Sudath Rannulu, M.D.

777 E. Wheatland Rd Suite 108 Duncanville, TX 75116
Phone: (972) 296-9930
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Office Policies

Welcome to Duncanville Children's Pediatric Care, the office of Sudath Rannulu, M.D. We are excited to welcome you into our family!! Below is a few of our policies and procedures. Please feel free to let us know if you have any concerns!!

No Shows/Late Arrival:

At our practice, we strive to adequately serve our patients within a reasonable time frame. In order for that to happen, we must have the cooperation of our patients/parents. This cooperation includes giving 24 hour notice to our office for cancellations/rescheduling of appointments. If 24 hour notice is not given, it will be considered a no show. There will be a charge of 25 dollars for each no show. After a patient's 3rd no show, there is a possibility of dismissal from our practice. Also, 15 minutes after the patient's appointment time they will be considered late. If late, a patient will be rescheduled to another day.

Emergency Contacts:

For the safety and privacy of you and your child, anyone that may bring the child into a visit will need to be listed on the child's emergency contacts. In order for a person to be added to the emergency contact list, a biological parent/legal guardian must come into the office in person to add them.

Forms:

FMLA forms will be a charge of 25 dollars. There may be a charge for other forms as well. We require 48 hours to complete forms. Forms may not be faxed to a parent, the parent will be expected to pick the form back up after completion.

Medical Records:

Medical records are available to the parents for a fee of 25 dollars. We do require 2 weeks to prepare the medical records for pick up. Should you decide to switch physicians, you may fill out a medical release form at the new physician's office and we will send the medical records at no charge.

By signing below, you verify that you understand and agree to abide by our policy and procedures. Again, we are happy that you chose our practice to care for your child/children. Please let us know if we can help in any way!!

Parent/Guardian Signature _____

Date: _____

CHILDREN'S HEALTH
1935 Medical District Drive • Dallas, Texas 75235

AUTH
CMC77448-001NS Rev. 4/2017

MyChart Request Form

Thank you for your interest in MyChart at Children's Health. Children's Health is pleased to offer this tool that provides parents / legal representatives access to their child's personalized medical and health insurance information over a secure internet connection.

To sign up for access to your child's information, please complete the request form and return it to:

Children's Health
Health Information Management Department
1935 Medical District Drive
Dallas, Texas 75235
Fax 214-456-6170

Patient's Name: _____

Patient's Date of Birth: _____

Parent / Legal Representative: _____

E-Mail Address: _____

Guardian Date of Birth: _____

I certify that I am the Legal Representative of: _____

_____ _____ _____
Signature of Patient / Parent / Responsible Party Date Time

_____ _____
Printed Name Relationship to Patient

Sudath Rannulu, M.D.

Yun Baek, FNP

HIPAA--Health Insurance Portability and Accountability Act

The first ever federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals, and other healthcare providers took effect on April 14, 2003. Developed by the Department of Health and Human Services, these new standards provide patients with access to their medical records and more control over how their personal healthcare information is used and disclosed. State laws providing additional protections to consumers are not affected by this new rule.

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality protected health information about their patients. These requirements are flexible to allow different covered groups to implement them as appropriate for their practice. Covered groups must provide all the protections for patients mentioned above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered groups must take some additional steps to protect their privacy.

OUR HIPAA POLICY

- **Shot records, medical records or any other information pertaining to your child will not be faxed. Exceptions to this policy would be faxing immunization records to your child's school or another physician's office (with a medical release form signed by the parent).**
- **If you are not able to bring your child personally, only the people on the emergency contact list are authorized to bring the child. The child cannot be seen if an unauthorized person brings him/her.**
- **No information about the child will be released over the phone. NO EXCEPTIONS**
- **All new patients must be accompanied by a biological parent or guardian, (with court documents) on the first visit.**

I have read and understand the HIPAA laws and regulations. Any and all questions have been answered to my satisfaction, and i agree to the above HIPAA policies.

Name of child/patient: _____

Signature of parent/guardian:_____

Date: _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry 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.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized 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 the state's central immunization registry ("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;
- 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 to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

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

Date

Signature

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 on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

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

Medical Record Release Form

Duncanville Children's Pediatric

Newborn, Pediatric and Adolescent

Patient/Guardian Authorization

By signing this form, I authorize you to release confidential health information about the patient below by releasing a copy of medical records or summary or narrative of the protected health information to the person or entity listed below.

Please fill ALL blanks with information

I herby request that the medical records for:

Patient name:_____ Date of Birth:_____

Previous Physician Information:

Name of Physician or Clinic:_____

Address:_____

Phone#_____ Fax#_____

Specific Description of the following to be disclosed:

__All medical records (including immunization record) __Immunization record ONLY

Faxed/Mail: Sudath Rannulu, M.D

Duncanville Pediatric

777 E Wheatland Suite 108

Duncanville, Texas 75116

Phone# (972)296-9930 Fax# (972) 709-1340

_____ _____

Patient or legal guardian authorized signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (Parent/legal guardian)

This authorization is to allow records to be sent within 30 days upon receiving request. If more than 30 pages please mail instead of faxing. Thank You!

Duncanville Children's Pediatric

777 E. Wheatland, suite 108

Duncanville, Texas

Date: _____

Patient Name: _____ Dob: ____/___/____

Home Address: _____

City: _____ Zip: _____

Emergency Contacts:

Name: _____Relationship: _____

Phone Number: (_____) _____

Name: _____Relationship: _____

Phone Number: (_____) _____

Name: _____Relationship: _____

Phone Number: (_____) _____