HEALTHY TOTS CHILDREN'S SERVICES, LLC

REGISTRATION FORM

Please print

Today's Date:_____ Pharmacy:_____

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	
Preferred Name:	Date of Birth:	Gender: ☐ M ☐ F	Preferred Language:

Race (Please check all boxes that apply to the patient):
☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian
☐ Caucasian/White ☐Native Hawaiian/Pacific Islander ☐ Other Race:_____

Please check one:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

☐ Check here if patient's address, contact information and parent/legal guardian information are the same as that of an existing patient of the clinic (Patient No. _____)

Street Address:	Apt No.	City:	State:	Zip Code:
Home Phone No.	Cell Phone No.	Email:		

Contact Preferences: ☐ Home Phone ☐ Cell Phone Is it okay to leave a message at the box you have selected? ☐ Yes ☐ No

PARENT/LEGAL GUARDIAN 1 INFORMATION

Last Name:	First Name:	Middle Name:	
Street Address:	Apt No.	City:	State:	Zip Code:
Home Phone No.	Cell Phone No.	Email:		

Contact Preferences: ☐ Home Phone ☐ Cell Phone Is it okay to leave a message at the box you have selected? ☐ Yes ☐ No

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian ☐Foster Parent ☐ Case Worker ☐ Other _____

Marital Status (circle one):
Single / Mar / Div / Sep / Wid

PARENT/LEGAL GUARDIAN 2 INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:
Street Address:	Apt No.	City:	State:	Zip Code:
Home Phone No.	Cell Phone No.	Email:	

Contact Preferences: ☐ Home Phone ☐ Cell Phone Is it okay to leave a message at the box you have selected? ☐ Yes ☐ No

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian ☐Foster Parent ☐ Case Worker ☐ Other _____

Marital Status (circle one):
Single / Mar / Div / Sep / Wid

INSURANCE INFORMATION

Primary Insurance:	Subscriber's Name:	Subscriber's Date of Birth:
Relationship to Patient:	Group No.	Policy No.
Secondary Insurance:	Subscriber's Name:	Subscriber's Date of Birth:
Relationship to Patient:	Group No.	Policy No.

PATIENT PORTAL INVITATION

If your child is under the age of 18, you will receive an invitation at the email you provided to sign up for a patient portal account.
If you are a patient of 18 years of age or above you will receive an invitation at the email you provided to sign up for a patient portal account.

IN CASE OF EMERGENCY

Name of local friend or relative:	Home Phone No.
Relationship to Patient:	Work Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Healthy Tots Children's Services, LLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Parent/Guardian Signature Date

Healthy Tots Children's Services, LLC

Consent for Treatment and/or Services

GENERAL CONSENT: I hereby voluntarily authorize Healthy Tots Children's Services, LLC to provide healthcare services encompassing medical services, diagnostic testing and therapeutic procedures to me/my child. I understand that these services may include an evaluation and assessment to help determine the treatment or services needed.

After my/my child's evaluation, I will receive an explanation of the provider's initial impressions and treatment recommendations. This explanation will cover all types of services that Healthy Tots Children's Services, LLC has determined will benefit the therapeutic process. I understand that I will be actively involved in my/my child's treatment plan.

I understand that all services provided to me/my child are confidential except in certain situations. I understand that providers are legally mandated to report actual or suspected child abuse to the appropriate authorities. I understand I will be informed if Healthy Tots Children's Services, LLC's providers determine my child is in danger of hurting themselves or others. In this event, additional assessment and notification of appropriate authorities may be warranted. I further understand that Healthy Tots Children's Services, LLC's providers may be required to release information to or testify in court, if summoned.

If there are any changes to my/my child's treatment/services they will be explained to me. I understand that all services are voluntary.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I authorize that payment be made to Healthy Tots Children's Services, LLC and I authorize release of any information necessary to process claims for services rendered to me/my child. I also authorize the release of information to Medicare, Medicaid or third party payers, medical and non-medical information, including employment status, and whether I have group insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which a Medicare, Medicaid or other claim is made.

I authorize Healthy Tots Children's Services, LLC, as a holder of medical or other information about me/my child, to release to insurance companies, health plans, agencies or representatives of any companies handling my/my child's claims, any information needed for this or any other claim for services obtained from Healthy Tots Children's Services, LLC.

PATIENT FINANCIAL RESPONSIBILITY: I understand that Healthy Tots Children's Services, LLC shall bill all insurance companies and third party payers if contractually obligated to do so. If my insurance fails to pay for any services provided to me/my child, I hereby acknowledge that I am responsible for any unpaid balances that are deemed my responsibility by Medicare, Medicaid, or other third party payers.

