

# BLUE FISH

## P E D I A T R I C S

### Instructions

Thank you for choosing Blue Fish Pediatrics. To register a new patient, please fill out all of the following forms. We ask you to have these forms completed, signed, and dated before you arrive so that your wait period is not longer than necessary.

Below is a brief explanation of each form.

#### **Office Policy:**

This form explains Blue Fish's policy regarding office visits.

#### **New Patient Registration:**

This form records general and health insurance information about the patient.

#### **Patient Medical History Questionnaire:**

This form records the medical background of the patient and blood relatives.

#### **Houston-Harris County Immunization Registry (HHCIR):**

This form allows Harris County to have an electronic copy of your child's immunization records. If you consent and you ever lose your child's immunization records, HHCIR can replace them for you. If you do not consent, please sign and date under the "WITHDRAWAL OF WRITTEN CONSENT" area. If you do consent, please sign and date above the "WITHDRAWAL OF WRITTEN CONSENT" area.

#### **Texas Vaccines for Children Form (TVFC) Patient Eligibility Screening Record:**

This form determines whether your child is eligible for TVFC. If your child is qualified for TVFC, please sign and date.

#### **Texas Vaccines for Children (TVFC) Program Information:**

This form is a disclaimer stating that your child is not qualified for TVFC and that the parent/guardian is responsible for all costs associated with vaccinations. If your child is not qualified for TVFC, please sign and date.

#### **Health Insurance Portability and Accountability Act (HIPAA) Authorization:**

This form explains the privacy rights of the patient's medical records.

If you are having problems filling out these forms, please contact our office at 713-467-1741. If it is after hours, please leave a message and a receptionist will contact you the following business day.

# Office Policy

## For All Visits

Please do not forget to:

- Schedule an appointment
- Bring a current immunization record
- Bring all relevant medical information (ex. discharge paperwork for newborns, ER & hospital visits)
- Bring current insurance information
- Ensure the doctor listed as your PCP (for HMO or Medicaid) is a Blue Fish doctor
- Be on time and come early if your insurance or demographic information has changed

## Initial Visits

The first time you visit Blue Fish; there are some forms you must fill out prior to being seen. To make the process of filling out forms as painless as possible, we have put all our new patient forms on our website. If you have internet access, please download and print the forms off our website or request them via email so you can fill out the paperwork in the comfort of your own home. If you do not have access to the internet, we can fax or mail the paperwork to you. If you are unable to fill out the new patient forms before you arrive at our office, please come thirty minutes prior to your appointment so that you will have ample time to complete the forms.

## Newborn Visits

If your newborn was in the hospital for less than 48 hours, please schedule an appointment for a newborn follow-up visit two to three days after discharge. Appointment slots are always reserved for newborn babies.

If your newborn was in the hospital for more than 48 hours, please schedule an appointment for a follow-up visit 7 - 14 days after discharge. Appointment slots are always reserved for newborn babies.

If your newborn was discharged from the hospital with special follow-up instructions from the doctor, please call us and schedule your appointment accordingly. Again, appointment slots are always available for your newborn.

## Well Visits

For well child care, such as immunizations and check-ups, please make an appointment as early as possible (at least two to four weeks prior to the requested date). Demand may vary throughout the year so we encourage you to call as early as possible to schedule a well visit. Please arrive at least 15 minutes prior to your appointment time so that any required paperwork (ex. change of address or telephone number) can be handled before your scheduled time.

## Sick Visits

Please contact our office for an appointment as soon as you think you might need to be seen. If you need help determining if you should duke it out at home or get checked, please call early in the day so that we can guide you through the decision making process. We will see sick children the same day you call, but please understand if there is a wait in the office for these visits.

## Office Policy on Tardiness and Rescheduling

Blue Fish Pediatrics endeavors to provide timely and convenient service. Patients who come late, unprepared, or without an appointment inconvenience those patients who are on time, prepared, and call in

advance to schedule an appointment time. If you have an appointment and you cannot make it, please contact us to either cancel or re-schedule your appointment. If you know you will be at least 15 minutes late for your scheduled appointment, please call us and let us know. This will enable us to see patients as timely as possible.

In order to protect your time, patients who:

- have missed their appointment by being more than 20 minutes late,
- have come unprepared for their visit (ex. their primary care doctor listed with Medicaid has not been changed to a Blue Fish doctor),
- or, have dropped in for an office visit without an appointment

will have the option to either reschedule their appointment or wait until the next available appointment. We will always do everything to ensure that your child is seen as soon as possible.

