

Blanco Regional Clinic, PA

PATIENT INFORMATION FOR MINOR

NAME: _____ DOB _____ SS# _____

ADDRESS: _____ CITY: _____ ST _____ Zip _____

HM# _____ CELL# _____ EMAIL _____

PREFERRED PHARMACY _____ PH# _____

PLEASE SELECT ONE OF THE FOLLOWING: WHITE BLACK HISPANIC ASAIN AMERICAN INDIAN OTHER

GAURANTOR INFORMTION

INSURANCE:

POLICY HOLDER INFORMATION:

NAME _____ DOB _____ Phone _____
Address: _____ City _____ ST _____ Zip _____

ASSIGNMENT OF BENEFITS:

Our office will file insurance for all reimbursable services to your primary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered services. These fees are due at the time of your office visit. I assign benefits to Blanco Regional Clinic, PA for all health services provided to me. I understand that BRC has the right to refuse or accept assignments of such benefits.

Signature of patient or responsible party

Date

HIPAA INFORMATION

I acknowledge that BRC, PA has provided me with a written copy of the Notice of Privacy Practices, and I have afforded the opportunity to read and ask questions about the Notice of Privacy Practices.

May we release health information about you to family members or other individuals? Yes or No
If you answered yes, please list the names of each individual.

NAME Relationship Phone

NAME Relationship Phone

Patient signature _____ Date _____

PLEASE NOTE THAT IT IS THE RESPONSIBILTY OF THE PATIENT TO OR LEGAL GAURDIAN TO NOTIFY OUR OFFICE OF ANY OF THE ABOVE CONTACT INFOFRMATION CHANGES.

PAST MEDICAL HISTORY

PLEASE CIRCLE WHAT APPLYS

ACNE	ECZEMA
ADD/ADHD	FREQUENT UTI'S
ANEMIA	REFLUX (HEARTBURN)
ANXIETY	SEASONAL ALLERGIES
ASTHMA	SEIZURES
BIPOLAR DISORDER	SINUS INFECTIONS
CHRONIC BRONCHITIS	STD TYPE_____
DEPRESSION	STOMACH ULCERS
DIABETES	
EATING DISORDER	

SURGICAL HISTORY

SURGERY	YEAR

FAMILY HISTORY

DISEASE	SPECIFICITY	FAMILY MEMBER	CAUSE OF DEATH YES OR NO?
CANCER			
DIABETES			
HEART DISEASE (SPECIFY)			
GENETIC			
PSYCH			

Any complications during birth?

IMMUNIZATION HISTORY:

Please provide us with a copy of record

SOCIAL HISTORY

Are you sexually active? Y or N Birth Control used: none condoms pill other_____

Do you smoke? Y or N If so how many packs a day _____ how long _____ if you quit what year _____

Do you consume alcohol? Y or N How many drinks day or week? _____

Do you consume Caffeine? Y or N How many a day? _____

Do you use illegal substances? Y or N if so what type _____

CURRENT MEDICATIONS

DRUG NAME	STRENGTH	HOW OFTEN DO YOU TAKE IT

MEDICATION ALLERGIES

DRUG NAME	REACTION

Texas Immunization Registry (ImmTrac2)

Minor Consent Form



A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name	Child's Middle Name	Child's Last Name
____/____/____	_____ - _____ - _____	_____
Child's Date of Birth (mm/dd/yyyy)	Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone _____ Email address _____

Child's Address	Apartment # / Building #
City	State _____ Zip Code _____ County _____

Mother's First Name	Mother's Maiden Name
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Race (select all that apply)			Ethnicity (select only one)	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race	<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Recipient Refused			<input type="checkbox"/> Other	

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 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. For more information, see Texas Health and Safety Code § 161.007 (d). <https://statutes.capitol.texas.gov/Docs/H/S/htm/H.S.161.htm#161.007>.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder. For more information, see Texas Health and Safety Code § 161.00705. <https://statutes.capitol.texas.gov/Docs/H/S/htm/H.S.161.htm#161.00705>.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.

I am an IMMEDIATE FAMILY MEMBER of a first responder.

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	Signature	Date
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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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to ImmTrac2. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • <https://www.dshs.texas.gov/immunize/immtrac/>
 Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347



REGISTRO DE INMUNIZACIÓN DE TEXAS (ImmTrac2)
Consentimiento para menores de edad



Si el cliente es menor de 18 años, uno de los padres, el tutor legal o el titular de la custodia debe firmar este formulario.

