Notice to Patients

1. PLEASE SIGN IN UPON ARRIVAL. PARENT OR LEGAL GUARDIAN MUST BE PRESENT. ANYONE OTHER THAN THE PARENT MUST PROVIDE DOCUMENTATION AUTHORIZING CARE OF THE PATIENT.

2. PAYMENT IS DUE AT THE TIME OF SERVICE.

3. PROOF OF INSURANCE IS REQUIRED AT EACH VISIT.

4. COMMUNITY FIRST PATIENTS MUST PRESENT CURRENT MONTHLY SHEET AND ID CARD TO BE VERIFIED BEFORE SERVICE CAN BE PERFORMED.

5. PATIENTS MORE THAN 15 MINUTES LATE MAY BE RESCHEDULED.

6. WALK-IN PATIENTS WILL BE WORKED INTO THE DAILY SCHEDULE AS TIME ALLOWS.

7. PARENTS MUST CALL TO REQUEST REFERRALS FOR ALL SPECIALISTS APPOINTMENTS ONE WEEK IN ADVANCE.

8. PLEASE TURN OFF CELL PHONES DURING VISITS.

9. LOITERING IN THE HALLWAYS IS NOT ALLOWED.

10. CHILDREN MUST BE ACCOMPANIED BY AN ADULT AT ALL TIMES.

11. IMMUNIZATIONS WILL BE GIVEN ON TIME ACCORDING TO THE SCHEDULE RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS.

THIS INSTRUCTION SHEET IS PROVIDED FOR THE INFORMATION OF OUR PATIENTS AND YOUR SIGNATURE IS REQUIRED FOR OUR FILES.

SIGNATURE: ____________________________     DATE: _____________________
Night and Day Pediatrics
4499 Medical Drive, Suite 280
San Antonio, Texas 78229
Office (210) 614-4499

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we will provide the minimum necessary information to only those we feel are in need of your health care information and in formation about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relies on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ___________________________ Signature: __________________________________

Date: _________________

Print Child’s Name & DOB: ____________________________________________________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.
Patient's Name (Child) _________________________________________________________________________________________

Male ___________  Female _______________  Age ______________________  Date of Birth ___________________

Father's Name ____________________________________________________  Date of Birth ___________________

Mother's Name (Maiden) ____________________________________________  Date of Birth ___________________

Address _________________________________________________________  Telephone _______________________

City ___________________________________________________________ State ___________  Zip Code __________

Father's Employer _________________________________________________  Occupation _______________________

Employer's Address ________________________________________________  Telephone _______________________

Mother's Employer _________________________________________________  Occupation _______________________

Employer's Address ________________________________________________  Telephone _______________________

Father's Social Security No. __________________________________________  Driver's License No. _____________

Mother's Social Security No. _________________________________________  Driver's License No. _____________

Person, other than parent, to contact in an Emergency ____________________________  Telephone _______________________

Relationship ______________________________________________________

__________________________________________________________________________

**INSURANCE INFORMATION**

Insurance Company (1) ________________________________________________________________________________________

Group No. _______________________________________________________ Policy No. _______________________

Group with _______________________________________________________ Individual Policy ____________

Policyholder's Name _________________________________________________________________________________________

Address to which claims are sent ______________________________________________________________________________

__________________________________________________________________________

Insurance Company (2) ________________________________________________________________________________________

Group No. _______________________________________________________ Policy No. _______________________

Group with _______________________________________________________ Individual Policy ____________

Policyholder's Name _________________________________________________________________________________________

Address to which claims are sent ______________________________________________________________________________

__________________________________________________________________________

**ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans, to Valerie G. Ostrower, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

SIGNED: ___________________________ DATE: ___________________________
HISTORY SHEET

Name ___________________________ Birth Date ___________ Sex ___________

Referred by _______________________

CURRENT PROBLEMS/CONCERNS

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PAST HISTORY

Hospitalizations, date and diagnosis _______________________________________

Current medications ______________________________________________________

Allergies ________________________________________________________________

Check if child has had: □ Chicken pox □ Rubella (German measles) □ Measles
□ Mumps □ Recurrent tonsilitis
□ Ear infections □ Asthma □ Hepatitis □ Urine Infections □ Pneumonia

BIRTH HISTORY

Birth Weight ________________________ Feeding: Breast______________________ Bottle: ________________________

Problems as a newborn ____________________________________________________

Problems in pregnancy or delivery __________________________________________

Smoking during pregnancy? □ Yes □ No ______________________________________

Alcohol consumed during pregnancy? □ Yes □ No ______________________________

Medications during pregnancy? ____________________________________________

GROWTH AND DEVELOPMENT

Age at which sat ________________________ Walked alone ______________________

Spoke single words ________________________ Spoke in sentences ______________________

School Grade_________________________ Regular Class________________________ Special____________________

