Herrin Pediatric Clinic 601 River Pointe Dr, Suite 120 Conroe, TX 77304
James R. Herrin, M.D. (936) 788-6060

DATE_____ ACCT #_____

PATIENT INFORMATION:

Age Date of Birth Sex

Name (First, Middle, Last)

GUARANTOR NAME (FINANCIAL RESPONSIBILITY):

Legal Guardian Relationship to Patient Date of Birth

Social Security Number Driver's License Number (State)

Address City State Zip Code County

Home Phone Other Telephone (Cell) Number

Employer Name Business (Work) Number

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Legal Guardian Relationship to Patient Date of Birth

Social Security Number Driver's License Number (State)

Address (if different from above) City State Zip Code County

Home Phone (if different from above) Other Telephone (Cell) Number

Employer Name Business (Work) Number

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Emergency Contact (Other than parents) Phone Number Relationship to Child

Address City State Zip Code

***** INSURANCE INFORMATION (Copy of card needs to be made for patient's chart):

Primary Insurance:_____Effective Date:_____

Policy holder name:_____ DOB:_____

PCP Named (if applicable): Yes _____ No _____
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Patient Name_____

Please list all children in household under 18 years of age:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

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List people having permission to seek medical attention for your child:

Name	Relationship to Child
_____	_____
_____	_____
_____	_____

Please inform the above named people they must bring a form of Identification and a letter to place in the patient's chart at the time of visit.

Please list any allergies your child may have relating to medications or foods:

Please list any other important information that might be helpful from past medical history of your child:

Signature Date:
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H E R R I N P E D I A T R I C C L I N I C
JAMES R HERRIN, M.D., F.A.A.P.
601 River Pointe Dr. Suite 120
Conroe, Texas 77304

GUARDIAN / MINOR CHILD AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE[S]

I, _____the named legal guardian[s] of

_____[minor child] give permission to release protected health information including results of laboratory tests, x-ray and / or other test results to the following designated representative[s]:

Guardian's Initials

_____ My spouse [Name]_____

_____ My relative [Name]_____Relationship _____

_____ Other [Name]_ _____Relationship_____

_____ May be left on my answering machine at home / voice mail on cell phone.

_____ May be left on voice mail at work.

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF**

_____ _____
Guardian's Signature Date

_____ _____
Witness Date

As the legal guardian, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, HERRIN PEDIATRIC CLINIC must receive the revocation in writing. The revocation must include: [1] the patient's name, address, and date of birth, [2] the guardian's desire to revoke the authorization, and [3] the date of the revocation and the guardian's signature. All revocations must be sent in writing to the attention of Privacy Officer at 601 River Pointe Dr, Suite 120 – Conroe, Tx 77304 or faxed to 936-788-6061. It will not be considered effective until received by the Privacy Officer.

3/14/2011

H E R R I N P E D I A T R I C C L I N I C
JAMES R HERRIN, M.D., F.A.A.P.
601 River Pointe Dr. Suite 120
Conroe, Texas 77304

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I am aware that I may request a personal copy for my records.

_____ _____
Signature Relationship to patient

_____ _____
Patient Name Date

Office Use Only

We have made the following attempt to obtain the Patient's/Parent's/ Legal Guardian's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

HERRIN PEDIATRIC CLINIC OFFICE POLICY
CONCERNING FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE

We know that you are concerned about the cost of health care and we want you to know that we are striving to hold down our professional fees. You can help us by selecting one of the following methods of payment for the professional services that you receive from Dr. Herrin:

A. Cash, check, or credit card **at the time of treatment**.

B. Insurance – giving us a copy of your insurance policy card and keeping us updated on any changes to your insurance coverage. (See below)

All accounts must be paid in full within 90 days. After 90 days, past due accounts will be turned over to a Collection Agency.

PATIENTS WITH INSURANCE

Please remember that **you**, not the Insurance Company, are responsible for payment of professional services. Please note the following points:

A. Dr. Herrin is responsible for the treatment discussed with you.

B. You are responsible for payment to Dr. Herrin

C. As a courtesy to our patients and at your request, we will be happy to file charges for your office visit and hospital services performed by Dr. Herrin with your Insurance Company. We have been instructed by ALL Insurance Companies that pre-certification and filing DOES NOT GUARANTEE PAYMENT. The determination of whether that bill is paid is made by the Insurance Company when they receive the claim. **If your insurance has not paid within 60 days, then you are responsible for the balance.**

D. When payment from the Insurance is received, **you are responsible for the prompt payment of any remaining balance.** Any overpayment will be promptly refunded to you.

