Patricia Azarcon-Samonte, M.D.
Leslie Cortes, M.D.
Roberta Durk-Gomez, CPNP-PC

INSURANCE INFORMATION

Primary Insurance Name: ______________________________

Policy Holder Name: ______________________________ Date of Birth: ______________

Policy Holder's Relationship to Patient: ______________

Secondary Insurance Name: ______________________________

Policy Holder Name: ______________________________ Date of Birth: ______________

Policy Holder's Relationship to Patient: ______________

AUTHORIZATION

I authorize that payment be made to Children's Clinic of El Paso and I authorize release of any information necessary to process claims for services rendered to my child. I authorize Children's Clinic of El Paso, as a holder of medical or other information about my child, to release to insurance companies, health plans, agencies or representatives of any companies handling my child's claims, any information needed for this or any other claim for services obtained from Children's Clinic of El Paso.

PRIVACY NOTICE

I have received a copy of the Notice of Privacy Practices for Children's Clinic of El Paso.

By the signature below, I have read, understand and agree to the Consent/Authorization, Financial Policy, Insurance Policy, and Privacy Notice for Children's Clinic of El Paso.

______________________________ ______________

Guarantor/Parent/Legal Guardian Signature Date

____

Guarantor/Parent/Legal Guardian Name (Please Print)

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NEW PATIENT INFORMATION

PREFERRED LANGUAGE: ENGLISH / SPANISH / OTHER

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ____________

Mailing Address: ______________________________

Gender: M or F

PARENT OR GUARDIAN INFORMATION

Name: ______________________________ Date of Birth: ____________ SS# ____________

Cell Phone: ______________ Home Phone: ______________

Mailing Address: ______________________________

Relationship to Child (check one) MOTHER ____ FATHER ____ LEGAL GUARDIAN ____

OTHER PARENT OR GUARDIAN INFORMATION

Name: ______________________________ Date of Birth: ____________ SS# ____________

Cell Phone: ______________ Home Phone: ______________

Mailing Address: ______________________________

Relationship to Child (check one) MOTHER ____ FATHER ____ LEGAL GUARDIAN ____

If patient is in the care of someone other than a biological parent, please provide legal documentation of guardianship / legal custody

EMERGENCY CONTACT – Outside of the Home

Name: ______________________________ Relationship to Child: ______________

Address: ______________________________ Phone Number: ______________

Name: ______________________________ Relationship to Child: ______________

~~Address:~~ ______________________________ ~~Phone Number:~~ ______________

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INITIAL MEDICAL HISTORY

Name of Patient: ______________________________

Date of Birth: ________________ Gender: M ___ F ___ Date: ____________

Form completed by: ____________________ Relationship: ________________

FAMILY HISTORY: (Please list all family members living in the patient's house)

Name	Relationship	DOB	Health Problems

PARENTS: Married [ ] Divorced [ ] Separated [ ] Single [ ]

If separated / divorced, who has custody of the patient ? ______________________

Are there any siblings living away from home Yes [ ] No [ ]

If yes, please give name, age and where they live:

	No	Yes	Comments
Does your child go to daycare ?			Where :
Does your child go to school ?			Where :
Does anyone in your family smoke ?			Where : Inside/Outside/Both
Does your family have any pets ?			Type:
Does your family wear seatbelts / carseats ?			
Does your family have well water ?			

BIRTH HISTORY:

What hospital was your child born in ? ______________________________

Was your child born Early [ ] Term [ ] Late [ ]

If early how many weeks gestation ? ______________

Was your child born by Cesarean ? _______ If yes, why? ____________________

Did your child have any problems after birth ? _____ If yes, what ? ____________________

Did mom have any complications with pregnancy ? ______ If yes, what ? ____________________

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Patient Name: ____________________

PAST MEDICAL HISTORY

	No	Yes	If Yes, Please Comment
Is your child allergic to any medications ?			
Has your child ever been hospitalized ?			
Has your child had any surgery ?			
Does your child have any developmental problems ?			
Does your child have any serious medical conditions or chronic issues ?			
Has your child had any serious accidents or injuries ?			
Is your child behind on vaccines ?			
Is your child on any medications ? (over the counter or presciption)			

FAMILY HISTORY (Any parents, siblings, grandparents, aunts, uncles who have the following)

