Elias Ezike, MD, PA
710 South 8th Street, Suite A • Beaumont, TX 77701 • (409) 838-9944

Patient Information

Appointment Date:_____

Patient's Name:_____ ❑ Male ❑ Female

Patient's Date of Birth: _____

Address: _____

City/State/Zip:_____

Home Phone: ( ) _____ Cell:( ) _____ Email: _____

Father:_____Phone:_____ DOB: _____

S.S.# _____

Employer_____

Work Phone: ( ) _____

Mother:_____Phone:_____ DOB: _____

S.S.# _____

Employer_____

Work Phone: ( ) _____

Child's Previous Doctor:_____

Primary Insurance

Insurance Company:_____Policy#_____ Group# _____

Insured Name:_____ Insured DOB:_____

Address:_____ City/State/Zip _____

Phone:( ) _____Relation to Patient:_____ Insured S.S.# _____

Insured Employer:_____ Employer Address: _____

Secondary Insurance

Insurance Company:_____Policy#_____ Group# _____

Insured Name: (if different)_____ Insured DOB: _____

Address:_____ City/State/Zip _____

Phone:( ) _____Relation to Patient:_____ Insured S.S.# _____

Insured Employer:_____ Employer Address: _____

Emergency Contact

Name:_____ Relationship: _____

Home Phone:( ) _____ Cell:( ) _____ Work: ( ) _____

Referred By: _____

Assignment of Benefits/Consent for Treatment

I hereby agree to pay in full for medical services unless contractually or statutorily prohibited. I am aware that I will be financially responsible for any charges not paid by my insurer, employer or other third party. I also agree that any payment due from me will be made at the time services are rendered or promptly upon billing. We aspire to deliver the best medical care to every client but no guarantee is made as to the outcome of treatments or testing.

I authorize Elias Ezike, MD PA to release to my insurance companies all medical and confidential information necessary to process my insurance claims.

_____ _____

Parent/Patient Signature Date

PATIENT NAME:_____ DATE:____/____/____

MEDICAL HISTORY:

Birth Weight:_____ Length:_____ Hospital:_____

Problems during pregnancy/labor/delivery:_____

_____

Problems as newborn:_____

_____

Development:

Normal:_____ Delayed:_____

Held head up:_____ Sat up:_____ Crawl:_____ Walk:_____ Say words:_____

Potty train:_____ Ride Bike:_____

Accidents/Illness:_____

Surgery/Broken bones:_____

Hospitalization:_____

Drug Allergy:_____

Other Allergies:_____

Medications your child is on:_____

_____

Past Medical History:

_____

_____

_____

Family History: If Yes, List how related to the child.

Cancer	Yes	No	_____
Heart Problems	Yes	No	_____
Diabetes	Yes	No	_____
Inherited Anemia	Yes	No	_____
Other	Yes	No	_____

Please circle the following if you feel a problem exists and then explain:

Head - Chronic nasal problems - Hearing - Ear Infections - Vision - Teeth - Headaches - Sore Throats

Other_____

Lungs - Cough - Wheezing - Chest Pain - Numerous Infections

Heart - Chest Pain - Rapid Heart Beat - Heart Murmurs

Genital/Urinary - Problems w/urine - Blood - Problems w/stream Urine - Infections - Pain

Unusual lump in genital area

Abdomen - Pain - Chronic Vomiting - Constipation Diarrhea - Blood in Stool - Food Intolerance

Other_____

Skin - Chronic Rash - Unusual Moles - Birth Marks

Explain circled problems:_____

_____

Are immunizations up to date: Yes No

Previous reactions to vaccines:_____

Other problems not listed above:_____

Elias Ezike, MD PA
710 South 8th Street, Suite A.
Beaumont, TX 77701. (409)838-9944

POLICY

No show and Cancellation Policy: It is important that you keep your appointment. If for any reason you could not keep your appointment, call at least 2 hours ahead of time to reschedule. We try to call one day before your appointment as a courtesy, however, you are responsible for keeping your appointment even if we cannot reach you. If NO SHOW FOR 3 APPOINTMENTS in a year, a warning letter will be sent. Any subsequent NO SHOW within one year of receiving a warning letter will be followed by a dismissal letter.

Immunization Policy: Our office does not accept families who are unwilling to vaccinate their children because we strongly believe in the importance of immunization as one of the most high quality preventive medicine. Families who have question on immunization can discuss their concern with the physician at the visit.

Prescription Refill Policy: Refills cannot be obtained after hours or on the weekends as the Doctor on call may not have access to your medical record.

Late Arrival Policy: Clients arriving more than 20 minutes late to their appointment time will be asked to reschedule to any available appointment.

Early Arrival Policy: If you arrive earlier for your appointment, you still have to respect your appointment time.

Change of Contact/ Insurance Information: You are encouraged to inform our office of any change of address, phone number or insurance so that we can update your profile.

Conduct: Because ours is a pediatric office, we aspire to show good example to the children. Use of inappropriate language may result to dismissal.

_____ _____

Patient's Name Date

_____ _____

Parent/Patient/Guardian Signature Name of Parent/Guardian

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize_____ _____ _____
Name of Facility/Physician | Phone Number | Fax Number

to release medical information from the records of:

Patient Name:_____ D.O.B.: _____

Address:_____

City:_____ State:_____Zip Code:_____

Information to be released:

- ❑ All Available Pertinent Information
- ❑ Records
- ❑ Consultation Records
- ❑ Immunization Record
- ❑ Radiology Reports
- ❑ Progress Notes
- ❑ Other_____

Purpose of Release (Please check appropriate box)

- ❑ Change of Primary Care Physician/Clinic
- ❑ Other (Specify)_____

Please initial below to include the following:

_____ Alcohol/Drug Treatment
_____ HIV Related Information
_____ Mental Health Information
_____ Genetic Testing

Information to be released to:

Recipient's Name: **Dr. Elias Ezike**
Street Address: **710 South 8th Street, Suite A**
City: **710 South 8th Street, Suite A** State: **TX** Zip Code: **77701**
Phone Number: **(409) 838-9944** Fax Number: **(409) 838-9086**

Conditions of Authorization:

I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization and that in any event this consent expires as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure to a third party such as the treating physician or insurance.

This authorization expires on:_____ or on the following event:_____
(If I fail to specify an expiration date or event, this authorization will expire 1 year from the date signed)

_____ _____
Signature of Parent/Patient/Legal Responsible Person | Date

_____ _____ _____
Printed Name of Parent/Legal Responsible Person | Relationship | Phone Number

Elias Ezike, MD, PA
710 S 8th Street, Suite A
Beaumont, TX, 77701
(409)838-9944

Authorization - Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances. However, we must have written auhtorization allowing this person to accompany your child(ren). The person bringing your child(ren) will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, vaccinations, medication, certain procedures, and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child(ren) to Elias Ezike, MD, PA and to discuss and share medical information about my child(ren). I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of Elias Ezike, MD, PA.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
SIgnature (Parent/Guardian) **Date**

HIPAA Notice of Privacy Practices

[Name of Practice]

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 Practices 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 and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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, coordinate, 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, marketing and fundraising activities, 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-in sheet at the registration desk where you will be 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: Workers' 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 authorization.

Elias Ezike MD - Pediatrics
710 South 8th Street, Suite A
Beaumont, TX 77701
Fax 409-838-0986
409-838-9944

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_____
Patient Parent/Guardian

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ Male ☐ Female

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, 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 (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. 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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 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.texas.gov* 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 ImmTrac2 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 • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**