If I do not have insurance, Healthy Tots Children's Services, LLC will make arrangements with me to pay for my/my child's healthcare services on Healthy Tots Children's Services, LLC's Self-Pay Program. I agree to make all payments that have been arranged for me.

Patient Name (Print):_____ **Date of Birth:** _____

Signature of Patient/Legal Guardian: _____ **Date:** _____

Healthy Tots Children's Services, LLC

Designee Request Form

Authorization - Pediatric Patients Today's Date: _____

As **parents/legal guardians of children who are patients at Healthy Tots Children's Services, LLC**, you may give permission in advance for certain individuals (over the age of 18) to accompany your child/children to Healthy Tots Children's Services, LLC for their healthcare services when you cannot be present. Please list those individuals below.

I request and authorize Healthy Tots Children's Services, LLC and its personnel to deliver healthcare services in my absence to my child named below when accompanied by any of the following persons I have designated. I understand that as a result of my authorization these "Designees" have the ability to make medical and treatment decisions regarding my child. They also may obtain, have access to, or become aware of my child's protected health information and information regarding my child's billing account with Healthy Tots Children's Services, LLC. I understand that it is my responsibility to contact Healthy Tots Children's Services, LLC to remove names from this form, as needed, otherwise the "Designee Request" as shown will be honored.

Child's Name: _____ **Date of Birth:** _____

Parent/Legal Guardian Signature: _____

Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Authorization - Adult Patients

As **one of Healthy Tots Children's Services, LLC's adult patients**, you may also desire to designate certain individuals to assist you while obtaining healthcare services at Healthy Tots Children's Services, LLC. You may like to designate persons to call and make your appointments, to check on your lab results, to accompany you into your exam, assist you with billing questions, etc. Please list those individuals below.

I request and authorize Healthy Tots Children's Services, LLC and its personnel to deliver healthcare services to me in the presence of any of the "Designees" I have listed below. I also give Healthy Tots Children's Services, LLC permission to share information with the "Designees" I have listed regarding my appointments, test results, insurance and billing issues and any other healthcare issues that may arise. I understand that as a result of my authorization these "Designees" may obtain, have access to, or become aware of my protected health information and information regarding my billing account with Healthy Tots Children's Services, LLC. I understand that it is my responsibility to contact Healthy Tots Children's Services, LLC to remove names from this form, as needed, otherwise the "Designee Request" as shown will be honored.

Adult Patient's Name: _____ **Date of Birth:** _____

Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Acknowledgement of Receipt of
Healthy Tots Children's Services, LLC's
Notice of Privacy Practices and Patient Rights

By signing this form, I hereby acknowledge receipt of Healthy Tots Children's Services, LLC's **Notice of Privacy Practices and Patient Rights:**

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Patient's Name: _____ DOB: _____

_____ _____

Signature of Parent/Legal Guardian* Date
(If patient is under 18 years of age)

Relationship to Patient: _____

_____ _____

Signature of Patient (if 18 years of age or older)* Date

*If signature is by a thumb print or "X," a Healthy Tots Children's Services, LLC staff member must witness:

_____ _____

Signature of Healthy Tots Children's Services, LLC Staff Member Date

HEALTHY TOTS CHILDREN'S SERVICES, LLC

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

This Notice is effective July 17, 2017

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

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU/YOUR CHILD

We are required by law to protect the privacy of medical information about you/your child and that identifies you/your child. This medical information may be information about health care we provide to you/your child or payment for health care provided to you/your child. It may also be information about your/your child's past, present, or future medical condition.

We are also required by law to provide you with this **Notice of Privacy Practices** explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request (you may always contact our Privacy Officer to obtain a copy of the current notice).

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you/your child.
- Explain your rights with respect to medical information about you/your child.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU/YOUR CHILD IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you/your child in order to provide health care, obtain payment for that health care, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you/your child. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer.

1. Treatment
We may use and disclose medical information about you/your child to provide health care treatment to you/your child. In other words, we may use and disclose medical information about you/your child to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your/your child's treatment and coordinating and managing your/your child's health care with others.

2. Payment
We may use and disclose medical information about you/ your child to obtain payment for health care services that you received. This means that, within Healthy Tots Children's Services, LLC, we may use medical information about you/your child to arrange for payment (such as preparing bills and managing accounts). We also may disclose medical information about you/your

child to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you/your child to an insurance plan before you receive certain health care services because, for example, we may want to know whether the insurance plan will pay for a particular service.