	Yes	No	Relationship			Yes	No	Relationship
Allergies					Eye Problems			
Asthma					Hearing Problems			
Heart Disease					Mental Illness			
High Cholesterol					Seizure Disorder			
Diabetes					Cancer			
Thyroid Disease					Birth Defects			
Anemia					Tuberculosis			
Kidney Disease					Drug / Alcohol Abuse			
Liver Disease					Bleeding Disorders			
Immune Problems					Eczema			
Gastrointestinal								

REVIEW OF SYSTEMS (Does your child had or has any of the following problems or concern)

	Yes	No	Comment if Yes			Yes	No	Comment if Yes
Asthma, Wheezing					Skin Problems			
Anemia					Seizures			
Vision / Eye Problems					Frequent Headaches			
Ear Infections					Diabetes			
Nasal Problems					Thyroid Problems			
Heart Murmurs					Bleeding Disorder			
Liver Problems					Chicken Pox			
High Blood Pressure					Developmental issues			
Pneumonia					Attention problems			
Abdominal Pain					Sleep issues			
Constipation					Allergies			
Joint pain or swelling					Menstrual problems			
Broken bones					Drug or Alcohol use			
Bladde Problems					Frequent strep throat			
Hearing Problems					Bedwetting/Soiling			
Other					Other			
Other					Other			

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To whom it may concern,

I am the legal parent and/or guardian of ______________________________, date of birth______________, a patient under the care of *Children's Clinic of El Paso, P.A.*

In the event I am unable to accompany ______________________ to *Children's Clinic of El Paso*, I authorize the following person(s) to serve as my representative(s) and bring my child to the office for treatment. I authorize *Children's Clinic of El Paso*, its physicians and staff, to provide medical information to the following person(s) pertinent to my child's immediate care as if I was personally present. I understand that each person designated may be required to provide copy of a photo ID.

______________________________	____________________
Name	Relationship
______________________________	____________________
Name	Relationship
______________________________	____________________
Name	Relationship
______________________________	____________________
Name	Relationship

______________________________	____________________
Parent or Guardian	Date
______________________________	____________________
Witness	Date

11544 Vista Del Sol, El Paso, Texas 79936 915-592-2600
[illegible]

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GENERAL CONSENT TO TREAT

I am the parent/guardian of ______________________________ . I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that *Children's Clinic of El Paso, P.A.* and their designated associates or assistants believe are necessary for this child.

I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

______________________________ ______________

Patient Name Date of birth

____

Parent Name

______________________________ ______________

Signature Date

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FINANCIAL POLICY

Patient Name ________________________________ **Date of Birth** ____________________

Children's Clinic of El Paso would like to take this opportunity to welcome new members to our practice and thank our returning patients. To avoid confusion regarding our current billing policy, please review the following and sign below. A copy will be provided for your records upon request.

1. Co-payments are due prior to being seen by the physician or the nurse. If you are unable to pay your copay at the time of service, you must make arrangements with the practice administrator before your appointment. A service fee for not paying your copay at the time of service may apply.
2. **If your child is seen for a wellness visit and also treated for a medical condition, your insurance carrier may process the visit with a copayment or coinsurance, for which you will be responsible.**
3. If you do not have insurance or are under-insured, or are subject to a deductible, payment is due at the time of service.
4. Private paying patients are eligible for a discount only if payment is made at the time of service. Please ask the front desk person for details.
5. We accept Cash, Visa and Mastercard for your convenience.
6. All payment arrangements must be made with the practice administrator prior to your child being seen. If payment arrangements are allowed, it is your responsibility to submit payment within 30 days, whether or not you receive a statement.
7. You may only be sent three statements before we begin collection proceedings. All accounts sent to an outside agency for collections will be assessed up to a 35% collection fee and any applied discounts will be added back to your account.
8. We will verify coverage through your insurance company's website or by telephone. If computer and/or phone systems are down and we are unable to confirm coverage, or if your child is not eligible, you will be responsible for full payment at the time of service.
9. Whoever brings your child to the office is responsible for payment. This includes grandparents, babysitters and other caretakers. Please complete the Consent to Treat form specifically naming anyone other than a parent authorized to accompany your child to our office and giving us permission to release your child's medical information to this person.
10. No one under age 18 will be treated without a parent present.
11. **Be aware of your insurance coverage!** We do our best to verify coverage and benefits before your child is seen but this is not a guarantee of coverage. You need to know if you have a deductible or coinsurance, if you have well child coverage, if you need referrals, if a doctor is an in-network physician, etc. Call your insurance carrier if you have questions.
12. ~~**Please bring your child's current insurance card and/or current Medicaid card to every visit.**~~
Please make sure that Patricia Azarcon-Samonte, M.D. is your primary care provider.

