

Emergency Contact

In the event of an emergency, whom should we contact? (Someone other than parent/guardian)

Name: _____ Relationship to patient: _____

Home Ph #: _____ Work Ph #: _____

The following person(s), aside from parents/legal guardians, are authorized to access my child's medical information and have permission to bring my child to appointments and make medical decisions on my behalf.

Name: _____ Relationship: _____

Patient's Name: _____ Date: _____
(Please Print)

Parent/Guardian's Name: _____ Parent/Guardian signature; _____

Release and Assignment

Because your child is a minor, it becomes necessary that a signed permission be obtain from a parent/guardian before any and/or all necessary medical services can be started and accomplished at Head Pediatrics.

I authorize the release of any medical or other information required in the processing of claims. I authorize my insurance benefits to be paid directly to the health care provider.

My signature as parent/guardian affixed below authorizes the rendering of medical services. This consent shall remain in full force and effect until canceled by either party. I understand that I am financially responsible for all charges incurred as a result of medical services rendered.

(signature of Parent/Guardian)

(Date)



Date: _____

Person filling out this form: _____

Relationship to child: _____

Number of adults that live with child: _____

Number of children that live with child: _____

PLEASE CHECK THE BOXES WHERE CHILD'S BLOOD RELATIVES HAVE ANY OF THESE PROBLEMS

	Father	Mother	Brother(s)	Sister(s)	Father's Side	Mother's Side
Allergies (Asthma, Eczema, Hayfever)						
Birth Defects (Cleft Lip, Club Foot, Hip Dysplasia)						
Blood Disorders (Bleeding, Sickle Cell, Anemia)						
Bone/Joint Disorders (Arthritis, Gout)						
Cancer (Leukemia, Breast Cancer, Tumors)						
Cholesterol Problems						
Diabetes						
Eye Problems (Blindness, Lazy Eye, Crossing Eyes)						
Gastrointestinal Disorders (Ulcer, Chron's, Celiac)						
Genetic Disorders (Down Syndrome, CF)						
Heart Disease (Heart Attack, High Blood Pressure)						
Kidney Disease (Absent Kidney, Cystic Kidney)						
Lung Disorders (Asthma, Tuberculosis)						
Muscle Disorder (Multiple Sclerosis, Stiffness)						
Nervous Disorders (Migraines, Seizures, Epilepsy)						
Psychiatric Disorders (Depression, Suicide, Schizophrenia)						
Thyroid Problems						
Venereal Disease (Syphilis, Gonorrhea, HIV)						
Alcoholism, Drug Dependency						
Smoker						
Other:						

The following information is of value in the complete examination of your child. Answering 1s optional and of course confidential.

Are there any problems at home we should be made aware of? _____

Are parents divorced or separated? _____

VACCINATION POLICY

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of vaccines.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults is one of the single most important health-promoting interventions we perform as health care providers and that you can perform as parents/caregivers.

As the topic vaccinations continue to be debated, we here at Head Pediatrics believe that vaccines are vital and necessary. With that said, we will not accept patients that refuse or wish to delay vaccines, (other than the influenza, Sars CoV-2 or HPV vaccine) except those who have a medical indication. Infants and children with certain medical conditions, such as leukemia, are very susceptible to these preventable diseases. Unvaccinated individuals may be harboring these illnesses, and though not outwardly sick, may pass them along to these at-risk patients in our clinic. We take the tremendous responsibility of caring for your child very seriously. This is also why vaccinations are very serious to us. We feel if we would allow children to skip or delay vaccinations it would ultimately be a disservice to your child with potentially disastrous results. This care we have for your child is the ultimate reason we require vaccinations.

I have read and understand the above vaccination policy. I agree to adhere to it and understand that should I choose to not keep my child(ren) current on their vaccinations, I will be asked to secure the services of another physician.

Patient Name

Date

Signature of Parent/Guardian

Printed Name of Parent/Guardian

OFFICE POLICY & PROCEDURES

In order for each and every appointment to go as smoothly as possible and so that we can be sure that all of our patients get the same care and attention, we have implemented the following policies and procedures. Please read over them carefully.

1. **PLEASE ARRIVE FOR YOUR APPOINTMENT ON TIME-** If a patient is late for a scheduled appointment, they will need to be rescheduled to the next available appointment, which may or may not be the same day. You may still be seen arriving less than 15 minutes late, but this is not guaranteed and will be at the discretion of the office. Additionally, arriving for your appointment early will not guarantee that you will be seen earlier than your scheduled time. Dr. Head will typically see patients in the order they are scheduled, not in the order that they arrive.
2. **DO NOT LEAVE YOUR CHILDREN UNATTENDED-** Children under the age of 12 will need to have a parent/guardian/caregiver with them at all times. If you bring more than one child with you and only one is being seen, please make arrangements for either someone to come with you or otherwise care for them during the appointment time. Children 17 and under will require a parent or guardian with them for any procedures done in the office.
3. **PRESCRIPTION REFILL REQUESTS REQUIRE A MINIMUM OF 72 HOURS NOTICE.** Any prescription refills not made in conjunction with an appointment will need to be requested at least 72 hours in advance. Please DO NOT wait until the medication is empty and keep weekends and holidays in mind.
4. **IT IS YOUR RESPONSIBILITY TO KNOW WHAT FACILITIES ARE APPROVED BY YOUR INSURANCE PLAN-** In the event that it is necessary for a patient to be referred to an outside laboratory, imaging center, hospital, or other facility, it is up to the insured/responsible party to know if that facility is covered by your insurance. If you are not sure, you may contact the facility directly or request a provider directory from your insurance plan or human resources office.
5. **WE DO NOT SEE 'WALK-IN' PATIENTS-** We do not see walk-in patients, but rather will see them at the earliest appointment time we have available. If you come into the office for a routine follow-up, vaccination, etc. without an appointment, one will be scheduled for you at that time, which may or may not be on the same day.
6. **IT WILL BE YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGE IN HEALTH STATUS OR VISITS OUTSIDE OF OUR OFFICE THAT MAY PERTAIN TO THE PATIENT'S CARE-** If your child has a visit with another provider or goes to the emergency room or urgent care, it is your responsibility to bring this to our attention and make sure that the other provider or facility forwards any records or results related to that visit.
7. **IT WILL BE YOUR RESPONSIBILITY TO KEEP US UP-TO-DATE WITH CURRENT CONTACT INFORMATION.** Please let us know as soon as possible when any changes in personal or business phone numbers or physical and mailing addresses are made. We need to be able to get in touch with you for appointment reminders, test results, billing questions, etc., in a timely manner.
8. **TERMINATION OF DOCTOR/PATIENT RELATIONSHIP-** If you request your records sent to another physician or physician's office, we may take this as your desire to terminate the doctor/patient relationship. If you disparage Head Pediatrics, Dr. Head or any of his employees publicly online in any forum, website or app, we reserve the right to interpret that as your desire to terminate the doctor/patient relationship. We will notify you of this change, and will see your child for the following (30) days, as required by law, so you may find your child a new provider.
9. **PLEASE LET US KNOW IMMEDIATELY IF THERE ARE ANY CHANGES THAT COULD AFFECT PATIENT CARE OR WELL BEING.** Changes at home, school, etc., that could affect a patient's care or well being should be brought to our attention as soon as possible. Changes in living conditions, academic difficulties, changes in appetite or mood, or even the death of a loved one or pet can affect a patient's health. Please make us aware of any changes, so that we can address or be sensitive to new issues as needed.

I have read and understand the above office policies and agree to adhere to them.

Patient's Name

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Relationship to Patient

FINANCIAL POLICIES

At Head Pediatrics, we are committed to treating all of our patients with the highest quality of care and respect. In order to make sure that your account is handled in the most efficient manner and to get the maximum benefit from your insurance carrier or to avoid any discrepancies in billing, we have implemented the following policies and are producing a copy of them to our patient's parents, guardians, and/or responsible parties. It is important that you have a clear understanding of, and cooperate with, these policies. All questions concerning your billing should be directed to office staff. Also, please keep in mind that none of the fees addressed in this financial policy are covered by insurance except for co-pays, co-insurance, etc., that might be covered if you have a secondary insurance or Medicaid.

