children'shealth
Pediatric Group

Demographics Patient Information Form

PATIENT INFORMATION

Child's Name (Last Name, First Name, Middle Name) _____ Male (☐) Female (☐)

Date of Birth (Month/Day/Year) ____/____/____ SSN #____-____-____

Child Lives With: ☐Mother ☐Father ☐Guardian/Other:_____ Phone #:_____

Child's Street Address (City, State, Zip Code): _____

Preferred Pharmacy Name:_____Cross Streets: _____ Pediatrician / PCP:_____Phone #: _____

School District: _____ School Name _____ Ethnicity (Please select appropriate group): ☐Latino/Hispanic ☐Decline to Answer

Race (Select appropriate group): ☐ American Indian/Alaska Native ☐Asian ☐ Black/African American ☐Native Hawaiian/Other Pacific Islander☐ White/Caucasian ☐Other

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name:_____Primary Phone: _____ Alternate Phone: _____

Guardian's Date of Birth: ____/____/____ Email: _____ OPT Out of email contact: ☐ YES

EMERGENCY CONTACT- In case of an emergency, who should we contact? _____ Phone: _____

Relationship: _____ Children's Health Pediatric Group may disclose *Medical* and *Billing* information to this contact. ☐ YES ☐ NO

INSURANCE INFORMATION

Is the patient covered by insurance? ☐YES ☐ NO Is the Patient covered by Medicaid Insurance: ☐ YES ☐ NO

Name of Person Responsible for Paying the Bill ☐ Mother ☐ Father ☐ Other: _____ Primary Phone Number: _____

Street Address: ☐ Same As Child ☐ Other (City, State, Zip Code) _____

Insurance Policy Holder's Name ☐ Child ☐ Mother ☐ Father ☐ Other: _____ Date of Birth:____/____/____

Employer: _____ Insurance Name: _____ Phone #: _____

Insurance ID#: _____ Group #: _____

Patient Name: _____ Date of Birth: _____

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CHILDREN'S HEALTH SYSTEM OF TEXAS

General Consent for School Health Telemedicine Services and Treatment and Acknowledgements

Consent for School Health Telemedicine Care and Treatment

General Consent: I request and consent for Children's Health Pediatric Group ("CHPG"), an entity of Children's Health System of Texas ("Children's Health"), and its physicians and other health care providers to examine Patient, which may be defined as me, my child, or a child for whom I have a legal guardianship, and provide care and treatment through School Health Telemedicine Services, which may include the evaluation, diagnosis, consultation on and treatment of Patient's medical condition using advanced telecommunications technology ("Telemedicine Services"). I agree that by signing this form, I consent for Patient to receive Telemedicine Services in my absence. I understand that the practitioners providing Telemedicine Services at CHPG may include Patient's treating physicians and consultants and such associates, technical assistants and other health care providers as deemed necessary (the "Telemedicine Providers"). I understand that CHPG is a teaching institution and agree that resident physicians, fellows, and students may observe and participate in the Telemedicine Services under appropriate supervision.

I understand that Telemedicine Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telemedicine. I understand that Telemedicine Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination while using the Telemedicine Services, and (iii) must rely on information provided by Patient and any other health care providers on site. I further understand that Telemedicine Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telemedicine Services or distortions of images or other information from electronic transmissions. I acknowledge that the Telemedicine Providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission. I further acknowledge that no guarantees or warranties have been made with respect to Telemedicine Services to be provided. I understand that all supplies, medical devices and other goods provided to Patient are provided by CHPG **AS IS** and Children's Health and CHPG disclaim any expressed or implied warranties.

If the Telemedicine Providers determine that Telemedicine Services do not adequately address Patient's medical needs, the Telemedicine Provider will refer Patient for on-site medical evaluation at a CHPG clinic or other provider location. If after the Telemedicine Services, Patient experiences an urgent or emergent matter, such as a negative reaction to any treatment, or if the telemedicine session is interrupted due to a technological or equipment failure, alternative means of communication and treatment may be needed and I will consult with Patient's providers to obtain follow up care and assistance as needed.

I consent and authorize CHPG Telemedicine Providers to audio record, video record, and/or still photograph the Telemedicine Services. I understand that any part of Patient's body may be included in these visual displays. I agree that these recordings will remain the property of CHPG Telemedicine Providers and may or may not become part of the medical record. I understand that these Telemedicine Services may be viewed by certain medical and non-medical persons for informational, research, and educational purposes. I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Text Messaging: I understand that CHPG can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I ☐ DO / ☐ DO NOT authorize CHPG to send text messages to the cell phone number I provide for that purpose.

Duration of Consent: I understand and agree this Consent for Telemedicine Services and Treatment is valid for the 2016-2017} school year unless I revoke the consent prior to that time by providing written notice to CHPG at 2777 North Stemmons Fwy. Floor 4, Dallas, Texas 75207

I certify that I have read and understand the information in this General Consent for School Health Telemedicine Services and Treatment form.