Problems/Concerns _______________________________________________________
FAMILY HISTORY

Mother’s age ____________________________ Health problems ____________________________
Father’s age ____________________________ Health problems ____________________________
Sibling’s name __________________________ Age ______ Problems ____________________________
_________________________ Age ______ Problems ____________________________
_________________________ Age ______ Problems ____________________________
_________________________ Age ______ Problems ____________________________
_________________________ Age ______ Problems ____________________________

Are these both the biologic (natural) parents? □ Yes □ No
If no please explain ____________________________

Have any siblings died? □ Yes □ No
If yes, cause ____________________________ age and date ____________________________

Family History: please check if any of the following diseases in close family members. If checked, please explain:

□ Heart attacks/disease in those less than 45 ____________________________
□ Diabetes ____________________________
□ Cancer ____________________________
□ Epilepsy ____________________________
□ Asthma/allergies ____________________________
□ Kidney disease ____________________________
□ Cystic fibrosis ____________________________
□ Muscular dystrophy ____________________________
□ Blood disorders ____________________________
□ Deafness ____________________________
□ Mental retardation ____________________________
□ Depression/other psychiatric problems ____________________________
□ Other ____________________________

Additional Information: ____________________________
__________________________
__________________________
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TO: Texas Vaccines for Children (TVFC) Providers
Regional Directors, Health Service Regions
Regional Immunization Program Managers, Health Service Regions
Directors, Local Health Departments
Immunization Managers, Local Health Departments

FROM: Karen Hess, Manager
Vaccine Services Group

THRU: Jack C. Sims, Manager
Immunization Branch

DATE: December 28, 2011

SUBJECT: Texas Vaccines for Children (TVFC) Program: Eligibility Policy Changes

DSHS has developed policy changes to the TVFC childhood vaccine program in response to reductions in state and federal immunization funds, increased federal accountability for publicly-funded vaccines, as well as increases in prices for some vaccines.

This memo addresses (1) updates to the TVFC provider eligibility, (2) updates to the patient eligibility criteria, and (3) new TVFC standardized forms. The policies described below are effective beginning January 1, 2012.

(1) TVFC Provider Eligibility

TVFC has expanded provider eligibility to include registered pharmacists (RPh). With this addition, the list of health care professionals eligible to enroll in TVFC include: Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), and Registered Pharmacist (RPh).

The health care providers who must continue to enroll under the standing delegation orders of a physician include: Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Assistant (MA), Nurse Assistant (NA), and Emergency Medical Technicians (EMT).
(2) TVFC Patient Eligibility

The following changes to TVFC patient eligibility are effective beginning January 1, 2012.

1. Children who have private insurance that covers vaccines will no longer be eligible for TVFC vaccines in public health department clinics, but instead will be referred to their medical home for immunization services. In some cases, local health departments may be the medical home that provides comprehensive healthcare services. In these cases, private insurance is accepted in those public health settings. Private stock vaccine must be purchased and/or acquired in order to continue vaccinating fully, privately insured children.

2. Individuals who begin a vaccine series at age 18 or younger (and TVFC-eligible), may only finish that series at public health clinics that are Adult Vaccine Safety Net (ASN) providers (typically the public health department), provided the series is completed prior to their 20th birthday. Historically providers have been able to vaccinate these individuals at any TVFC-enrolled site.

3. The definition of “Underinsured” will be modified as described in the section below. Insured children with vaccine coverage who have high copays or deductibles are no longer considered underinsured. These children are now considered fully, privately insured and are no longer eligible for TVFC vaccines. Children qualifying under the new definition of underinsured will continue to be eligible to receive vaccines in any TVFC-enrolled provider office. Underinsured children are not required to be referred to a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Updated Policy:
Children, birth through 18 years of age, who meet at least one of the following criteria, are eligible to receive TVFC vaccine from any TVFC-enrolled provider:

- Medicaid eligible: A child who is eligible for the Medicaid program
- Uninsured: A child who has no health insurance coverage
- American Indian or Alaskan Native
- **Underinsured (**New Definition**): A child who has commercial (private) health insurance, but coverage does not include vaccines; a child whose insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.
- Enrolled in CHIP
(3) New TVFC Standardized Forms

Attached are three forms to be used to support this revised TVFC policy: Patient Eligibility Screening Record (C-10, 12/2011), TVFC Patient Screening Decision Tree, and Patient Referral Form for Vaccination from Local Health Department or Public Health Clinic (for public health agencies only).

Patient Eligibility Screening Record (C-10, revised 12/2011)
It is a federal requirement that providers document the eligibility of each client receiving TVFC vaccine. Providers may use the Patient Eligibility Screening Form, (C-10), or electronically store this information. This C-10 (revised 12/2011) is now consistent with the updated definitions and insurance status guidelines. A new C-10 is to be completed once for all patients, including patients with an old form on file. Once the new form is completed it may be used until the child’s category of eligibility changes. Patient eligibility must be verified each time prior to vaccine administration.

