DIANA EISNER, M.D., F.A.A.P.
Pediatrics
2030 N. Loop West Suite #125
Houston, Texas 77018
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Website: www.memorialdoctors.com / Diana Eisner, M.D.

Welcome and thank you for choosing Dr. Eisner for your medical care.
We are committed to providing you with quality medical care, our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area physician's charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Method of Payment: Dr. Eisner accepts personal checks, cash, debit cards or credit cards (Master Card/Visa) for payment of your medical services. A $30.00 fee will be accessed to your account for all returned checks.

Regarding Insurance
Indemnity and Private Insurance Policies: Dr. Eisner will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. **REMEMBER: You are responsible for paying your bill or seeing to it that your bill gets paid.**

Contracted Managed Care Plans (HMO, PPO, POS, EPO, etc.): Each time you make an appointment with Dr. Eisner it is your responsibility to make sure the physician is currently under contract with your plan. Verification of your plan benefits/coverage is required. Often this verification requires us to share the reason for your visit with a managed care plan. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Office Charges and/or Fees: The following charges and/or fees will be accessed to your account when incurred.

- If appointments are missed more than two times without advance notification: **$25.00**. Following missed appointments: **$25.00**/each.
- No advance notification when running more than 15 minutes late for an appointment: **$25.00**.
- Paying co-pay late (not at time of visit): **$10.00**.
- Non-Urgent referrals or other paperwork without at least one week notice**: $25.00**.
- Not giving 48 hours advance notice for an ADHD medication refill: **$10.00**.
- Re-writing the same ADHD prescription or having to complete paperwork twice either because the prescription was not picked up/filled in a timely manner or some other patient responsibility not met: **$25.00**.
- Copies of immunization records: **$10.00** (excludes forms completed at no charge at time of routine office visits or well child care visits).
- Completion of forms, such as camp, day care or athletic activity participation forms: **$10.00 - $25.00** (depending on complexity of form).
- Copying records: **$25.00** for the 1st twenty pages, and **$0.50** per page for every other copy thereafter.

I have read and understand the above terms and conditions and will verify so by giving my signature.

Signature Date

Insurance Assignment and Consent for Treatment:

I request payment of authorized Insurance company benefits be made on my behalf to Dr. Eisner for any services furnished me by that party who accepts assignment/physician.

I hereby consent to medical care for myself/my child, including a general pediatric examination, vaccines recommended by the Texas Dept. of Health, and treatment in Dr. Eisner's office by Dr. Eisner or her assistants, as authorized by Dr. Eisner. Dr. Eisner's office has provided educational materials for all of the vaccines required by the Texas Dept. of Health

Signature Date

Statement of Coverage: I hereby attest that I do not have additional health care coverage afforded to me other than the primary insurance supplied by myself or legal guardian at the time of my appointment.

Signature Date

PATIENT INFORMATION FORM

TODAY’S DATE _______________

PATIENT NAME ____
LAST FIRST MIDDLE

PATIENT DATE OF BIRTH _______________________ COUNTY RESIDE__________________

HOME ADDRESS ______________________________CITY _____________________________

STATE _________________ ZIP _________________ HOME PHONE _____________________

MOTHER'S CELL PHONE _________________ FATHER'S CELL PHONE __________________

MOTHER'S E-MAIL ADDRESS____

MOTHER’S NAME __________________________________ STATUS M___ S ___ D ___W___

MOTHER'S MAIDEN NAME____

MOTHER'S EMPLOYER ____

WORK ADDRESS ____

POSITION ________________________WORK # _____________________________________

SOCIAL SECURITY # ___________________________TDL# ____________________________

FATHER’S NAME ___________________________________ STATUS M___S___D___ W___

FATHER'S E-MAIL ADDRESS____

FATHER'S EMPLOYER ____

WORK ADDRESS ____

POSITION _______________________WORK # ______________________________________

SOCIAL SECURITY # ___________________________ TDL# ___________________________

EMERGENCY CONTACT ____

PHONE # ___________________________ CELL/BEEPER# _____________________________

INSURANCE COMPANY _____________________INSURED NAME_____________________

NAME OF PREVIOUS PHYSICIAN____

HOW WERE YOU REFERRED TO OUR OFFICE ____________________________________

FAMILY HISTORY

PLEASE STATE THE NAMES AND AGES OF ALL PEOPLE LIVING IN YOUR HOUSEHOLD, INCLUDING PARENTS, CHILDREN AND ANY CHILDREN FROM PREVIOUS MARRIAGE IF APPLICABLE..
MOTHER'S DOB ________________ FATHER'S DOB ________________________

