LEGACY
Developmental Pediatrics

PATIENT INFORMATION

Today's Date: _____

Name: Last_____ First_____Nickname _____

Date of Birth _____

Address_____ City_____ State_____ Zip_____

Phone: (Home)_____(Cell) _____

Primary E-Mail for MyTeamcare: _____

Additional Patients:

Name: Last_____ First_____Nickname _____

Date of Birth _____

Name: Last_____ First_____Nickname _____

Date of Birth _____

Parent/Guardian's Name: _____ Phone number_____

Parent/Guardian's Name: _____ Phone number_____

□ (check if same as above)

Address_____ City_____ State_____ Zip_____

INSURANCE (INFORMATION NEEDED FOR PRIOR AUTHORIZATIONS OF TREATMENT)

□ Check if you have no insurance

Primary Insurance Name: _____Phone _____

Policy # _____ Group #_____

RX BIN_____RxGrp_____RXPCN_____

Secondary Insurance Name: _____ Phone _____

Policy # _____ Group #_____

RX BIN_____RxGrp_____RXPCN_____

PREFERRED PHARMACY

Name_____Phone _____

Address (Cross-Street)_____ City_____ State_____

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Acknowledgments and Agreements

The undersigned hereby makes the following Acknowledgments and Agreements regarding treatment to be provided to the patient whose name appears below.

1. Consent to Treatment.
   a. Adults or authorized guardian for mentally disabled adult-I understand that medical treatment is necessary, and that such medical treatment will be performed by independent medical providers, and or by the employees of the Practice. I understand that the provider may utilize a medical aide or medical student to assist with the plan of care. I hereby grant my authorization and consent for such treatment.
   b. Minor *Under Texas law, a patient is considered a "minor" if he or she is younger than 18, has never been married, and has not been legally declared an emancipated minor (Texas Family Code, §101.003).*
      a) *I, the parent or legal guardian, do hereby agree and give consent to the medical provider to furnish medical care and treatment considered necessary and proper in diagnosing and/or treating my child's physical and mental condition.*
2. Notice of Privacy Practices. I hereby acknowledge that I have been provided with a copy of this office's "Notice of Privacy Practices."
3. Agreement to Pay for Services. I acknowledge and accept that no guarantee has been given as to the results these treatments may produce in me. I further acknowledge and accept that any treatment(s) given may not help me and may make my condition worse. For and in consideration of the care and treatment provided to myself, I promise to pay, or arrange for payment, AT THE TIME OF THE VISIT all charges due for services rendered to or on behalf of the patient. Payment may be made by cash or credit card. Any fees associated with the collection of a past due balance will be the responsibility of the patient. I understand that I am fully financially responsible for all these charges at all times.
4. Telehealth Visits. I hereby authorize Legacy Developmental Pediatrics to use the telehealth practice platform for telecommunication for evaluating, testing, and diagnosing my medical condition. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met. I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.
5. Release of Medical Information. I authorize the release of any and all information pertinent to my case to any insurance company, adjuster, or attorney involved in this case who makes the request in writing. Further, I authorize the release of my medical information to my personal or referral physician.
6. Risks. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of any medical, and/or diagnostic procedures planned for me. I realize that common to a medical, and/or diagnostic procedure is the potential for infection, allergic reactions, failure of treatment, and even death.
7. Cancellation Charge. A $30.00 fee will be charged to the patient if you are a no show or fail to reschedule/cancel an appointment without giving the 24-hour notice. Insurance companies including Medicare will not pay for this charge; therefore, the patient will be 100% responsible for this fee. In the event you fail to cancel 2 (two) appointments you may be dismissed from the practice. Patients who have late cancellations or no-show records may be required to prepay their appointment fee for all upcoming appointments thereafter. An outstanding balance can result in a delay to prescription refills.
8. Health Information Exchange. I authorize my provider(s) to e-prescribe my prescriptions and request my prescription medication history from other healthcare providers or third-party pharmacy payors. I understand this means my provider(s) may send or receive my prescription electronically. My medical records will also be made available to other healthcare providers through a Health Information Exchange (HIE) or shared electronic medical record (EMR) with participants in UMC's clinically integrated network. I may opt out of participating in the HIE by completing an opt-out form upon request.

I have read the above Acknowledgments and Agreements, and fully understand and agree to them.

Dated at the **Office of Legacy Developmental Pediatrics, PLLC**

DATE _____ ,20_____

Patient Name (Print) _____ **Patient Signature** _____

Guardian Name (Print) _____ Guardian Signature _____

A photocopy of this form shall be considered as acceptable and valid as the original.

2505 79th Street Suite B Lubbock, Texas 79423 (806) 300-8228 fax (806) 300-8223

LEGACY
Developmental Pediatrics

Authorization To Release and Disclose Patient Information

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

Address: _____ Phone: _____

Managing Information	Check if you want Legacy to **Send** the information to a party OR allow Legacy to **Receive** information from a party
Name: **Phone:** **Fax:**	☐ **Send** ☐ **Receive**
Name: **Phone:** **Fax:**	☐ **Send** ☐ **Receive**
Name: **Phone:** **Fax:**	☐ **Send** ☐ **Receive**
Name: **Phone:** **Fax:**	☐ **Send** ☐ **Receive**
Name: **Phone:** **Fax:**	☐ **Send** ☐ **Receive**

INFORMATION to be RELEASED (**What** do you want sent or **released**? Check the appropriate box.)	**Only record types checked below**: ☐Progress notes/clinic notes ☐ Appointments ☐Educational/School Records ☐Laboratory reports ☐Medication record ☐Billing Records (dates) ☐Other (please specify)_____
PURPOSE of RELEASE (Why is it needed?)	☐Continuing Care by other health care provider ☐Disability ☐ School ☐ ADHD Evaluation ☐ Psychological treatment ☐Insurance ☐Personal review ☐Attorney/Legal ☐Other_____
To the RECEIVING PARTY of this INFORMATION	This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. Federal rules prohibit you from further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

- This authorization is voluntary, and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to Legacy Developmental Pediatrics, PLLC. Information may be released until my written notice of cancellation is received.
- I understand that my behavioral health treatment records (including drug and alcohol) and information are protected under the federal regulations governing Confidentiality and Behavioral Health Patient Records, 42 CFR, Part 2, and the HIPAA Privacy Rule, 45CRF, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations.

RELEASE FROM LIABILITY: I release and agree to hold harmless Legacy Developmental Pediatrics, PLLC and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand Legacy Developmental Pediatrics, PLLC cannot be responsible for use or rediscover of information to third parties.

I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY AND TREATMENT HISTORY

SIGNATURE _____ PRINT NAME _____ DATE _____
Patient or Legally Authorized Representative

If you are a representative, specify your relation to the patient: ☐ Parent ☐ Guardian ☐ Other

SIGNATURE OF MINOR _____ DATE _____
Federal Regulations require us to obtain the signature of BOTH the MINOR and PARENT/GUARDIAN if the patient is under the age of 18 and has had drug and/or alcohol diagnosis, mental health treatment or education, sexually transmitted diseases, and certain types of reproductive care (e.g., Tex. Fam. Code §32.003).