If you have any questions at all, please do not hesitate to call us.

# BLUE FISH

## P E D I A T R I C S

### Patient Registration

<b>Child's Name:</b> _____ <small>First/Middle/Last</small>	<b>Date of Birth:</b> _____ <small>mm/dd/yyyy</small>
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address: _____	
City, State Zip Code: _____	Telephone: _____
Who referred you to our office? _____	

### Parent(s) / Guardian Information

<b>Father's Name:</b> _____	<b>Mother's Name:</b> _____
Date of Birth: _____	Date of Birth: _____
Social Security #: _____	Social Security #: _____
Employer Name: _____	Employer Name: _____
Employer Address: _____	Employer Address: _____
Occupation: _____	Occupation: _____
Home Phone: _____	Home Phone: _____
Cellular Phone: _____	Cellular Phone: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____

<b>Siblings:</b>	Name: _____	Date of Birth: _____
	Name: _____	Date of Birth: _____
	Name: _____	Date of Birth: _____
Do they attend this office?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, do you plan to bring them to this office? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Name: _____	Phone: _____	

### Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Drs. Peter Jung, William Pielop, Secily Torn, Amanda Brack or R. Adrian Clarke for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, i.e. lab work, blood tests, x-rays etc., that are not covered by insurance will be my financial responsibility.

### Authorization to Release Information

I hereby authorize Drs. Peter Jung, William Pielop, Secily Torn, Amanda Brack or R. Adrian Clarke to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

### Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

_____ Patient Name (Please Print)	_____ Date
_____ Parent/Guardian Name (Please Print)	_____ Signature



**Patient Name:** \_\_\_\_\_ **Completed by:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Please check yes or no, circle, or ✓ where required. N/A – Not Applicable

Previous medical care – Dr. \_\_\_\_\_

PREGNANCY & BIRTH		Mother's age at pregnancy?	FAMILY MEDICAL HISTORY												
Any illnesses during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO			<i>List all blood relatives of your child who have had the following problems – use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin</i>												
Medication during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO (exclude vitamins & iron)															
<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs – during pregnancy?															
At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)															
Type of delivery?	Birth Weight:	Length:													
Complications? <input type="checkbox"/> YES <input type="checkbox"/> NO		Apgar:													
Problems with baby at birth? Breathing: <input type="checkbox"/> YES <input type="checkbox"/> NO Jaundice: <input type="checkbox"/> YES <input type="checkbox"/> NO		Other:													
Pass Hearing Screen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Mother's Blood Type:													
Were you ever told baby was breech in the third (3 <sup>rd</sup> ) trimester? <input type="checkbox"/> YES <input type="checkbox"/> NO															
PAST MEDICAL HISTORY		Allergic reactions? Medicine: <input type="checkbox"/> YES <input type="checkbox"/> NO					Anemia/Blood Dis								
Food: <input type="checkbox"/> YES <input type="checkbox"/> NO Animals: <input type="checkbox"/> YES <input type="checkbox"/> NO Insect Bites: <input type="checkbox"/> YES <input type="checkbox"/> NO			Asthma												
Medications taken on a regular basis? (exclude vitamins)			Mental Retardation												
Immunizations – up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have records? <input type="checkbox"/> YES <input type="checkbox"/> NO			Drug Problem												
Hospitalizations – (when-where-why?)			Alcoholism												
Surgeries (when-where?)			Cancer												
	YES	NO	YES	NO	YES	NO	Aids								
Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (3 day)	<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis						
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Musc. Dystrophy						
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis						
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures						
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease						
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure						
FEEDING & NUTRITION		Food Allergies								Cholesterol Problem					
Appetite usually good? <input type="checkbox"/> YES <input type="checkbox"/> NO										Migraine					
Colic or feeding problems during the first 3 months? <input type="checkbox"/> YES <input type="checkbox"/> NO										Sudden Infant Death					
Breast fed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of months?										Birth Defects				
Formula? <input type="checkbox"/> YES <input type="checkbox"/> NO	Current brand?										Early Deafness				
Vitamins? <input type="checkbox"/> YES <input type="checkbox"/> NO	Brand?		Flouride? <input type="checkbox"/> YES <input type="checkbox"/> NO								Diabetes				
FAMILY PROFILE		Parents <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced								DEVELOPMENT & BEHAVIOR					
Father's Age?	Highest school grade?		Health?								Age at which child				
Mother's Age?	Highest school grade?		Health?								Sat alone: _____ Walked: _____ Used sentences: _____				
		(List child's brothers, sisters, and their ages)										Toilet trained: _____ Bicycled: _____			
												Development compared to other children? _____			
												Grade in school: _____			
												Problems in school? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Learning problems? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Getting along with other children? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Behavior problems? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Bad Habits? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Bedwetting? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Nail biting? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Sleeping? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												Hobbies / sports? _____			
												Use of street or illegal drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO			
SYNOPSIS															