____

____

2. DID THE MOTHER OF THESE CHILDREN HAVE ANY MISCARRIAGES OR CHILDREN WHOM HAVE PASSED AWAY? IF SO, WHEN AND THE CAUSE.

____

____

3. DOES THE BIOLOGICAL MOTHER, FATHER OR THE CHILD HAVE ANY SIGNIFICANT HEALTH PROBLEMS OR ARE THEY DECEASED?

____

____

4. ARE THEIR ANY FAMILY MEMBERS (I.E. GRANDPARENT, AUNTS, UNCLES AND COUSINS) WHO HAVE ANY SIGNIFICANT HEALTH PROBLEMS OR ARE DECEASED?

____

____

5. ARE ANY OF THE FOLLOWING TO YOUR KNOWLEDGE IN YOUR FAMILY? ANSWER YES OR NO AND RELATIONSHIP TO YOUR CHILD.
MENTAL RETARDATION ____
BIRTH DEFECTS ____
INFANT DEATHS ____
SICKLE CELL ANEMIA ____
CYSTIC FIBROSIS ____
ANY OTHER DISEASES WHICH YOU THINK ARE GENETIC

____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number
- ☐ Other ______________________

____ ______________________

Parent's ~~Patient~~ Signature Date

____ ______________________

Patient's ~~Print~~ Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD
REGISTRO DE INMUNIZACIÓN (ImmTrac)
FORMULARIO DE CONSENTIMIENTO

(***Please print clearly** / Sirvase escribir claramente con letra de molde*)

For Clinic/Office Use

Child's Last Name / Apellido del niño(a)

Child's First Name / Nombre del niño(a)

Child's Middle Name / Segundo nombre del niño(a)

/ /

***Children under 18 years only** / Solamente niños menores de 18 años*

Child's Date of Birth / Fecha de nacimiento del niño(a)

Child's Gender / Género: ☐ **Male** / Masculino ☐ **Female** / Femenino

Child's Address / Dirección del niño(a)

Apartment # / Apartamento #

Telephone / Teléfono

City / Ciudad

State / Estado **Zip Code** / Código postal

County / Municipio

Mother's First Name / Nombre de la madre

Mother's Maiden Name / Nombre de soltera de la madre

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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.

El registro de inmunización (ImmTrac) de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud. El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

Consentimiento Para Registrar al Niño(a) y Para Poder Dar a Conocer a Entidades Autorizadas el Récord de Inmunizaciones del Niño(a)

Entiendo y acepto que al autorizar mi consentimiento en la parte inferior, registro a mi niño(a) en el registro de inmunización del Departamento Estatal de Servicios de Salud de Texas y autorizo al registro para que incluya la información de mi niño(a) en el registro y que el récord de inmunizaciones de mi niño(a) del pasado, presente y futuro sea dado a conocer a alguno de los padres del niño(a), y a cualquiera de los siguientes:

- distrito de salud pública o departamento de salud local;
- médico o proveedor de atención de salud;
- compañía de seguros, organización para el mantenimiento de salud o pagador;
- escuela o centro de cuidado de niños, en el que el niño(a) está inscrito y/o
- agencia estatal que tenga custodia legal del niño.

Reconozco y acepto que en cualquier momento puedo retirar mi consentimiento de poder incluir la información de mi niño(a) en el Registro ImmTrac, y también retirar mi consentimiento para poder dar a conocer la información del registro, por medio de comunicación escrita dirigida al Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Al firmar abajo, YO **AUTORIZO el consentimiento** para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:
Alguno de los padres, tutor legal o administrador de bienes:

____
Printed Name / Escriba con letra de molde

______________________ ______________________________
Date / Fecha **Signature** / Firma

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.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a **http://www.dshs.state.tx.us** para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code,* sección 552.021, 552.023, 559.003 y 559.004)

Questions? / ¿Tiene preguntas? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • 1100 West 49th Street • Austin, TX 78756

Stock No. C-7
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TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – please fax this **signed** (by parent) Consent Form to ImmTrac **only if the child is not** currently registered with ImmTrac.*
Fax to: Toll free (866) 624-0180