_____ _____ _____
Signature of Patient/Parent or Legally Authorized Representative* Date Time

_____ _____
Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

_____ _____ _____
Witness Date Time

_____
Witness Printed Name

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**

Patient Name: _____ **Date of Birth:** _____

Acknowledgments: Protected Health Information - Notice of Privacy Practices: Children's Health *Notice of Privacy Practices* addresses how Children's Health may use and disclose Patient's Protected Health Information (PHI) for treatment, payment, and healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received the Children's Health *Notice of Privacy Practices* and that any questions or concerns may be directed to the Children's Health Privacy Officer.

Use and Disclosure of Information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment/psychiatric care and alcohol/substance abuse diagnosis or treatment ("Medical Information"). I authorize release of that Medical Information as part of Patient's medical record. I understand that Children's Health must keep Patient's medical records for a time period required by law and then may dispose of such medical records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize Children's Health to use Patient's Medical Information for the purposes of treatment, payment, regular healthcare operations (collectively referred to as "Purposes"), or as otherwise allowed by law. I acknowledge that Children's Health will release and send, electronically or otherwise, Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by the recipient. Medical Information may become part of Patient's medical records kept at non-Children's Health healthcare providers and may be further disclosed.

Health Information Exchange: Children's Health participates in Health Information Exchange programs ("HIE(s)") to store and exchange Patient's Medical Information. Patient's Medical Information from non-Children's Health healthcare providers may also be stored and shared in HIE(s), and Children's Health and these other providers can use HIE(s) to see Patient's Medical Information for the Purposes set forth above, to coordinate Patient's care, and as allowed by law. I understand that Patient may opt out of HIE(s) Medical Information sharing by indicating that decision below. Patient may opt back in to HIE(s) Medical Information sharing at any time. I understand that even if Patient opts out of HIE(s) Medical Information sharing, Patient's Medical Information will still be stored in HIE(s). I understand that Patient does not have to participate in HIE(s) Medical Information sharing to receive care.
☐ I do **not** want Patient's Medical Information shared in HIE(s). I understand, however, that if Medical Information sharing with HIE(s) is required by law, Children's Health must act in compliance with the law. I further understand that certain Medical Information may be shared with HIE(s) in a manner that does not identify Patient.

Financial Responsibility and Assignments - Financial Responsibility: I agree to pay for the full billed charges associated with goods and services provided to Patient regardless of any applicable insurance or benefit payments and understand that all amounts are due upon request and are payable to Children's Health and any provider who provides services to Patient at Children's Health (the "Provider(s)"). Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and/or benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and / or plan limitations, exclusions, and/or failure to comply with insurance and/or plan requirements. An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services. I also agree and understand that if Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre-recorded message calls to my cellular telephone and to any telephone number provided during Patient's registration process from Children's Health, Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

Medicare / Medicaid Patients Only: I understand that the goods and services that I request to be provided to Patient may not be covered under Medicare/Medicaid as being reasonable and medically necessary for Patient's care. I understand that Medicare/Medicaid or their insuring agent determine the medical necessity of the goods and services requested for Patient. If Medicare/Medicaid determines that certain goods and services are not medically necessary for Patient's care and I request such goods and services be provided despite Medicare/Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If Patient is a Medicare/Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of Patient in applying for payment under Medicare/Medicaid is correct. I authorize the release of medical or other information about Patient to the Social Security Administration, intermediaries, or carriers as needed for Medicare/Medicaid claims.

Notice to Patients - Third Party Payor (Health Plan Member) Information:
I acknowledge that based on the information I have provided about Patient's third-party payor coverage, insurance, or benefit plan, Children's Health
☐ IS / ☐ IS NOT a participating provider under Patient's third-party payor coverage, insurance, or benefit plan.

Assignment of Benefits: I irrevocably assign and convey directly to Children's Health, and any Provider, all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal/administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payor providing benefits on Patient's behalf for goods and services provided to Patient by Children's Health and Providers. I also authorize direct payment to Children's Health and Providers for the goods and services Children's Health and Providers provide to Patient. I authorize Patient's plan administrator, insurer, and/or attorney to release to Children's Health and Providers all plan documents, summary benefit description, insurance policy, and settlement information upon written request from Children's Health or Providers needed to claim medical benefits.
Under this assignment, I convey to Children's Health and Providers all of my rights to claim or place a lien on benefits related to goods and services provided by Children's Health and Providers to Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. Children's Health and Providers have the right to: (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; and/or (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. Children's Health and Providers may bring suit against any such benefit plan, plan administrator or insurance company in my name and/or Patient's name with derivative standing. This assignment is not and shall not be construed as an obligation of Children's Health and/or Providers to pursue such interest and rights.

I certify that I have read and understand the information in the Acknowledgments for Protected Health Information and Financial Responsibility and have received Children's Health's Notice of Privacy Practices.

_____ _____ _____
Signature of Patient/Parent or Legally Authorized Representative* Date Time

_____ _____
Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

_____ _____ _____
Witness Date Time

_____
Witness Printed Name

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**