PATIENT INFORMATION

First Name:_____ Middle:_____ Last Name:_____

DOB:11/07/2021 Sex:_____ Social Security:_____ Race:_____

Address:_____City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Other:_____

PARENT/LEGAL GUARDIAN INFORMATION

MOTHER

Name:_____

Maiden:_____

DOB:___/___/_____ SS#:_____

Race:_____

Address:_____

City:_____ State:____ Zip:_____

Phone:_____

Employer:_____

Occupation:_____

Work Phone:_____

Primary Language:_____

EMAIL:_____

FATHER

Name:_____

DOB:___/___/_____ SS#:_____

Race:_____

Address:_____

City:_____ State:____ Zip:_____

Phone:_____

Employer:_____

Occupation:_____

Work Phone:_____

Primary Language:_____

EMAIL:_____

EMERGENCY CONTACT INFORMATION

Name:_____

DOB:___/___/_____ Phone:_____

Address:_____

City:_____ State:____ Zip:_____

Relationship:_____

PRIMARY INSURANCE

Subscriber:_____

DOB:___/___/_____ SS#:_____

Payer:_____

Policy Number:_____

Group Number:_____

Valley Kidz Clinic
Riaz Shareef MD
5325 S. McColl Rd, Edinburg, Texas, 78539
Ph: 956-331-2244. Fax: 888-569-5439

Valley Kidz Clinic
Riaz Shareef MD
1900 S Jackson Rd, McAllen, TX 78503
PH: 956-331-2117 Fax: 888-568-5242

Patient Name:_____DOB:_____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to clinic/physician for services rendered to me or my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that clinic is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of me or my dependents authorized benefits be made directly to the clinic or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize the release of any of mine or my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risk of mail, phone calls, and e-mail. I hereby authorize a representative from the clinic to mail, call, or e-mail me with communications regarding me or my dependents healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying clinic in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that me or my dependents may receive a separate bill if medical care including labs, x-ray, or other diagnostic services that are not covered by insurance carrier. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by mine or my dependents insurance carrier for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed and is necessary by provider.

SIGNATURE: _____ DATE: ____/____/_____

RELATIONSHIP TO PATIENT: _____

GUARANTOR SIGNATURE: _____ DATE: ____/____/_____

GUARANTOR NAME: _____

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Patient Name:_____ **DOB:**_____

May this form serve as a legal notice that I,_____, parent/ legal guardian herewith my signature give legal consent for the individuals listed below to act on my behalf/capacity with regards to the disclosure of medical information, signing medical release forms and consents, and accepting medical treatment deemed necessary by the staff at the Clinic including, but not limited to laboratory testing, immunizations, x-rays, nebulizer treatments, injections, and/or any medications in office for immediate acute care of your child.

1. _____.
2. _____.
3. _____.

By signing below, I give consent and fully acknowledge that I have read the above information and that I fully understand the consent I am affording the above referenced individuals.

_____. _____.
Parent/Legal Guardian Signature Date

Sirva esta forma como un aviso legal que yo, _____ padre / tutor legal adjunto mi firma dar consentimiento legal para los individuos listados abajo para actuar en mi nombre y capacidad en cuanto a la divulgación de información médica, firma los formularios de alta médica y consentimientos, y aceptar tratamiento médico necesario por el personal de la clínica, incluyendo pero no limitado a pruebas de laboratorio , vacunas, rayos x, tratamientos con aerosoles, inyecciones o medicamentos en la oficina para la atención aguda inmediata de su hijo.

1. _____.
2. _____.
3. _____.

Al firmar abajo, doy consentimiento y reconocer que he leído la información anterior y que comprendo totalmente el consentimiento estoy permitiendo lo anterior hace referencia a individuos.

_____. _____.
Parent/Legal Guardian Signature Date

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Release of medical records

Patient Name:_____ **D.O.B.:**_____

TO:_____

I HEREBY AUTHORIZE YOU TO RELEASE MEDICAL RECORDS:

Any information including the diagnosis and records of any treatment or examination rendered at your office. If you have any questions please call our office.

1. LABS
2. X-RAYS / IMAGING
3. CONSULTATION REPORTS
4. DISCHARGE SUMMARY
5. PROGRESS NOTES
6. IMMUNIZATION RECORDS
7. OTHER _____

_____

Patient signature: _____ **Date:** _____

Witness: _____ **Date:** _____

VALLEY KIDZ CLINIC
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Valley Kidz Clinic. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Valley Kidz Clinic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting staff at Valley Kidz Clinic. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Valley Kidz Clinic
Riaz Shareef MD
5325 S. McColl Rd, Edinburg, Texas, 78539
Ph: 956-331-2244. Fax: 888-569-5439

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Valley Kidz Clinic
Riaz Shareef MD
5325 S. McColl Rd, Edinburg, Texas, 78539
Ph: 956-331-2244. Fax: 888-569-5439

Effective Date
This notice is effective on or after 03/01/2016

Reservation of Right to Change Privacy Practices
Valley Kidz Clinic reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission Valley Kidz Clinic for the use and disclosure of my health information in accordance with this consent.

Patient Name:_____

Signature (Parent or Guardian):_____

Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____