GALAXY PEDIATRICS
556 BLUEBIRD LANE
STE100
RED OAK, TX 75154
P: 972-617-6660 F:469-218-0070

TRINITY PEDIATRICS
6105 WINDCOM CT
PLANO, TX 75093
P: 972-473-9063 F: 972-473-9059

Date:_____ Referred by: _____

Patient Last Name: _____ First Name:_____MI___

Date of Birth: _____Gender: (circle one) Male/Female
Address: _____City:_____
State: _____ Zip Code: _____
Phone:_____

Mother Last Name: _____ First Name:_____MI____
Date of Birth: _____Gender: (circle one) Male/Female
Address: _____City:_____
State: _____ Zip Code: _____
Phone:_____
Driver License /ID #:_____
Employment:_____
Occupation:_____ Work Ph:_____

Father Last Name: _____ First Name:_____MI____
Date of Birth: _____Gender: (circle one) Male/Female
Address: _____City:_____
State: _____ Zip Code: _____
Phone:_____
Driver License /ID #:_____
Employment:_____
Occupation:_____ Work Ph:_____

Are both parents Legal Guardians? _____
If not, please fill out Legal Guardians information below.

(If Legal Guardian of Child is someone other than parent, please provide a court ordered legal document)

Guardian Last Name: _____ First Name:_____MI____
Date of Birth: _____Gender: (circle one) Male/Female
Address: _____City:_____

State: _____ Zip Code: _____
Phone:_____
Driver License /ID #:_____
Employment:_____
Occupation:_____ Work Ph:_____

I _____(Guardian Name) authorize the following person(s) to bring _____ (Child's name) to Trinity Pediatrics/Galaxy Pediatrics for patient care.

Full Name: _____ Relation to Pt.:_____
Full Name: _____ Relation to Pt.:_____
Full Name: _____ Relation to Pt.:_____

(Authorized person must present photo identification at check in)

Emergency Contact:
Name: _____Ph: _____ Relation_____
Name: _____Ph: _____ Relation_____
Name: _____Ph: _____ Relation_____

Print Guardian Name:_____
Guardian Signature:_____

Explanation of Payment Policy
(Payment is due at Check In, at time of Service)

We accept cash, debit card, and credit cards (Visa, MasterCard, Discover, American Express).
All payments for deductibles not met are due at time of service rendered. If incorrect payer information is provided and service is not covered by payer (insurance) it is the responsibility of parent/guardian to provide payment in full.
All insurance benefits from claims filed by Trinity Pediatrics/Galaxy Pediatrics prior to payment in full are assigned to Trinity Pediatrics/Galaxy Pediatrics. In the event that insurance is canceled, the services rendered are not covered, or partially covered, the undersigned is responsible for full payment of services rendered.

I, _____ understand that I am financially responsible for all medical charges incurred by my dependent child for services rendered by Trinity Pediatrics/Galaxy Pediatrics. I understand that all fees required to collect on my account are payable by me. I understand and agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for additional fees by collection agency.

Signature: _____ Patient Name: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- -Conduct, plan and direct my treatment and followup among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- -Obtain payment from third-party payers.
- -Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name:_____ Date of Birth:_____

Guardian's Name: _____ Signature:_____

Date:_____

AUTHORIZATION FOR TREATMENT

I, _____, parent/legal guardian of_____,

born on_____, do hereby consent to medical care and/or the administration of vaccines ordered by the physician to be necessary for the welfare of my child, while said child is under the care of a Provider at Galaxy/Trinity Pediatrics.

Signature: _____Date: _____