Care First Pediatrics

Dr. Anitha Sathyanarayana Singh M.D., FAAP
5501 Independence Parkway, Suite #300
Plano, Texas 75023
(972) 867-8979 Fax: (972) 758-0871

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: TX *Zip: _____*

Primary Ph No: (_____) _____

Email ID: _____

Emergency Contact: Not Living with Pt

Name: _____

Phone Number: _____

Relationship to Pt: _____

***Pharmacy Name**: _____*

***Pharmacy City**: _____*

***Pharmacy Phone**: _____*

Parent/Guardian Information:

Father: _____

Date of Birth: _____

Phone Work: _____

Phone Cell: _____

Mother: _____

Date of Birth: _____

Phone Work: _____

Phone Cell: _____

Insurance Information:

Subscriber: Father / Mother / Guardian / Self (all Medicaid members)

Insurance Company: _____

Policy ID# _____

Secondary Insurance (If you have): _____

I authorize Anitha Sathyanarayana Singh M.D. to treat my child and I accept full responsibility for this medical care. I understand that claims are only filed for primary insurance and if Dr. Singh is contracted with my insurance plan. I agree to pay the co-payment, deductible and any fees determined to be my responsibility at the time of the visit. **I understand and agree that regardless of my insurance plan. I am ultimately responsible for the balance for services rendered.** I authorize payment of medical benefits to Anitha Singh M.D. for all medical services provided during the term of the policy. I certify that all information on this form is true and correct to the best of my knowledge. I will pay by **CASH or CREDIT CARD** at the time of services rendered.

Signature of Parent/Guardian: _____ Date: _____

Anitha Sathyanarayana Singh M.D.
5501 Independence Pkwy Suite#300
Plano-TX 75023

Notice Privacy Practices
Acknowledgement of Receipt Form

Notice of Privacy Practices provides information about how health information can be used and disclosed about you. You have the right to review the Notice before signing this consent. A copy to the current Notice is posted in the waiting room.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice.

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

_____ _____
Signature of Parent/ Legal Guardian **Date**

In order to better protect your privacy under HIPPA, we have created this consent form for releasing medical information to the family members and other people of the patients choosing. Many times, we have patients whose family members call requisition medical information and legally we are not allowed to release that information without parental consent. This portion of the form will remain effective until it is revoked in writing and will remain as part of the health record.

I, _____ (**Parent/ Guardian Name),**

hereby give my consent for the names listed below to accompany my child at doctor appointments and permission for the release of medical information regarding appointments and questions about my child's condition and treatment to the following person (s):

Name: _____ Relationship: _____

Name: _____Relationship: _____

Name: _____ Relationship: _____

Signature of Parent/Legal Guardian: _____Date: _____

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.**

CAREFIRST PEDIATRICS

REQUEST FOR RELEASE OF MEDICAL RECORDS

Dr. Anitha Sathyanarayana Singh M.D., FAAP
5501 Independence Parkway, Suite #300
Plano, Texas 75023
Phone: (972) 867-8979 Fax: (972) 758-0871

I request that my child(s) complete records include Immunization record or specific information to be released to as listed above.

(From OR To) X _____

Physician or Practice Name

_____

Address

Phone # _____ Fax # _____

****

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

☐ All Records (Via Fax or Mail) ☐ Shot Record only ☐ Specific Record

I, _____ here by authorize the release of my child(s) medical records including progress notes, growth charts, labs, immunization records, radiology reports and consultations to Dr. Anitha Sathyanarayana Singh. If the requestor or receiver is not a healthcare provider, the released information no longer be protected by federal privacy regulations or may be redisclosed. I have read and authorize the disclosure of the protected health information as stated.

Clinical Professional or
Parent/Guardian Signature: _____ Date: _____