RAMONA S ATAYA-DAKOUR MD, FAAP
REBECCA BALFANZ, APRN, CPNP-PC
3070 COLLEGE #205 BEAUMONT TEXAS 77701

TODAY'S DATE: ___/___/_____

Patient's Last Name: _____ **Patient's First Name:** _____ **D.O.B.** ____/____/_____

Sex: □ M □F **Sibling's Name(s):** _____DOB ___/___/___, _____DOB___/___/___, _____DOB ___/___/___

RACE □ American Indian or Alaska Native □Asian □ White □ Africa American □ Native Hawaiian □ Other □ Refused to disclose.

ETHNICITY □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to disclose

Mailing Address	City	State	Zip

Email for Patient Portal:_____@_____ **Insured's Employer:** _____

1)Parent's Name: _____ **D.O.B:** ____/____/_____ **Cell Phone:** _____-_____-_____

Email: _____@_____ **Social Security Number:** _____-_____-_____

2)Parent's Name: _____ **D.O.B:** ____/____/_____ **Cell Phone:** _____-_____-_____

Email: _____@_____ **Social Security Number:** _____-_____-_____

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Company Name		**Insurance Company Name**	
Address **Phone #:**		**Address** **Phone #:**	
Identification Number	**Group Number**	**Identification Number**	**Group Number**
_____	_____	_____	_____
Responsible Party Name	**Date of Birth** - -	**Responsible Party Name**	**Date of Birth** - -
Patient's relationship □Self □Spouse □Dependent	**Responsible Party Social Security** _____-_____-_____	**Patient's relationship** □Self □Spouse □Dependent	**Responsible Party Social Security** _____-_____-_____

Preferred Pharmacy: _____ **Preferred Pharmacy Location:** _____

EMERGENCY CONTACT AND AUTHORIZATION FOR NON-PARENT/GUARDIAN TO ACCOMPANY PATIENT, SPEAK TO DOCTOR/STAFF, GIVE AUTHORIZATION TO TREAT, MEDICATE, VACCINATE, AND MAKE GENERAL HEALTH DECISIONS REQUESTED BY TH DOCTOR. THE PERSONS LISTED BELOW WILL NEED TO PRESENT A PHOTO IDENTIFICATION AT TIME OF SERVICE

Name	Relationship to patient	Cell Phone
Name	Relationship to patient	Cell Phone
Name	Relationship to patient	Cell Phone

Bloom Pediatrics Consent Form

Assignment and Release of Financial and Medical Records

I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company, health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to be used in place of the original.

_____ _____/_____/_____

Patient or Authorized Person's Signature Date

RAMONA S ATAYA-DAKOUR MD, FAAP
REBECCA BALFANZ, APRN, CPNP-PC
3070 COLLEGE #205 BEAUMONT TEXAS 77701

PATIENT'S NAME: _____ **TODAY'S DATE:** ___/_____/_____

Financial Obligation

I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and I fully understand that I am fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

Divorce/Custody/Adoption Case Policy

The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance. To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the front desk. If parent or guardian exclusions are stated in any court order, you must provide the order for documentation for the patient's safety. A court order is required for the patient's chart for all adoptions and guardian assignments outside of the biological parents.

Annual Wellness/Physical Policy

- All patients are required to have an annual well exam regardless of the need for vaccines. Any patient that fails to have annual physical TWO consecutive years will be considered NOT COMPLIANT and might not be able to schedule any appointment with this practice.
- If a patient has any symptoms or treatment other than wellness, the annual check-up could be rescheduled for a later date and the copay (if applicable) will be applied.

Vaccination Policy

The providers at this facility follow the required and recommended vaccines according to the schedule published by the centers for disease control (CDC) and the American Academy of Pediatrics (AAP). I acknowledge and consent to the above policy unless otherwise indicated.

No Show Policy

Patients must give us advance notice if they need to reschedule their appointments. A "No Show" of $25 could be applied to missed appointments that are not canceled 24 hours in advance. If any family member exceeds more than **3" No Shows",** the family may be subjected to dismissal from the practice effective 30 days past the last no show appointment.

Consent For Treatment

I hereby authorize the providers, nurses, medical assistants, and staff to conduct examinations, administer treatment and medications as they deem necessary and advisable. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care procedures consistent with Dr. Ramona Ataya-Dakour Notice of Privacy Practices. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Authorization for Release of Information

1. Can we leave results to internal and external office testing or referrals in voicemail? □ Yes □ No

Advanced Practice Nurse Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical care.
An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.
I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.
I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

RAMONA S ATAYA-DAKOUR MD, FAAP
REBECCA BALFANZ, APRN, CPNP-PC
3070 COLLEGE #205 BEAUMONT TEXAS 77701

PATIENT'S NAME: _____ **TODAY'S DATE:** ____/____/_____

Advanced Practice Nurse Consent for Treatment

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I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.
I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

Permission for Telehealth Visits

Telehealth is a way to visit with health care providers, such as your doctor or nurse practitioner.