I certify that the answers to health questions are correct to the best of my knowledge; also, I grant to the physician and staff to perform all procedures and treatments that may be necessary. **(This includes minor consent.)** I authorize release of information to my Insurance Company and for payment of benefits to
James R. Herrin, M.D.

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's condition including blood tests, x-rays, developmental testing, and any other pertinent tests performed by Dr. Herrin.

I understand that I am responsible for any balance due on my account. Finally, I agree to pay collection costs and attorney's fees if collection procedures become necessary for a delinquent account. I further understand, that if collection action is necessary, the Clinic may choose to give me a thirty day notice of termination in order to locate another physician to care for my child.

Print Name _____

Signature_____**Date**_____

Patient Name _____ Acct #_____

H E R R I N P E D I A T R I C C L I N I C

MISSED APPOINTMENT POLICY

In consideration of other patients
and your medical staff ~ ~

AFTER TWO (2) MISSED APPOINTMENTS
YOU WILL BE CHARGED $30

THIS IS YOUR PERSONAL RESPONSIBILITY ~ ~
IT IS NOT FILED WITH YOUR INSURANCE.

WELL CHILD CHECK-UP APPOINTMENTS **MUST** BE CANCELLED 24 HOURS IN ADVANCED

~ ~Thank you for your cooperation ~ ~

_____ _____
Guardian's Signature Date

_____ Account #:_____
Staff initials

H E R R I N P E D I A T R I C C L I N I C

NURSE PRACTIONER CONSENT FOR TREATMENT

Herrin Pediatric Clinic has on staff Nurse Practitioners in the delivery of Primary medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner (NP) is a registered nurse who has completed specific advanced nursing education (generally a master's degree or doctoral degree) and training and can diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. In addition, the NP may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of Nurse Practitioner for my child/children health care needs.

I understand that at anytime I can refuse that my child be seen by a Nurse Practitioner and request to see Dr Herrin. I do understand, however, that because of the patient load, there will be times when Dr Herrin's schedule will be full and my child will need to be treated by a NP.

_____ _____

Patient Name Date of Birth

_____ _____

Parent/Guardian signature Date

JAMES R. HERRIN, M.D., F.A.A.P.
601 River Pointe, Ste 120 Conroe, Tx 77304
TEL: 936-788-6060 **FAX: 936-788-6061**

REQUEST / RELEASE OF INFORMATION

Name of Patient:_____Date of Birth:_____

_____Date of Birth:_____

_____Date of Birth:_____

_____Date of Birth:_____

Address:_____Tel #:_____

~~~ I hereby authorize physicians and representatives of HERRIN PEDIATRIC CLINIC ~~~

( ) To obtain confidential information from:

Name:_____

Address:_____

Tel:_____Fax:_____

( ) To release confidential information to:

Name:_____

Address:_____

Tel:_____Fax:_____

Purpose:
( ) Continuation of care
( ) Legal Attorney
( ) Other (please specify):_____
( ) Commercial Insurance
( ) Personal Use

The following information will be Released / Obtained (check & initial beside requested records):

( ) Entire Records
( ) Diagnostic Test Results
( ) Other (please specify):_____
( ) Immunization Records
( ) Hospital Records

I understand that I may revoke this authorization in writing at any time prior to the release of the information specified above. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. I hold harmless HERRIN PEDIATRIC CLINIC and / or their representatives from liability resulting in the released / obtaining of the above information. This authorization expires 90 days from the date signed.

Pursuant to State and Federal law you are hereby advised that the information that you authorized for release may include: Any/all test results, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol abuse.

PRINT NAME:_____

_____ _____ _____
Signature Relationship to Patient Date

Notice to Recipients of Information: This information has been disclosed to you from records whose confidentiality has been protected by Federal Law. Federal Regulation (42, CPR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.