LEAGUE CITY
PEDIATRICS

Dear Parent,

Thank you for choosing League City Pediatrics as your child's medical home!

We strive to provide the most comprehensive, evidence-based, family-centered care possible for your child. We adhere to the highest standards set for both preventative and acute care by the American Academy of Pediatrics. We strive to provide easy access to the practice and that our approach to your child's care coordinates many different aspects that contribute to a positive healthcare experience.

Central to the success of this care is that we work together as a team. Please call our office before you decide to go to Urgent Care or Emergency Department for non-life- threatening health issues and notify the office immediately in the event that your child received any care outside the practice. This enables us to follow up with you and make necessary updates to the medical record.

Please note that League City Pediatrics is dedicated to the health and safety of all our patients. We believe that all children should receive the recommended vaccines according to the guidelines provided by the American Academy of Pediatrics and the CDC. Vaccines are safe and effective in warding off infections and preventing diseases/health complications in children and young adults.

For your convenience, the office hours are: Monday – Saturday from 9:00am to 6:00pm.

Expecting mothers and fathers are welcome to come for a visit to our office to meet and talk with our providers to ensure the very best care for your upcoming bundle of joy! After delivery and before leaving the hospital, please contact our office for your newborns follow up visit, usually within 1-2 days of your discharge home.

To enable you to get in and out of the office without delays, please fill out any paperwork necessary before the visit. If you are unable to do so, please arrive at least 15 minutes before your visit to complete your forms in time for your appointment.
Before your first visit, please bring a copy of all previous Medical/Immunization records. If you could also complete the Authorization for Release of Medical Information and submit this to your child's previous doctor or clinic, so all previous medical records can be transferred to us.

We are glad to have you join us at League City Pediatrics!

PATIENT INFORMATION

TODAY'S DATE: _____

Last _____ First _____ Middle _____

Birth Date ____ /____ /____ Sex: M ☐ F ☐ SSN# _____

Race: White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Not Provided

☐ Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Provided ☐ Language: _____

Address _____

City _____ State _____ Zip _____

SIBLINGS

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

PRIMARY GUARDIAN INFORMATION

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ____ /____ /____ Sex M ☐ F ☐ SSN# _____

Driver's License # _____ Address: Same as Patient Y ☐ N ☐ (if no, please enter below)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (1) _____

Preferred method of contact to confirm appointments: Phone (home ☐ cell ☐) Text Msg ☐ (Number: _____)

Employer _____ Work Phone _____

SECONDARY GUARDIAN INFORMATION

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ____ /____ /____ Sex M ☐ F ☐ SSN# _____

Driver's License # _____ Address: Same as Patient Y ☐ N ☐ (if no, please enter below)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (2) _____

Employer _____ Work Phone _____

EMERGENCY CONTACT (1)

Last _____ First _____ Middle _____

Relationship to Patient _____**To authorize consent for treatment, please complete attached consent form**

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

EMERGENCY CONTACT (2)

Last _____ First _____ Middle _____

Relationship to Patient _____**To authorize consent for treatment, please complete attached consent form**

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

PRIMARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ____ /_____ /_____ Relationship to Patient _____ Effective Date ___/___/___

SS # or ID # _____ Group # _____

SECONDARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ____ /_____ /_____ Relationship to Patient _____ Effective Date ___/___/___

SS # or ID # _____ Group # _____

PHARMACY INFORMATION:

Name: _____ Phone: _____

Address _____ City _____ State _____ Zip _____

PHARMACY AUTHORIZATION:

By signing this consent form you are agreeing that League City Pediatrics can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment and payment purposes. Understanding all of the above, I hereby provide informed consent to League City Pediatrics to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature _____ Date _____

AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD (BY OTHER THAN GUARDIAN)

I, the undersigned parent or legal guardian of _____ _____/_____/_____

Patient's name Patient's DOB

authorize the following individuals to accompany my child, make decisions for treatment necessary by a physician and sign any necessary waivers at League City Pediatrics in my absence:

_____

(Name) (Relationship to patient) (Phone#)

_____

(Name) (Relationship to patient) (Phone#)

I understand that this consent authorization is given in advance of any specific diagnosis, treatment or hospital care being required in order to provide authority for a licensed physician to render any and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child. I understand that I am responsible for settling any costs arising from this care provided in my absence.

This consent will remain in effect indefinitely unless otherwise noted here: _____(Date to end consent)

_____

Parent or Legal Guardian Signature Date Print Name

LEAGUE CITY
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

List where you want your current medical records to *be* ***SENT FROM:*

The person named above authorizes information to be released by representatives of:

Name of Person, Provider, or Facility	
Address	
Phone	
Fax	

The person named above hereby authorizes _____ **to**
Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☒ Send health information to
- ☐ Discuss health information with

List where your current medical records are to be *SENT TO*:

Name Of Person, Provider, Or Facility	League City Pediatrics
Address	3831 E. League City Pkwy, Suite A League City, TX 77573
Phone	281-581-7008
Fax	281-581-7009

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____	_____	_____	_____
Signature of Patient or Authorized Representative	Date	Signature of witness	Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge.