PATIENT INFORMATION (Please Print)

Patient Name (Child) _____
First Middle Last

Date of Birth _____Patient SS# _____Patient's Sex _____

Address _____City _____ State _____ Zip Code_____

Phone: Home _____ Work_____ Cell_____

Emergency Contact Person _____ Phone _____

Patient's Pediatrician/Family Doctors, Phone Number: _____

Dentist Name, Phone Number: _____

Orthodontist Name, Phone Number: _____

GIVE BOTH PARENTS INFORMATION-WITH THE INSURED FIRST:

Insured Parent Name	Other Parent Name
Date of Birth	Date of Birth
Address	Address
City, State, Zip	City, State, Zip
SS#	SS#
Driver's License #	Driver's License #
Employer	Employer
Occupation	Occupation
Cell Phone	Cell Phone
Primary Insurance	Secondary Insurance
Policy ID #	Policy ID #
Group #	Group #

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by Craniofacial Team of Texas and understands and consents to the review and use of his/her medical records by Craniofacial Team of Texas. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage and it's customary to pay for services when rendered. *** Craniofacial Team of Texas does not accept Medicaid. ***

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Craniofacial Team of Texas to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by Craniofacial Team of Texas. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

GENERAL CONSENTS & ACKNOWLEDGEMENTS

HIPAA & Office Protocol

I acknowledge that I have been presented with a copy of Craniofacial Team of Texas Notice of Privacy Practices as well as the Office Protocol and understand my responsibilities.

Automated Calls

I consent to receive automated calls and text messages re: my child, including patient portal communications. [ ] Yes [ ] No

Medical Records Release for Insurance

I hereby authorize the release of any medical records, inclusive of all results of any testing and other pertinent information acquired during my treatment, to my insurance company. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Authorization for the release of Medical photographs/slides and or videotapes

INSTRUCTIONS: This is a content document that has been prepared to help inform you concerning permission to take photographs, slides and or videotapes and to use these images for a purpose as defined with this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your Plastic Surgeon.

INTRODUCTION: Medical photographs/slides and videotapes may be taken before, during or after surgical procedure or treatment. Consent is required to take such images. Additionally, patient may consent to release these medical photography / slides and videotapes for stated purpose.

CONSENT TO TAKE PHOTOGRAPH/SLIDES/VIDEOTAPES

I hereby authorize Craniofacial Team of Texas. to take pre-operative, intraoperative and post-operative photograph, slides and/or videotapes. I additionally consent to photograph, slides and or videotapes of my interview.

1. I consent for these photographs to be used with your office to show prospective patients.
2. I consent for these photographs to be used in patient and professional education materials to include presentations, brochures, web content, and research publications produced by the Craniofacial Team of Texas.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO: CRANIOFACIAL TEAM OF TEXAS

PATIENT NAME (Please Print Name) _____DATE OF BIRTH _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:

___Continuation of Care ___ Insurance Application ___Billing Records

___History & Physical ___Other (description)

Specific Description of the Information to be Used or Disclosed (including the date of service(s):

___All Medical Records ___ Newborn Records (Name of Hospital)_____

___Shot Records Only ___Other _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: Craniofacial Team of Texas

The above information may be released (FROM)_____ (specify name or title of individual or the name of the organization from which records are to be released and the appropriate address):

(Doctor, Hospital, Insurance Company, Self, etc.) Phone Number Fax Number

_____Address

(Street, City, State, Zip Code)

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Craniofacial Team of Texas in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by Craniofacial Team of Texas before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.

Print Name of Patients Representative_____ Date _____

Relationship to Patient_____ Signature of Parent or Guardian _____

Craniofacial
TEAM OF TEXAS

Permission to treat a Minor/Consent for Care

I, _____, parent or legal guardian of,

_____, give permission for the following people

1. _____
2. _____
3. _____

to authorize medical treatment for my child listed above.

This may include bringing the child into the Craniofacial Team of Texas office, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, providing consent, and being responsible for relaying any diagnosis and treatment or prescriptions to the parent or legal guardian mentioned above.

Please give them any instructions and/or prescriptions that may be needed. In case of emergency, I can be reached at _____.

This authorization is effective as of today, _____ and expires on _____.

Signed,

_____

_____

Print Name