3. Healthcare Operations
We may use and disclose medical information about you/your child in performing a variety of business activities that we call "health care operations." These "health care operations" activities allow us to, for example, improve the quality of care we provide and reduce health care costs.

Our Business Associates – Healthy Tots Children's Services, LLC will contractually require our Business Associates to follow the same confidentiality laws and rules required of all other healthcare providers and health plans. Furthermore, the HITECH Act of 2009 requires that all Business Associates comply with the privacy and security regulations in the same manner as is required of the health care provider. Note: Business Associates perform various activities such as billing services, after-hours telephone answering services, medical software vendors, etc.

4. Persons Involved in Your Care -Designees
We may disclose medical information about you/ your child to a relative, close personal friend or any other person you identify as a "DESIGNEE". If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in
limited circumstances. If you want certain persons to be allowed to bring you/your child for services at Healthy Tots Children's Services, LLC, you must complete a **Designee Form** and this person must be listed on the form. Be aware that listing them as a DESIGNEE may allow them to obtain information regarding your/your child's protected health information and billing information. For more information on the privacy of minors' information, contact our Privacy Officer. We may also use or disclose medical information about you/your child to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you/ your child to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or

may not be able to agree to your request. You may remove persons as "DESIGNEES" at any time.

5. Required by Law
We will use and disclose medical information about you/your child whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Texas Child Protective Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures
When permitted by law, we may use or disclose medical information about you/your child without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you/your child in these circumstances when we are permitted to do so by law.

7. Authorizations
Other than the uses and disclosures described above (#1-6), we will not use or disclose medical
information about you/your child without the "authorization" – or signed permission – of you/your child or your personal representative. In some instances, we may wish to use or disclose medical information about you/your child and we may contact you to ask you to sign an **Authorization Form**. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an **Authorization Form**.

If you sign a written authorization allowing us to disclose medical information about you/your child, you may later revoke (or cancel) your authorization (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you must fill out an **Authorization Revocation Form. Authorization Revocation Forms** are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU/YOUR CHILD

You have several rights with respect to medical information about you/your child. This section of the Notice will briefly mention each of these rights. If you would like to know more about your/your child's rights, please contact our Privacy Officer.

1. Right to a Copy of This Notice
You have a right to have a paper copy of our **Notice of Privacy Practices** at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer.

2. Right of Access to Inspect and Copy
You have the right to inspect (which means see or review) and receive a copy of medical information about you/your child that we maintain in certain groups of records. If we maintain your /your child's medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your/your child's medical records. You may also request an electronic copy of your/your child's medical records be sent to a third party. If you would like to inspect or receive a copy of medical information about you/your child, you will need to complete a **Medical Record Release Form**. These forms are available from our office.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you/your child, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request. Healthy Tots Children's Services, LLC will follow the Texas Medical Board guidelines for charging for copies of medical records either paper or electronic. We may be able to provide you with a summary or explanation of the information in your/your child's medical record. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended
You have the right to have us amend (which means correct or supplement) medical information about you/your child that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must complete an **Amendment Request Form** and explain why you would like us to amend the information. **Amendment Request Forms** are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made
You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you will need to complete an **Accounting of Disclosures Request Form. Accounting of Disclosure Request Forms** are available from our Privacy Officer. The accounting will not include several types of disclosures, including disclosures for treatment, payment or health care operations. If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures
You have the right to request that we limit the use and disclosure of medical information about you/your child for treatment, payment and health care operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of health care operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a health care item or service for which the health care provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation. All requests for restrictions must be made by completing a **Restriction Request Form**. This form can be obtained by contacting Healthy Tots Children's Services, LLC's Privacy Officer.

6. Right to Request an Alternative Method of Contact
You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must complete an **Alternative Communication Request Form. Alternative Communication Request Forms** are available from our Privacy Officer.

7. Breach Notification
The HITECH Act of 2009 requires that health care providers and other covered entities (such as Business Associates) promptly notify affected individuals when there has been a breach of protected health information. Health care providers who experience a breach of information affecting 500 or more individuals must report the breach to the HHS Secretary and the media. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require that the Business Associates notify the health care provider or covered entity of any breaches at or by the Business Associate.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your/your child's privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you/your child in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

HIPAA Privacy Officer
Healthy Tots Children's Services, LLC
2804 Southmost Rd.
Brownsville, TX 78521

To file a written complaint with the federal government, please use the following contact information:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W. Room
509F, HHH Building Washington,
D.C. 20201

Toll-Free Phone: (800) 368-1019
TDD Toll-Free: (800) 537-7697
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html Email:
OCRMail@hhs.gov