointment with a Livingston/Cleveland Pediatrics physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current insurance card at each visit. Verification of your benefits is not a guarantee of payment.

Referrals

It is your responsibility to keep track of expiration dates and for giving us, your PCP a minimum of 48-hours’ notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans; therefore, if a referral is not obtained from your PCP, you may be held responsible for payment in full by the specialist.

No-Show Policy

I understand that this practice has a no-show policy as follows:

- 1st no show: verbal reminder in person/over the phone. We send a letter to your insurance company.
- 2nd no show: verbal reminder in person/over the phone. We send you a letter. We also send a letter to your insurance company.
- 3rd no show: verbal reminder in person/over the phone. We send a letter to your insurance company. Your chart is sent to management for review, and you may be discharged from the clinic.

Any changes to this authorization must be received in writing within 30 days of effective date.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

Patient’s Name: _____ Patient’s Date of Birth: _____

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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices: You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition.
- Provide disaster relief.
- Include you in a hospital directory.
- Provide mental health care.
- Market our services and sell your information.
- Raise funds.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions.

Your Rights When it comes to your health information, you have certain rights. **This section explains your rights and some of our responsibilities to help you.**

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

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Ask us to limit what we use or share:

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we have shared information:

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices For certain health information, you can tell us your choices about what we share. **If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.**

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

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In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you:

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Do research We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Written Acknowledgment of Receipt of Livingston/Cleveland Pediatrics Integrated Delivery System Notice of Privacy Practices

By signing below, you acknowledge receiving (upon request) the Livingston/Cleveland Pediatrics Integrated Delivery System Notice (LPCPA IDS) of Privacy Practices (Notice.) This Notice explains how the LPCPA IDS may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

LPCPA IDS reserves the right to change the Notice at any time. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout each location and on our website at www.livpeds.com. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you check-in or out at Livingston/Cleveland Pediatrics for treatment, Livingston/Cleveland Pediatrics will have available for you, upon request, a copy of the current Notice in effect.

Your signature below only acknowledges that upon request, you received a copy of this Notice.

If you have any questions about this Notice, please contact the Livingston/Cleveland Pediatrics Privacy Officer, Julie Lairmore at extension 301, or speak to an employee today for additional contact information.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

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

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TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC) PATIENT ELIGIBILITY SCREENING RECORD

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed; if patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Today's Date: _____

Pt Acct #: _____

Child's Name: _____

Last Name

First Name

MI

Child's Date of Birth: _____ **Age:** _____

mm/dd/year

Parent/Guardian/Individual of Record: _____

Last Name

First Name

MI

Provider's/Clinic's Name: LIVINGSTON/CLEVELAND PEDIATRICS

Please check the first category that applies; check only one.

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance (uninsured), or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- ☐ (f) is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) Insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

- ☐ (g) has private insurance that covers vaccines (not TVFC eligible)

Signature: _____

Date: _____

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.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Texas Department of State Health Services Stock No. C-10
Immunization Branch Revised 12/20

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