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13. Insurance information should be provided at the time of service. If updated insurance information is not provided to our office within the timely filling limit of your insurance policy, the balance will become the patient's responsibility. Please be advised – timely filing may be as little as 60 days.
14. We file your insurance as a courtesy. If payment is not received from your insurance company within 60 days, the balance is your responsibility.
15. If you are sent to a specialist and your insurance requires a referral, please contact the front office once you have the appointment scheduled. We need to know the appointment date and time to complete the referral. Most insurance require at least 48 hours notice for referral. Please do not wait to contact us the day of your child's appointment.
16. We do not give credit card refunds. We will gladly credit your account.

We appreciate your cooperation. Please let us know if you have any questions or need assistance with your child's insurance and/or account.

I accept financial responsibility for the above named child and acknowledge that by signing below, I have read and understand this billing policy. Upon request, a copy of this policy has been provided for my records.

______________________________ ______________________
Parent's Signature Date

11544 Vista Del Sol, El Paso, Texas 79936 915-592-2600
1700 N. Oregon, Ste 700, El Paso, Texas

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TEXT MESSAGE CONSENT FORM

Children's Clinic of El Paso is in the process of offering Text Message notifications for appointment reminders and other patient care related information. If you wish to have the opportunity to receive information of this type, please provide us with your text messaging number below. This service should not be solely relied upon, as the responsibility of attending and canceling appointments still rests with you, but we hope this will make things easier.

We will start utilizing this system once we have enough consents from our patients' parents/guardians. Standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Texts are generated using a secure facility, however they are transmitted over a public network unto a personal device that may not be secure. We will not transmit any information that would enable an individual patient to be identified.

______ I CONSENT to the practice contacting me by text.

______ I DO NOT CONSENT to the practice contacting me by text.

Patient Name: ______________________________

Date of Birth: ______________________

Mobile Number: ______________________

Signature: ____________________________________

Date: ___________________________

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"NO SHOW" Policy

Patient Name: ______________________________ Date of Birth: __________

Children's Clinic of El Paso is dedicated to providing excellent patient care. Appointments that are missed hinder our ability to provide the highest quality of care possible.

If a patient is unable to keep an appointment, they are asked to contact the office 24 hours prior to the appointment time. If an appointment is not kept, or not cancelled it will be considered a "NO SHOW".

- After the 3 "NO SHOW" appointments the parent or guardian has two choices:

    1. Pay a $20.00 missed appointment fee. Every missed appointment after that will be charged an additional $20.00 missed appointment fee.

    2. Or the parent or guardian and all patients on the account will be dismissed from the practice and required to find another pediatrician. If the parent or guardian chooses to be dismissed there will be no charge.

- If the parent or guardian choose to leave our practice and a patient's insurance carrier or Medicaid has assigned the patient to our office, the insurance carrier or Medicaid will be contacted to have the patient reassigned to another primary care physician's office.

As a courtesy, our office will attempt to contact the parent of their child's appointment the day prior. However, if we are unable to make contact, it is still the obligation of the parent to keep or cancel the appointment.

The intent of this policy is to prevent delays and care and utilize physician's time more efficiently by reducing unused appointment slots, and making those times available to other patients.

We appreciate you respecting and adhering to our practice's "NO SHOW" policy.

I have read and understand the Children's Clinic of El Paso's "NO SHOW" policy. I also understand that if I do not agree to this policy that I can request my child's insurance carrier to assign my child to another Primary Care Physician's office if applicable.

______________________________ ______________
Parent's Signature Date

11544 Vista Del Sol, El Paso, Texas 79936 915-592-2600
1700 N. Oregon, Ste 700, El Paso, Texas [illegible]

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)			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). The Texas Immunization Registry 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 the Texas Immunization Registry. 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 Sec. 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 the Texas Immunization Registry. Once in the Texas Immunization Registry, 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 Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. 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 Sec. 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 on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

~~PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization~~ Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **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