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

<b>CLINIC USE ONLY:</b> TVFC Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No
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Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the *Texas Vaccines for Children Program*. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last Name First Name MI

Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian/Individual of Record: \_\_\_\_\_  
Last Name First Name MI

Provider's/Clinic's Name: \_\_\_\_\_

**The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one)\*:**

- (a) is enrolled in Medicaid, or
- (b) does not have health insurance, or
- (c) is an American Indian, or
- (d) is an Alaskan Native, or
- (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage) \*, or
- (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
- (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).
- (h) has private insurance, or is paying for services

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 Vaccines For Children (TVFC) Disclaimer

As a service to our patients, our office participates in the Vaccines For Children (VFC) program, which provides vaccines at no charge for those patients who meet the program's eligibility requirements.\*

A patient who meets any one of the following requirements automatically qualifies for the VFC program:

- is enrolled in Medicaid
- is enrolled in Children's Health Insurance Plan (CHIP)
- does not have health insurance
- is underinsured (has health insurance that DOES NOT pay for vaccines\*\*, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)
- is an American Indian
- is an Alaskan Native

\* Pneumococcal conjugate vaccine (also known as Prevnar) will NOT be provided for patients who are underinsured.

\*\* Overseas travelers insurance policy holders (e.g. AIU) are considered underinsured.

If your child meets any of the requirements listed above, please request a screening record form from our front office staff. Once completed and signed, please return to our front office staff along with this signed information form. **A screening record form must be completed and signed for EACH child that is eligible for the VFC program.**

If your child DOES NOT meet any of the requirements listed above, please sign below and return this form to our front office staff.

Please be aware that if your child does not meet the VFC requirements and your insurance does not cover the cost of the vaccination(s), you will be responsible for payment.

There are 4 public health clinic locations in the city of Houston that provide all necessary vaccinations for a nominal fee. Please let us know if you need this information.

### Disclaimer

I have read and I understand the VFC information above.

\_\_\_\_\_  
Full Name of Child (PLEASE PRINT)

\_\_\_\_\_  
Name of Parent / Guardian (PLEASE PRINT)

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

**HIPAA: Authorization of Use and Disclosure of Protected Health Information**

**How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Blue Fish Pediatrics (“BFP”)?**  
**(Please check all that apply)**

Regular Mail                       Home Telephone                       Work Telephone

Appointment Cards               Email                                       Fax Machine

Other: \_\_\_\_\_

**If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at BFP? (Check one)**

Yes                                       No     N/A

**If “No,” how else may we contact you regarding this information?**

\_\_\_\_\_

**Please list any other restriction regarding messages or reminders about your healthcare:**

\_\_\_\_\_

**Other Uses and Disclosures:** Disclosure of your health information or its use for any purpose other than those listed in the “Notice of Privacy Practices” and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your protected health information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to BFP of your decision to revoke the authorization. You have the right to request restrictions on use or disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Persons Authorized to Receive Information:**

Health information BFP collects or receives about you may be disclosed to the following persons:

\_\_\_\_\_  
Name of person / relation / organization

\_\_\_\_\_  
Name of person / relation / organization

**Use and Disclosure of Information:**

\_\_\_ I authorize the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at BFP.

\_\_\_ I do not authorize the following information to be disclosed to any other parties except to me as the patient (please specify):

**Expiration Date of Authorization**

This authorization is effective through \_\_\_/\_\_\_/\_\_\_\_\_ unless revoked or terminated by the patient or patient’s personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to BFP. You should contact Masako Whitford to terminate this authorization.

**Potential for Re-Disclosure**

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

\_\_\_\_\_  
Name of Patient (print or type)

\_\_\_\_\_  
Signature of Patient (print or type)

\_\_\_\_\_  
Signature of Patient Representative (print or type)

\_\_\_\_\_  
Relationship of Patient Representative to Patient (print or type)

## NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction, if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Offices of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human  
Services Office of Civil Rights  
800 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-686-8775

## **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority