Children's Specialty Care Clinic of N.W. Houston

Patient Information

Full Name: _____ D.O.B.: _____ Age: _____ Sex: M ___ F ___

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Social Security Number: _____

Father's Name: _____ Occupation: _____ Employer: _____

Home Tele. #: _____ Work #: _____ Emergency #: _____

Mother's Name: _____ Occupation: _____ Employer: _____

Home Tele. #: _____ Work #: _____ Emergency #: _____

Emergency Contact: _____ **Relationship:** _____ **Telephone #** _____

How did you hear about the clinic?: _____

Insurance:

Self Pay: _____ Medicaid: _____ Private Insurance Name: _____

Assignment and Release:

I, the undersigned certify that (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to **Children's Specialty Care Clinic of N.W. Houston, P.A.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

First Time Visit

I, _____ give my permission as a
(Relationship to child)

Parent/Legal Guardian of the above named Children's Specialty Care Clinic of N.W. Houston to treat my child.

_____ _____ _____

Parents/Guardian Signature | Date | Telephone

Children's Specialty Care Clinic Of N.W. Houston

Pt. Name:_____ Date Of Birth:_____

Pregnancy Complications:	Yes	No
Pregnancy less than 9 mos.	____	____
High Blood Pressure	____	____
Toxemia	____	____
Bleeding	____	____
If yes, what month	____	____
Previous Miscarriages	____	____

Birth History:
Place of birth:_____
Birth Weight:_____
Length of Labor:_____
Adopted: No_____ Yes_____
Problems :_____
_____

Hospitalization and Operations:	**Date**
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____

Allergies to Medications:
_____
_____
Smokers in household? Yes or No
Drug users in household? Yes or No

Child's Illness:	Yes	No	Date
Wooping Cough	____	____	_____
Measles	____	____	_____
Rubella	____	____	_____
Mumps	____	____	_____
Chickenpox	____	____	_____
Scarlet Fever	____	____	_____
Menengitis	____	____	_____
Pneumonia	____	____	_____
Diabetes	____	____	_____
Rheumatic Fever	____	____	_____
Convulsions	____	____	_____
Bed Wetting	____	____	_____
Kidney Disease	____	____	_____
Sickle Cell	____	____	_____
Allergies	____	____	_____
Asthma	____	____	_____

Family History:	**Mother's Side**	**Father's Sid**
Diabetes	_____	_____
Heart Trouble	_____	_____
Heart Attack	_____	_____
High Blood Pressure	_____	_____
Stroke	_____	_____
Cancer	_____	_____
Tuberculosis	_____	_____
Ulcer	_____	_____
Arthritis	_____	_____
Obesity	_____	_____
Suicide	_____	_____
Mental Illness	_____	_____
Thyroid Trouble	_____	_____
Sickle Cell	_____	_____
Convulsions	_____	_____
Allergies	_____	_____
Hay Fever	_____	_____
Sinus	_____	_____
Asthma	_____	_____

Child's Family:	**Age**	**Present Health or Cause of Death**
Mother:	_____	_____
Father:	_____	_____
Brothers:	1)_____	_____
	2)_____	_____
	3)_____	_____
Sisters:	1)_____	_____
	2)_____	_____
	3)_____	_____

List medications child takes routinely:_____
_____

☐ Abdul Haseeb, M.D. ☐ Saifuddin Tahir, M.D. ☐ Rashida Abbas, M.D. ☐ Valerie Richard, FNP-C ☐ Tamara Kapplinger, P.A.
☐ Angela Miller, P.A. ☐ Alexis Sanders, P.A. ☐ Courtney Fincher, FNP-C ☐ Cynthia Sanders, CPNP-PC ☐ Sarah Clay, P.A.

HIPAA Notice of Privacy Practices

Children's Specialty Care Clinic of Northwest Houston

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18602 FM 1488, Suite 700, Magnolia, Texas 77355 * (281) 252-0013 * Fax: (281) 252-4644☐ Magnolia
31303 FM 2920, Suite G, Waller, Texas 77484 * (936) 931-3448 * Fax: (936) 931-3704 ☐ Waller
17330 Spring Cypress Rd, Suite 150, Cypress Texas 77429 * (281) 373-3786 * Fax: (281) 304-7786☐ Cypress
19722 Saums Rd., Houston, Texas 77084 * (281) 600-0786 * Fax (281) 600-0787☐ Katy

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.

This Notice of Privacy describes how we may use and disclose your protected health information(PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinates, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, for example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-sheet at the registration desk where you willbe asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by Law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authrization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Mid-Level Providers Consent

Children Specialty Care Clinic of NW Houston PA

Saifuddin Tahir, M.D. Abdul Haseeb, M.D.

This facility has on staff Mid-Level Providers to assist in the delivery of medical care.

Mid-Levels include nurse practitioners (NP), physician assistants(PA), and CRNAs. Mid-Level Providers can examine patients, diagnose them, and provide treatments under supervision of licensed physicians.

I have read the above, and hereby consent to the services of a Mid-Level Provider for my health care needs.

I understand that at any time I can refuse to see the Mid0Level Provider and request to see a physician.

_____

Patient Name

_____

Parent/Guardian

_____

Signature Date

TEXAS Department of State Health Services

Risk Assessment for Lead Exposure: Parent Questionnaire

Form Pb - 110

Healthcare Provider: For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.

Patient's Name:	DOB:	Medicaid #:
Provider's Name:	Administered by:	Date:

Parent Questionnaire

	Yes	Don't know	No
1 Does your child live in or visit a home, daycare or other building built before 1978?			
2 Does your child live in or visit a home, daycare or other building with ongoing repairs or remodeling?			
3 Does your child eat or chew on non-food things like paint chips or dirt?			
4 Does your child have a family member or friend who has or did have an elevated blood lead level?			
5 Is your child a newly arrived refugee or foreign adoptee?			
6 Is your child exposed to any of the following (if YES, check all that apply):			

If "Yes" or "Don't Know" Perform a Blood Lead Test

Contamination from a parent, relative, or friend with jobs or hobbies like these?

- ☐ Radiator repair
- ☐ Pottery making
- ☐ Lead smelting
- ☐ Welding
- ☐ Making fishing weights
- ☐ House construction or repair
- ☐ Battery manufacture or repair
- ☐ Burning lead-painted wood
- ☐ Automotive repair shop or junkyard
- ☐ Going to a firing range or reloading bullets
- ☐ Chemical preparation
- ☐ Valve and pipe fittings
- ☐ Brass/copper foundry
- ☐ Refinishing furniture
- ☐ Other:

Sources of lead in food and remedies?

- ☐ Imported or glazed pottery such as a Mexican bean pot
- ☐ Imported candy, (like Chaca Chaca) especially from Mexico
- ☐ Nutritional pills other than vitamins
- ☐ Other:
- ☐ Foods canned or packaged outside the U.S.
- ☐ Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Cuestionario de Padre

	Sí	No lo se	No
1 ¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio construida antes de 1978?			
2 ¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?			
3 ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?			
4 ¿Tienen parientes o compañeros de su hijo(a) que tienen o tuvieron altos niveles de plomo en la sangre?			
5 ¿Es su hijo recién refugiado o adoptado del extranjero?			
6 ¿Ha sido expuesto su hijo(a) a cualquier de los siguientes? (si SÍ, marque todos que apliquen):			

Si "sí" o "no lo se" Le haga al niño una prueba de plomo en el sangre

Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estas?

- ☐ Reparación de radiadores
- ☐ Fabricación de cerámica
- ☐ Industria del plomo
- ☐ Soldadura
- ☐ Fabricación de pesas para pescar
- ☐ Construción o reparación de casas
- ☐ Fabricación o reparación de baterías
- ☐ Quema de madera pintada con plomo
- ☐ Taller mecánico para autos o lote de chatarra
- ☐ Ir a un campo de tiro o recargar balas
- ☐ Preparación de químicos
- ☐ Partes sueltas para tubos de cañerías y válvulas
- ☐ Fundición de latón/cobre
- ☐ Terminado de muebles
- ☐ Otros:

Fuentes de plomo en comidas y remedios?

- ☐ Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México
- ☐ Productos enlatados o empacados fuera de los Estados Unidos
- ☐ Dulces importados, (como Chaca Chaca) especialmente de México
- ☐ Remedios tradicionales como greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda
- ☐ Píldoras alimenticias con excepción de las vitaminas
- ☐ Otros:

Fax completed form to 512-458-7699, or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Revised 03/14/11

TB Questionnaire

Name of Child_____Date of Birth _____

Organization administering questionnaire_____ Date_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?_____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only
****

PPD administered Yes___ No___
If yes,
Date administered _____/_____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

TEXAS Department of State Health Service

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

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No
Screener's Initials

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility 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 record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Provider's Name/Clinic's Name: _____ Phone Number: (_____) _____
Area Code + number

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

(a) ☐ Is enrolled in Medicaid, or

_____ _____
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

_____ _____
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(c) ☐ Is an American Indian, or

(d) ☐ Is an Alaskan Native, or

(e) ☐ Does not have health insurance (uninsured), or

(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.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: _____ Insurer Contact Number: (_____) _____
Area Code + number

Policy/Subscriber Number: _____ Group Number (if applicable): _____

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: _____ Date: _____
(mm/dd/yyyy)

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
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth / / **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized 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 state's central immunization registry ("ImmTrac"). Once in ImmTrac, 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;
- 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 to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

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

_____ _____
Date **Signature**

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

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.*
DO NOT fax to ImmTrac. Retain this form in your client's record.