- You can talk to your provider from any place, including your home.
- Your provider may decide you still need an office visit.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the internet for telehealth, use a network that is private and secure.
- There is a small chance that someone could use technology to hear or see your telehealth visit.
- You can stop using telehealth anytime, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- A telehealth visit will cost the same as an office visit.

If you decide you do not want to use telehealth again, please call 409-832-1225. By signing this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.

I have read each of the statements above and authorize, understand, and agree to each statement.

_____ ____/____/_____
Patient or Authorized Person's Signature Date

RAMONA S ATAYA-DAKOUR MD, FAAP
REBECCA BALFANZ, APRN, CPNP-PC
3070 COLLEGE #205 BEAUMONT TEXAS 77701

Patient's Information

Patient's Name:

D.O.B:

Place of Birth:

Birth Weight: lb oz

Birth Length: inches

Biological Adopted Stepchild Guardian

Hours of labor:

Delivery: _____ weeks

1. Newborn Blood Screening	Date: _____
2. Newborn Blood Screening	Date: _____

Nursery

Type of delivery:

Vaginal Caesarean

Age at Discharge: _____days

Complications: Breech Multiple birth Other

BIRTH

Difficulty with initial breathing	— YES — NO
Heart Murmur	— YES — NO
Infection	— YES — NO
Transfusion	— YES — NO
Seizures	— YES — NO
Jaundice req. treatment	— YES — NO
Referral Made	— YES — NO
Muscle/Bone disease	— YES — NO
Childhood Hearing Impairment	— YES — NO
Inherited/Genetic Diseases	— YES — NO
Major birth defects	— YES — NO
Tuberculosis	— YES — NO
Psychiatric Disorders	— YES — NO
Physical/emotional/sexual abuse	— YES — NO
Domestic violence	— YES — NO
Other	— YES — NO

Child's Medical History

New Born Hearing Test (in hospital)

__ Normal __ Abnormal

Hepatitis	— YES — NO
Immunization Current	— YES — NO
Dental Care Current	— YES — NO
Trauma/Injury	— YES — NO
Hospitalization	— YES — NO
Medications	— YES — NO
Anemia	— YES — NO
Early Childhood Caries	— YES — NO
Ear Infections	— YES — NO
Bladder/Kidney Inf.	— YES — NO
Strep Throat	— YES — NO
Pneumonia	— YES — NO
Developmental Delay	— YES — NO
Vision/Hearing Problem	— YES — NO
Seizures	— YES — NO
Toxin/Lead Exposure	— YES — NO
Allergies	— YES — NO
Asthma	— YES — NO
Eczema	— YES — NO
Substance Abuse	— YES — NO
Alcohol	— YES — NO
Drugs	— YES — NO
Tobacco	— YES — NO
Other	— YES — NO

Mother

Prenatal care provider:

Trimester prenatal care began:
—1 —2 — 3

Number of living children —

Mother's age at birth —

Vitamins	— YES — NO
Iron	— YES — NO

Number of years between previous pregnancy and this child:

Maternal Complications

Vaginal bleeding	— YES — NO
Anemia/Blood disorder	— YES — NO
Hypertension	— YES — NO
RH Negative	— YES — NO
Diabetes	— YES — NO
Premature labor	— YES — NO
Injury/Surgery	— YES — NO
Flu like illness	— YES — NO
Alcohol	— YES — NO
Street Drugs	— YES — NO
Kidney Problems	— YES — NO
STDs	— YES — NO
Hepatitis (A, B, C)	— YES — NO
Exposure to TB	— YES — NO
Dental Disease	— YES — NO
OTC Meds	— YES — NO
Prescription MEDs	— YES — NO
Tobacco	— YES — NO
Caffeine	— YES — NO

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)			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			☐ Recipient Refused

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)

Provider Statement

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.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

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

Release of Medical Records

Bloom Pediatrics

Ramona Ataya-Dakour MD, FAAP
Rebecca Balfanz, APRN, CPNP
3070 College Street Suite205 Beaumont, Texas 77701
Tel: 409-832-1225 Fax: 855-638-6067

Previous Pediatrician/Provider Information:

Doctor/Provider Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Parent/Guardian Information:

I, _____, authorize the release of my child/children medical records named below:

Patient Information:

Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____

Specific information to be disclosed

O	Entire Medical Record
O	Immunization Record
O	Labs/Imaging
O	Consult Notes

The undersigned understands and acknowledges that:

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and discloses(releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by privacy law.

_____ _____

Signature of Patient or Guardian Date:

Notice to the individual giving this authorization

This authorization shall operate as a complete release of liability of Dr. Ramona Ataya-Dakour's Office, its officers, agents and employees for the release of information as specified above. We have no control over the recipient's use of the information. The person who we disclose your information may disclose it to someone else and this office will no longer be able to protect the information.