NEW PT FORM

Sudath Rannulu, M.D.

777 E. Wheatland Rd Suite 108 Duncanville, TX 75116
Phone: (972) 296-9930
Fax: (972) 709-1340

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: _____

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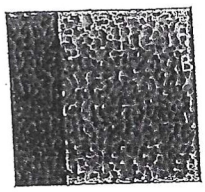

HIPAA ---- Health Insurance Portability and Accountability Act

The First-Ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospital, and other health care 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 of protected health information about their patients. These requirements are flexible to allow different covered groups to implement them as appropriate for their business or 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.

The HIPAA Rules In Our Office Are Explained Below:

- Immunization records, medical records, or any other information pertaining the patient will not be faxed.
- Medical Release forms must be filled out and signed before medical records will be transferred.
- Medical care authorizations must have the patient legal signature.
- No information about the patient will be discussed within the office or outside the office at any time.
- No medical information regarding the patient will be given over the phone.

Patient Name: _____ DOB: _____

Parent Signature: _____ Date: _____

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

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: ☐ Male ☐ Female | Telephone | Email address

Child's Address | Apartment # / Building #

City | State | Zip Code | County

Mother's First Name | Mother's Maiden Name

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. 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 Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.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 the Texas Immunization Registry. Once in the Texas Immunization Registry, 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 Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. 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 Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.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

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)

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.**

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

Texas Department of State Health Services
Immunizations

Stock No. C-7
Revised 02/2022

Duncanville Children's Pediatric

EMERGENCY CONTACT FORM/ PATIENT INFORMATION FORM

Today's Date___/___/_____

Patient Name:_____ DOB:___/___/_____

Patient Home Adress:_____

City:_____ ZIP Code:_____ Main Phone Number:_____

Mother's Name:_____ DOB:___/___/_____

Phone Number_____

Email:_____

Father's Name:_____ DOB:___/___/_____

Phone Number_____

EMERGENCY CONTACT (THE NAMES LISTED WILL BE ABLE TO BRING PATIENT TO THEIR APPOITMENT'S)

Name:_____

Relationship to patient:_____

Phone Number:_____

Name:_____

Relationship to patient:_____

Phone Number:_____

Name of the person bringing in the patient to the appointment today:_____

Relationship to the patient: _____

Medical Record Release Form

Duncanville Children's Pediatric

Newborn, Pediatric and Adolescent

Patient/Guardian Authorization:

By signing this form, I authorized 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.

Fax/Mail/Email: Sudath Rannulu, M.D

Duncanville Pediatric

777 E. Wheatland Rd Suite 108

Duncanville, Texas 75116

Phone #: 972-296-9930 Fax#: 972-709-1340

Email: Medicalrecords@bigkidpediatrics.com

_____

Patient or legal guardian authorization 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 email instead of faxing. NO DISC ACCEPTED. Thank you.

MyChart Child Proxy Form

Access to Your Child's MyChart Record

To sign up for access to your child's MyChart record, please complete both pages of this Child Proxy Form. Please note that your child's chart will be accessed through your MyChart record. Completing this form will establish a MyChart record for you (the parent) with access to your child's medical information.

Return all forms to: Your Primary Care Provider Office.

Parent/Guardian Information: (All sections required – please print clearly.)

Name (*last, first, middle initial*) _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Primary Clinic: _____

Requirements for accessing a child's record:

- Birth/adoptive parent or individual requesting access must have legal guardianship rights
- Complete and signed MyChart Child Proxy Form
- Each parent or individual requesting access must have their own MyChart account

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's record by other means.

- If your child is age 0-14: You will be granted full access to your child's MyChart record.
- When your child turns age 15: Your access will transition to a limited access to your child's MyChart record.
- When your child turns age 18: Your access to your child's MyChart record will expire.

Please provide the following information for each child: (All fields are required. If you have more than three children for whom you would like proxy access, please request another form or download one at https://mychart.fmolhs.org

A. Name *(last, first, middle initial)*: _____

Social Security Number: _____ Date of Birth: _____

Primary Clinic: _____

B. Name *(last, first, middle initial)*: _____

Social Security Number: _____ Date of Birth: _____

Primary Clinic: _____

C. Name *(last, first, middle initial)*: _____

Social Security Number: _____ Date of Birth: _____

Primary Clinic: _____

▶ Please remember to complete page 2 of this form.

MyChart Terms and Agreement

By signing below, I acknowledge that I have read, understand, and agree to the MyChart Terms and Conditions.
A copy of the MyChart Terms and Conditions can be requested at your physician's office and can be obtained online at https://mychart.fmolhs.org

Signature of Parent/Guardian	Relationship to Patient	Date	Time
_____	_____	_____	_____