Nassau Bay Pediatrics, Pa
150 E Medical Center Blvd Suite C
Webster, TX 77598

Pone: 281-212-2400
Fax: 281-212-2499

Patient Information

Last _____ First _____ Middle _____

DOB _____ Gender _____ SS# _____ Marital Status _____

Driver's Lic # _____ Exp Date _____ State _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Parent Information

Mother: Last _____ First _____ Middle _____

DOB _____ SS# _____ Marital Status _____

Driver's Lic # _____ Exp Date _____ State _____

E-mail Address _____

Employer Name _____

Address _____ Phone _____

Father: Last _____ First _____ Middle _____

DOB _____ SS# _____ Marital Status _____

Driver's Lic # _____ Exp Date _____ State _____

E-mail Address _____

Employer Name _____

Address _____ Phone _____

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Insurance Information

Primary Insurance Name _____
Claims Mailing Address _____
Insurance ID# _____ Group # _____
Subscriber Name _____ DOB _____
Address _____
Pone# _____ Cell # _____
Employer _____ Work # _____
Subscriber's relationship to patient _____
Secondary Insurance Name _____
Claims Mailing Address _____
Insurance ID# _____ Group # _____
Subscriber Name _____ DOB _____
Address _____
Pone# _____ Cell # _____
Employer _____ Work # _____
Subscriber's relationship to patient _____

Emergency Contact: In the event of an emergency, please list a contact person not living with you

Name: _____ Phone _____

Address _____ Relationship _____

Child Health History

Department of State Health Services
Child Health Record
Preventive Health Visit

Pregnancy and Birth

G ___ P ___ AB ___
Total number of living children _____ Weight gain/loss _____
Mother's age at birth _____
Number of years between previous pregnancy and this child _____
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider _____
Vitamins: ___Y __ N Iron: ___Y __N
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: ___ Y ___N*
**If yes, proceed with "Child's Medical History.*

Maternal Complications

____Vaginal bleeding
____Anemia
____Hypertension
____Rh negative
____Diabetes
____Premature labor
____Injury/hospitalization/surgery
____Flu-like illness or high temp.
____Kidney or bladder infection
____STDs
____Hepatitis (A, B, or C)
____Exposure to TB
____Exposure to lead/chemicals
____Dental disease

Maternal Substance Use

____OTC meds _____
____Prescription meds _____
____Tobacco _____
____Alcohol _____
____Street drugs _____
____Caffeine _____

Family Medical History

Abbreviations for relatives listed below.

M - Mother MGM - Maternal Grandmother PGM - Paternal Grandmother
F - Father MGF - Maternal Grandfather PGF - Paternal Grandfather
S - Sibling MA - Maternal Aunt PA - Paternal Aunt
MU - Maternal Uncle PU - Paternal Uncle

____ Anemia//blood disorder
____ Heart disease before age 50
____ Cholesterol req. treatment
____ Hypertension/stroke
____ Asthma/allergy
____ Cancer
____ Diabetes
____ Epilepsy/seizures
____ Kidney problems
____ Muscle/bone disease
____ Genetic disease or major birth defects
____ Childhood hearing impairment
____ Tuberculosis

Y N HIV + Individual in household ***(do not identify)***
____ Other immunosuppression
____ Dental decay
____ Alcohol/drug abuse
____ Tobacco use
____ Learning disorder
____ Mental retardation
____ Psychiatric disorder
____ Physical/sexual/emotional abuse
____ Domestic violence
____ Other

Explanation of positive history:

Client Information

Name: _____
DOB: _____ / _____ / _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Birth/Delivery

Place of birth _____
Birth attendant _____
Hours of labor _____

____Term
____Premature (Weeks)_____
____More than 2 weeks overdue

Type of delivery:
____Vaginal
____C-Section
____Forceps

Complications:
____Breech
____Multiple birth
____Other

Explanation/Other:

Nursery Course

Birth Weight _____ Birth Length _____ FOC _____

____Difficulty with initial breathing
____Heart murmur
____Infection
____Transfusion
____Jaundice req. treatment
____Seizures

Age at discharge: _____ICN _____ days

Newborn blood screening (date/location):
1. _____
2. _____

Newborn hearing test (in hospital): ____ Normal _____Abnormal
Type of test: ____ABR ____OAE ____Unknown
Referral made: ____Y ____N
Comments:

Child's Medical History

Immunizations current: ___Y ___N __ Record unavailable
Dental care/sealants current: ___Y ___N

____Trauma/Injuries
____Hospitalizations
____Surgery
____Medications
____Anemia
____Early childhood caries
____Hepatitis
____Strep throat
____Ear infections
____Bladder/kidney infections
____Pneumonia
____Developmental delays
____Vision problems
____Hearing problems
____Seizures
____Environmental toxin exposure (lead, etc.)
____Allergies
____Asthma
____Eczema
____Substance use (alcohol, drug, tobacco)
____Other

Explanation:

Date: _____ Signature/Title: _____ Signature/Title _____

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Patient Name (please print) DOB

To Our Valued Patient:

Today we are pleased to welcome you as one of our newest patients. It is our primary goal to provide you with quality medical care.

