HERRIN PEDIATRIC CLINIC

601 River Pointe Drive Suite 120
Conroe, Texas 77304
Phone: (936) 788-6060 Fax: (936) 788-6061

Date:

PATIENT REGISTRATION FORM

(PLEASE FILL IN ALL FIELDS COMPLETELY)

Patient Information:

Child's Full Legal Name (First, Middle, Last)	Date of Birth	Sex	Preferred Name
Child's Street Address	**City, State**	**Zip**	**County**

Race: □ American Indian or Alaska Native □ Asian □ White □ Black or African American □ Native Hawaiian and other Pacific Islander □ Other □ Prefer not to answer

Ethnic Group: □ Hispanic □ Non-Hispanic

Patient's Primary Language: □ English □ Spanish □ Other _____

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

Does the Parent/Legal Guardian require an interpreter? □ Yes □ No

Emergency Contacts:

MOTHER'S NAME (First, Middle, Last)	DOB:	Cell #:	Work#:
Mail address **if different from above:**			Social Security Number:
FATHER'S NAME (First, Middle, Last)	DOB:	Cell #:	Work#:
Mail address **if different from above:**			Social Security Number:
ADDITIONAL CONTACT (First, Middle, Last)	Cell #:	Home #:	Relationship to Patient
Home Address (City, State, Zip Code) if different from above:			

Guarantor Information (Person financially responsible if different from parents)

Name:		Relationship to Patient:	
Street Address (If different from patient)	City:	State:	Zip:
Date of Birth:	Home #:	Work#:	Cell#:
Employer Name:	City:	State:	Zip:

Patient Name:_____

Please list all children in household under 18 years of age:	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:

List people other than parent/guardian having permission to seek medical attention for your child:	
Name:	Relationship to Patient:
Name:	Relationship to Patient:
******Please inform the above-named people they must bring a form of Identification******	

_____ _____ _____

Parent/Guardian Signature Relationship to patient Date

Interested on the patient portal? Please give us your e-mail address to get set up.

_____

HERRIN PEDIATRIC CLINIC

TO RELEASE PROTECTED HEALTH INFORMATION

TO DESIGNATED REPRESENTATIVE[S]

I, _____the named legal guardian[s] of

_____[minor child] give permission to release protected health information including results of laboratory tests, x-ray and / or other test results to the following designated representative[s]:

Initials:	Name:	Relationship to Patient:
Initials:	Name:	Relationship to Patient:
Initials:	May be left on my answering machine at home / voice mail on cell phone, or voicemail at work	
Initials:	**MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.**	

As the legal guardian, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, HERRIN PEDIATRIC CLINIC must receive the revocation in writing. The revocation must include:
[1] the patient's name, address, and date of birth, [2] the guardian's desire to revoke the authorization, and [3] the date of the revocation and the guardian's signature. All revocations must be sent in writing to the attention of Privacy Officer at 601 River Pointe Dr, Suite 120 – Conroe, Tx 77304 or faxed to 936-788-6061. It will not be considered effective until received by the Privacy Office.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I am aware that I may request a personal copy for my records.

_____ _____

Parent/Guardian's Signature Date

Office Use Only

We have made the following attempt to obtain the Patient's/Parent's/ Legal Guardian's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____

Attempt:_____

Staff Name:_____

HERRIN PEDIATRIC CLINIC OFFICE POLICY

We know that you are concerned about the cost of health care and we want you to know that we are striving to hold down our professional fees. If you do not have insurance, payment can be made by Cash, Check, or Credit card **at the time of service .** Please remember that **you,** not the Insurance company, are responsible for payment of professional services. Please note and initial the following points:

Initials:

- _____ Dr Herrin is responsible for the treatment discussed with you.
- _____ You are responsible for payment to Dr Herrin.
- _____ As a courtesy to our patients and at you request, we will be happy to file charges for your office visit with your insurance company. We have been instructed by ALL insurance companies that pre-certification and filing DOES NOT GUARANTEE PAYMENT. The determination of whether the bill is paid is made by the insurance company when they receive the claim. **If your insurance has not paid within 60 days, then you are responsible for the balance.**
- _____ When payment from the insurance is received, **you are responsible for the prompt payment of any remaining balance.** Any overpayment will be promptly refunded to you.
- _____ **I understand that I am responsible for any balance due on my account. All accounts must be paid in full within 60 days. After 60 days, past due accounts will be turned over to collection agency. Finally, I agree to pay collection costs and attorney's fees if collection procedures become necessary for a delinquent account. I further understand, that if collection action is necessary, the Clinic may choose to give me a 30 day notice of termination in order to locate another physician to care for my child.**
- _____ For any missed appointments ***you will be charged $50***, this is your personal responsibility it is NOT filed with your insurance.
- _____ Herrin Pediatric Clinic does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. 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.

I certify that the answers to health questions are correct to the best of my knowledge; also, I grant to the physician and staff to perform all procedures and treatments that may be necessary. (**This includes minor consent.)** I authorize release of information to my Insurance company for payment of benefits to James R Herrin, M.D.

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's condition including blood tests, x-rays, developmental testing, and any other pertinent tests performed by Dr Herrin.

Patient's Name _____

_____ _____ _____

Parent/Guardian Signature Relationship to patient Date

VACCINE POLICY

We realize how hard it is to be a wise and prudent parent these days and how difficult it is to decide what is the right course of action to take on many issues concerning the medical care of your children. There are many sources of information available to you, some of which are inaccurate or completely untrue. Since we make it a point to be current and up to date on many medical issues, we would like to be a trusted resource for all medical concerns you may have. One of the issues that seems to be quite confusing is that of ***Vaccinations.*** There are many opinions concerning Vaccinations and even increasing numbers of people on the internet feel vaccines are unsafe.

Dr Herrin has reviewed all the credible medical evidence concerning vaccinations and we have concluded that **Vaccines <u>are</u> safe** and the schedule given by the American Academy of Pediatrics and Advisory Committee on Immunization Practices of the CDC is the most prudent and efficacious method to provide immunizations. We feel that the best medical practice is to adhere to this schedule at all times, since it is reviewed frequently and the latest recommendations are made every year based upon the best medical evidence available.

Furthermore, we are aware that many alternative vaccine schedules are being promoted on the internet by certain groups and even some physicians. Most of these are not medically evidence-based and the consequences of using these schedules *<u>have not</u>* proven not to harm children. Therefore, we will only use the medically proven schedules at Herrin Pediatric Clinic. As always, flu and Covid 19 vaccines are always optional. **By signing this policy you understand and agree, should you choose to not vaccinate your children or you feel that you must vaccinate your children by some other alternative schedule, you will be asked to find another provider of medical care for your children.**

Child's Name:_____ DOB:_____

Parent/Guardian Signature:_____ Date:_____