Primer nombre del menor Segundo nombre del menor Apellido del menor

Fecha de nac. del menor (mm/dd/aaaa) Sexo del menor: [] Femenino [] Masculino Teléfono Correo electrónico

Dirección del menor Núm. de apartamento o edificio

Ciudad Estado Código postal Condado

Nombre de la madre Apellido de soltera

Raza (seleccione todos los que correspondan):
[] Indio americano o nativo de Alaska [] Asiático [] Negro o afroamericano
[] Nativo de Hawái o de otra isla del Pacífico [] Blanco [] Otro
[] Se negó a contestar
Grupo étnico (seleccione solo una):
[] Hispánico o latino
[] No hispano o latino
[] Otro

El Registro de Inmunización de Texas (ImmTrac2), es un servicio gratuito del Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida y guarda los registros de vacunación de su hijo/a (hasta los 18 años de edad). Con su autorización, la información de las vacunas que recibe su hijo/a se incluirá en el ImmTrac2. Médicos, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso a esta información para verificar que no falten vacunas importantes. Para más información consulte la § 161.007 (d) del Código de Salud y Seguridad de Texas en https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

Consentimiento para incluir en el registro a un menor y para divulgar sus datos a las entidades autorizadas
Entiendo que, al dar aquí mi consentimiento, autorizo la divulgación de mis datos de vacunación al DSHS, y entiendo además que el DSHS incluirá esta información en ImmTrac2. Una vez que los datos de las vacunas de mi hijo estén en ImmTrac2, las siguientes entidades tendrán, por ley, acceso a ella: un distrito de salud pública o departamento de salud local, por razones de salud pública, dentro de sus zonas de jurisdicción; un médico u otro proveedor de salud legalmente autorizado para aplicar vacunas, como parte del tratamiento al menor como su paciente; una dependencia estatal que tenga la custodia legal del niño; una escuela o guardería en la que el niño esté inscrito; un pagador autorizado por el Departamento de Seguros de Texas para operar en Texas lo relacionado con la cobertura del menor. Entiendo que puedo retirar este consentimiento en cualquier momento, llenando y enviando el formulario Withdrawal of Consent al ImmTrac2 del Texas DSHS.

La ley estatal permite la inclusión de los registros de vacunación de los socorristas y sus familiares directos en ImmTrac2. Se define como "socorrista" al empleado de la seguridad pública o voluntario cuyas funciones incluyen el responder rápidamente a una emergencia médica. Se define como "familiar directo" a los padres, cónyuges, hijos o hermanos que viven en el mismo hogar que el socorrista. Para más información, consulte la § 161.00705 del Código de Salud y Seguridad de Texas. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Marque la casilla de abajo para indicar si su hijo/a es familiar directo de un socorrista.
[] Soy FAMILIAR DIRECTO de un socorrista.

Con mi firma a continuación, DOY mi consentimiento para el registro. Deseo INCLUIR los datos de mi hijo en ImmTrac2.
El padre o madre, tutor legal o titular de la custodia:
Nombre escrito a mano Firma Fecha

Aviso de confidencialidad: Con ciertas excepciones, usted tiene derecho a solicitar y recibir información sobre los datos que el estado de Texas recabe sobre usted. Usted tiene derecho a recibir y revisar la información si así lo solicita. También tiene derecho a pedir que la dependencia estatal corrija cualquier información que se determine que es incorrecta. Consulte el sitio http://www.dshs.texas.gov para más información sobre el aviso de confidencialidad. (Fuente: Código gubernamental, § 552.021, 552.023, 559.003 y 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to the Texas Immunization Registry. Retain this form in your client's record.

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**Blanco Regional Clinic, P.A.
825 Fourth Street
Blanco, TX 78606
830-833-5581**

Date _____

Mid-Level Provider Consent Form

This practice utilizes Physician Assistants (PA's) and Nurse Practitioners (FNPs) to provide health care. PAs and FNPs are educated, licensed and nationally certified providers that work in conjunction with a supervising physician. There is on-going communication between the physician and the Mid-level providers regarding patient care. If at anytime a patient requests an appointment with the physician, this request will be granted at the first availability.

I voluntarily consent to evaluation and treatment by the physician, physician assistant or family nurse practitioner on staff at Blanco Regional Clinic, P.A. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by the staff.

I have read the above regarding Mid-Level providers. I hereby give my consent to treatment.

Patient Name: _____ **DOB:** _____

Signature: _____

MEDICAL APPOINTMENT CANCELLATION /NO SHOW POLICY

Thank you for trusting your medical care to **Blanco Regional Clinic, P.A.** When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show policy below:

Effective August 1, 2024, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a **No Show** and will incur a **\$50.00** no show fee.

Any New Patient who fails to show for their initial visit will not be rescheduled.

As a courtesy, **when time allows**, we make reminder calls for annual appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office, we may be able to waive the No Show Fee.

Patient

Date