Due to the effect that missed appointments could have on your health, we have established the following guidelines regarding missed appointments.

Each time a patient does not show up for their scheduled appointment without prior notification, the office will attempt to notify the patient by phone and/or mail to reschedule the appointment.

Your physician will be notified of the missed appointment(s).

If there is a pattern of repeated missed appointments, the appointments you missed will be reviewed and a determination made whether we can continue to provide you with medical care.

Please make it your utmost concern to arrive at your appointed time. If for some reason you are not able to keep your appointment, except in the case of emergencies, please provide our office 24 hour notice so we can help you reschedule.

I have read and understand the Policy regarding missed appointments

Signature of patient or responsible party Date

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Consent to Treatment and Acknowledgement

I consent to treatment as necessary or desirable for the care of the patient named, including, but not restricted to drugs, medications, lab tests or other studies, which may be used by the physician or his/her qualified designee.

I accept responsibility for the payment of services and agree to pay my bill in full at the time of services, unless other arrangements have been made.

I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Nassau Bay Pediatrics, PA will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable period of time.

I authorize Nassau Bay Pediatrics, PA to release information as required to my insurance or third party payer for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues.

I also authorize Nassau Bay Pediatrics, PA to bill my insurance or third party payer and receive payment for services rendered.

Patient, Parent or Guardian _____

(Please Print)

Signature _____ Date _____

Nassau Bay Pediatrics, PA

Notice of Privacy Practices

May 19, 2008

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.

If you have any questions, please contact our Privacy Officer at the address and/or phone number at the end of this notice.

Who will follow this notice?

Nassau Bay Pediatrics, PA provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practice in this notice will be followed by:

- Any healthcare professional who treats you
- All employed staff or volunteers
- Any business associates of partners of Nassau Bay Pediatrics, PA with whom we share health information

Our Pledge to you

We understand that medical information about you is personal. We are committed to protecting medical and billing information about you. We create a designated record of the care and service you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to:

- Keep medical and billing information about you private
- Give you this notice of our legal duties and privacy practices with respect to your protected health information
- Follow the terms of the notice currently in effect

Changes to this Notice

We may change our policies and privacy practices at any time. Changes will apply to your protected health information we already hold, as well as any new information obtained after the change occurs. When we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and/or exam rooms.

You can receive a copy of our current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice on the date of the first service delivery. You will also be asked to acknowledge in writing the receipt of this notice.

How we may use and disclose your protected health information

- We may use and disclose medical and billing information about you for treatment (such as sending medical information about you to a specialist as part of a referral); to obtaid payment for treatment (such as sending billing information to your insurance company); and to support our health care operations (such as comparing data to improve treatment methods).

- We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected health information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, organ donations, workers' compensation purposes, and during emergencies. We may also disclose protected health information when required by law, such as in response to a request from law enforcement In specific circumstances, or in response to valid judicial or administrative orders.

- We may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health related benefits or services that may be of interest to you.

- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your protected health information. If you choose to authorize our use of disclosure of your protected health information, you can later revoke that authorization by notifying us in writing of your dicision.

Your rights regarding medical information about you

• In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If your request copies, we will charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of the decision.

• If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records. You request must be submitted in writing. A request for amendment must provide your reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

• You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less that a 6 year period and starting April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12 month period is free; other request will be charged according to our cost of producing the list. We will inform you of the cost before you incur any cost.

• If this notice was sent to you electronically, you have the right to a paper copy of this notice.

• You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

• You may request in writing, that we not sue or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will inform you of our decision on your request.

All written request or appeals should be submitted to our Privacy Officer listed on this notice.

Complaints

• If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact Christy D Cole @ 281-212-2400.

- You may also send a written complaint to the US Department of Health and Human Services Office of Civil Rights
- Under no circumstances will you be penalized or retaliated against for filing a complaint.

Nassau Bay Pediatrics, PA

Privacy Officer Contact Information

Christy D Cole

Privacy Officer/Manager

150 E Medical Center Blvd

Suite C

Webster, TX 77598

281-212-2400

Nassau Bay Pediatrics, PA

Acknowledgement of Notice of Privacy Practices

_____ _____

Patient Name Date

Was a notice of Privacy Practices given to the patient or their personal representative?

YES **NO**

If not, why not? _____

_____ _____

Signature Date

If a patient or personal representative received a Notice but refused to sign above, did you make a food faith effort to obtain this acknowledgement? YES NO

Why were you unable to obtain? _____

Restriction on use of PHI? YES NO

If "YES" please explain: _____

_____

_____

Printed Name of Associate

_____ _____

Signature of Associate Date