1. **PAYMENT WILL BE DUE IN FULL AT THE TIME OF SERVICE-** Any fees, co-pays, co-insurance percentages, or deductible amounts will be due the day the patient(s) is seen.
2. **WHOEVER BRINGS THE PATIENT IN IS RESPONSIBLE FOR PAYMENT-** Grandparents, aunts, uncles, caregivers, etc., will be expected to bring payment in with them. In the case of court-ordered custody arrangements, whichever parent brings the child in will be responsible for full payment at the time of service. It will not be Head Pediatrics' responsibility to bill the other party, nor will we intervene to determine how responsibility of payment will be split.
3. **CURRENT & CORRECT INSURANCE INFORMATION MUST BE PROVIDED PRIOR TO YOUR APPOINTMENT-** If we are not notified prior to the next scheduled appointment, be prepared for a delay in being seen or even being rescheduled. If you have not given us correct information and a claim does not get paid due to the time limit expiring, this will become YOUR financial responsibility.
4. **THERE WILL BE A FEE FOR RETURNED CHECK-** In the event a payment is rejected by your financial institution due to insufficient funds or for any other reason, there will be a \$30.00 fee IN ADDITION TO the original amount of payment.

I understand and agree to the terms and conditions of the above financial policies for Head Pediatrics and I have asked any questions and requested any clarification necessary for me to comfortably agree.

Patient Name

Date

Signature of Parent/Guardian

Relation to patient

Printed Name of Parent/Guardian

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect January 1, 2026, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We are permitted to use and disclose your medical information to those involved in your treatment.

Payment: We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you.

Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification or (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information for legal requirements without your written authorization.

Public Health, Abuse or Neglect, and Health Oversight: We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. Texas law requires physicians to report child abuse or neglect.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors: We may release medical information to organ procurement organizations if you are a donor. We may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

National Security and Law Enforcement Agencies: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: Unless you specify otherwise, in writing, we may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request a copy of your records by contacting our Medical Records office. You may request access to review your records by sending us a letter to the address at the end of this Notice. Federal and Texas State Laws permit us to charge a reasonable cost-based fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before May 26, 2015. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information.

Acknowledgement of Review of Notice of Privacy Practices

****You may refuse to sign this acknowledgement*****

****You may request a copy of the Notice of Privacy Practices*****

I, _____ [name of parent/guardian], have reviewed/received a copy of this office's Notice of Privacy Practices. Please list all current patients this acknowledgement applies to [patient's name(s)]:

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian



Standard Authorization of Use and Disclosure of Protected Health Information

Information to be Used or Disclosed

The information covered by this authorization includes:

- Operative/Procedure Report

Dated _____

- Pathology Report

Dated _____

- Office Notes

Dated _____

- Insurance Information

Dated _____

Other:

Patient Information

Patient's Name: _____ Date of Birth: _____ SSN #: _____

Address: _____ Phone #: _____

I, the undersigned, AUTHORIZE _____ to release my medical records, including but not limited to a report of my diagnosis, treatment, prognosis and recommendations as well as data pertinent to any treatment I receive during the time that I was a patient, to:

Provider/Etc. Name: **Ryan E Head, MD, FAAP**

Address: **625 Russell Blvd.
Nacogdoches, TX 75965**

Phone/Fax: **936 305 5050 / 936 305 5151**

This authorization covers dates of patient care from _____ to _____. I, the undersigned, understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire six months from the date of signature.

Signature of Patient/Parent/Guardian

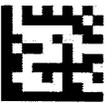
Date

Signature of Witness

Date



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) Ethnicity (select only one)
American Indian or Alaska Native Asian Black or African-American Hispanic or Latino
Native Hawaiian or Other Pacific Islander White Other Race Not Hispanic or Latino
Recipient Refused Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

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 ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

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.

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