# New Patient Registration Form

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

*Please complete the following truthfully and to the best of your ability. The * denotes a Required Field*

***Patient Information****

First name: ____________________ Middle name: _______________ Last name: __________________

Date of Birth: _____/_____/_______ Preferred name: _________________ Sex: Male [ ] Female [ ]

Home Address: ____________________________________________________ Apartment #: ________

City: ______________________________________ State: ________________ Zip Code: ___________

***Parent/Guardian Information****

Guardian 1 name : _________________________ Guardian 2 name: _________________________

Relationship to patient: _____________________ Relationship to patient: _____________________

Date of Birth: _______/_______/______________ Date of Birth: _______/_______/______________

Phone number: ____________________________ Phone number: ____________________________

Email: ___________________________________ Email: ___________________________________

Please check ***ONE*** primary contact, the denoted will be contacted first followed by the secondary: Guardian 1 **[ ]** Guardian 2 **[ ]**

***Emergency Contact:*** *This person will only be contacted for updated contact information and during medical emergencies, if we are unable to get in touch with either guardian.*

Name: _____________________________ Relationship to **patient:** _____________ Phone: ____________________

***Communication Preferences:*** *We will do our best to accommodate your preferences, but in the event our office does not have personnel who can translate, we ask that you bring someone who can assist you during the appointment.*

Preferred method of communication: Phone [ ] Text Message [ ] Email [ ]

Preferred language: English [ ] Spanish [ ] Other: ______________ [ ]

Do you require translation (written/verbal) services? Yes [ ] No [ ]

***Primary Insurance Policy****

Policy holder's name: ______________________________ Relationship to patient: _______________

Insurance name: ___________________________________________________________________________

Subscriber or Member ID: ________________________________ Group #: ___________________

***Secondary Insurance Policy (if applicable):*** *If your child has both medicaid and commercial insurance, the commercial insurance will be primary and medicaid will be secondary*

Policy holder's name: ______________________________ Relationship to patient: ________________

Insurance name: ___________________________________________________________________________

Subscriber or Member ID: ________________________________ Group #: ___________________

***Preferred Pharmacy*:*** *All medications will be electronically sent to your pharmacy. Please confirm with your insurance provider to find a pharmacy that is in-network with your coverage.*

Pharmacy name: ___________________________________________________________________________

Pharmacy address: _________________________________________________________________________

***Vaccination Policy****

CareFirst Pediatrics is a primary-care clinic that practices evidence-based medicine. Therefore, we believe in routine immunizations to protect your child from serious illness or disease. We require all patients under the care of Dr. Anitha Singh to adhere to the vaccination schedule endorsed by the Center for Disease Control and the American Academy of Pediatrics. We understand that parents may have questions regarding immunization, and CareFirst Pediatrics staff are more than willing to answer your questions. If you are unwilling to immunize your child on schedule, we recommend finding another physician who is able to better meet your needs. **Non-compliance with this vaccination policy may result in dismissal from the practice.**

_______________________________ ___________

Parent/Guardian Signature Date

***Consent for Treatment and Clinic Guidelines****

I authorize Dr. Anitha Bai Sathyanarayana Singh to treat my child. I understand that appointments are provided on a first-come, first-serve basis and that all forms requiring a physician's signature will have a turn-around time of 1 business day. I will adhere to the clinic guidelines and will abide by them and staff in a respectful manner. I certify that I have read the provided forms and understand the terms set forth by CareFirst Pediatrics. I certify that all information on this form is true and correct to the best of my knowledge.

_______________________________ ___________

Parent/Guardian Signature Date

# Patient Billing Policy

Dr. Anitha Bai Sathyanarayana Singh M.D., FAAP
5501 Independence Parkway, Suite 300, Plano, Texas 75023
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As of March 11th, 2024, the Financial Policies of CareFirst Pediatrics PLLC have been revised and are as follows. It is the patient's guardians' responsibility to read the aforementioned policies and understand them in their entirety.

CareFirst Pediatrics staff will verify your insurance coverage before your visit. However, you are ultimately responsible for understanding your insurance coverage, including but not limited to effective dates, in-network status, co-pays, co-insurance, deductibles, and premiums.

____________
Initial

If your deductible has not been met or your insurance benefits include coinsurance, a $75 fee will be collected at the start of the visit. If you are responsible for any balance due after any insurance claims are processed, the balance will be billed via a statement and expected to be paid at your next visit.

____________
Initial

If you are here for a routine wellness visit and you have other items to discuss with the provider, then you might receive an additional charge that could include Copay/Coinsurance and/or Deductible.

____________
Initial

It is expected that if your insurance policy changes at any time, you will inform CareFirst Pediatrics staff to update your coverage to bill your correct insurance provider. If your insurance is inactive or incorrect during the time services are rendered, you will ultimately be responsible for any balance your insurance company refuses to cover.

____________
Initial

Payment is due at the time services are rendered. If there is a balance due on your account, you will not be seen for an office visit until complete payment is received by CareFirst Pediatrics. From the date the explanation of benefits is received, you will have three months to provide proper payment. If non-compliance exceeds the three month grace period, your balance will be sent to a third-party collection agency.

____________

Initial

If your insurance policy is a Health Maintenance Organization (HMO) Plan, you are required to have a primary care provider assigned. If Dr. Anitha Singh is not listed as your primary care provider with your HMO provider, you may be responsible for additional charges at the discretion of your insurance provider.

____________

Initial

If you have questions or dispute your balance's validity, contact our billing department as soon as possible upon receipt of the statement. Delays in communicating with the billing department for any reason will result in personal responsibility for bills.

____________

Initial

If your child is a child of divorced parents, payment for treatment of minor children rests with the parent who seeks the treatment. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of CareFirst Pediatrics.

____________

Initial

I understand the financial policies described in this document in their entirety and will respectfully abide by them. I understand that violation of these guidelines may result in my child's dismissal from the clinic. We appreciate your cooperation with us as our clinic grows and our policies adapt to best fit our patients and our clinic's needs.

| | |
|---|---|
| __________________________ | __________________________ |
| Patient's Name | Parent/Guarantor's Name |
| __________________________ | __________________________ |
| Patient's Date of Birth | Parent/Guarantor's Signature |

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):

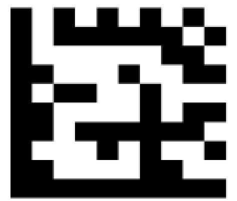
Name: _______________________________ Relationship: _________________________

Name: _______________________________Relationship: __________________________

Name: ______________________________ Relationship: __________________________

**Signature of Parent/Legal Guardian:** ___________________________Date: _________

# *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.**

## 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: ______________