TVFC Patient Screening Decision Tree (revised 12/2011)
This diagram may be used by screeners in both public and private clinics to aid in determining patient eligibility for TVFC vaccine under the new guidelines. The diagram also indicates when providers should use private stock vaccine, or refer patients to another provider that accepts the patients’ private insurance.

Patient Referral Form for Vaccination from Local Health Department or Public Health Clinics (revised 12/2011)
This form may be used when a fully, privately insured child presents for services in a public health clinic and must be referred to their medical home. The second page of the form includes a recommended referral process (questions to help identify eligibility) that can be used by clinic staff when a patient calls or presents in-person. Also on the form is space to include any identified referral sites. Public health agencies are encouraged to coordinate with local vaccine providers to establish options for referring fully insured patients.

If you have questions regarding any of these policy changes or use of any of the attached forms, please contact your Local Health Department, Health Service Region, or TVFC Consultant.

Attachments:
Patient Eligibility Screening Record
TVFC Patient Screening Decision Tree
Patient Referral Form for Vaccination from Local Health Department or Public Health Clinics
TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)  
PATIENT ELIGIBILITY SCREENING RECORD

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: ________________________________

Child’s Name: ________________________________

Last Name  First Name  MI

Child’s Date of Birth: ____________/mm/dd/yy  Age: ____________

Parent/Guardian/Individual of Record:

Last Name  First Name  MI

Provider's/Clinic's Name: ________________________________

Please check the first category that applies; check only one.

☐ (a) is enrolled in Medicaid, or
☐ (b) does not have health insurance (uninsured), or
☐ (c) is an American Indian, or
☐ (d) is an Alaskan Native, or
☐ (e) is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP)
☐ (f) is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

☐ (g) has private insurance that covers vaccines (not TVFC eligible).

Signature: ________________________________  Date: ________________________________

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)

Texas Department of State Health Services  Stock No. C-10
Immunization Branch  Revised 12/2011
Patient Referral Form for Vaccination
From Local Health Department or Public Health Clinic

(Patient Name) __________________________________________________________

Date of Birth (_____/_____/_____)

This patient needs one or more vaccinations but has private health insurance and is not eligible for publically purchased vaccines available through the Texas Vaccines for Children (TVFC) Program.

Effective January 1, 2012, Public Health no longer vaccinates clients who are privately insured. Therefore, we are referring this patient to his/her medical home for the needed vaccinations.

If the medical home is not able to provide the immunization(s), the patient should be referred to another clinic that accepts the patient’s medical insurance.

Referring Public Health Clinic:

NOTE: Issuance of this Patient Referral Form for Vaccination does not extend any state mandated vaccine requirements, or allow children to enter school without appropriate immunizations.
Referral Process

When a patient presents for services at a local health department or public health clinic, staff should first ask if the patient has health insurance.

If no: The patient is eligible for TVFC vaccine.

If yes: Is the insurance Medicaid, CHIP, or other private insurance? If private insurance: Explain to the patient that the clinic no longer accepts their insurance due to billing issues, and they need to receive vaccines from their medical home. Provide Patient Referral Form for Vaccination if helpful or necessary.

If the patient has Medicaid or CHIP: The patient is eligible for TVFC vaccine.

Local Referral Sites (if available):

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Texas Vaccines for Children
Patient Screening Decision Tree

Immunization Medical Home
(Private Practice, FQHC, RHC, School, Hospital, or Other)

Screen For

Fully Insured
Vaccinate with Private Stock Vaccine
OR
Refer to another private provider/community vaccinator that accepts insurance.
Do not refer to LHD or PHC unless you know that they stock private vaccine and can bill private insurance. Otherwise, patient will be referred back to their medical home.

Insured Without Full Vaccine Coverage*
Vaccinate with TVFC Vaccine
OR
If patient does not meet underinsured definition, treat as "Fully Insured"

TVFC Eligible
- Medicaid
- No insurance (uninsured)
- Amer. Indian
- Alaskan Native
- CHIP
Vaccinate with TVFC Vaccine

Local Health Department (LHD)/Public Health Clinic (PHC)

Screen For

Fully Insured
Vaccinate with Private Stock Vaccine

Insured Without Full Vaccine Coverage*
Vaccinate with Private Stock Vaccine Only
OR
Refer patient back to Medical Home

TVFC Eligible
- Medicaid
- No insurance (uninsured)
- Amer. Indian
- Alaskan Native
- CHIP
Vaccinate with TVFC Vaccine
OR
If patient does not meet underinsured definition, treat as "Fully Insured"

* Effective January 1, 2012, the definition of "Underinsured" is: 1) commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.