Ricardo Reyna MD
Pediatrician

Patient Information Form

Patient Information

Name of Patient and all siblings	Sex	Birth Date	Patients cell number (if applicable)
1. _____	M/F	____/____/___	_____
2. _____	M/F	____/____/___	_____
3. _____	M/F	____/____/___	_____
4. _____	M/F	____/____/___	_____
5. _____	M/F	____/____/___	_____

Responsible Party and Parent Information

Responsible Party Name _____ Other Parent _____

Policy Holders social_____ Address_____

Relationship to Patient _____ DOB _____

Policy Holders DOB _____ City_____ State_____ Zip_____

Address _____ Home Phone ( ) _____ - _____

City _____ State _____ Zip _____ Work Phone ( )_____ - _____

Home Phone ( ) _____ - _____ Cell Phone ( )_____ - _____

Cell Phone ( ) _____ - _____ Email address _____

Preferred Pharmacy _____ Dental Home_____

Emergency Contact

In an emergency please contact (other than above)

Name/ Relationship _____ Phone ( ) _____- _____

Signatures

Parent/Guardian Signature _____ Date _____/_____/_____

Ricardo Reyna III, MD PLLC
Credit and Financial Policy

In compliance with the Federal Consumer Protection Act, Ricardo Reyna wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

Insurance

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Cash Account

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service. If you subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will bill the charges to your insurance company for you. If we then receive insurance payment we will promptly issue a refund to you of any credit on your account.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement. A $25.00 per month late charge is assessed on all delinquent patient balances.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a $40 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 10 minutes late o more.

Urgent Care Appointments

There may be an extra fee charged for urgent care appointments outside of our regular Monday – Friday business hours.

Returned Checks

There is a $25 returned check fee in the event a patient's personal check is returned to us for any reason.

The undersigned has read and agrees to the above financial credit and payment policies of Ricardo Reyna III, MD PLLC

Signed: _____ Date: _____

(Parent / guardian/ responsible party

Ricardo Reyna III MD PLLC
Immunization Policy

Childhood immunization was one of the greatest advances in public health in the 20th century. It has saved millions of children and adults throughout the world from developing meningitis, encephalitis, brain damage, severe respiratory problems, poliomyelitis, paralysis, and other severe illnesses, which can require hospitalization or cause death. And to this day, childhood immunization remains a cornerstone of pediatric care and public health.

Immunizations are most effective when an entire community participates. In recent years, localized outbreaks of mumps, measles, whooping cough and polio have occurred in the United States in communities with low vaccination rates. When you immunize your child, you are not only protecting your child from serious disease but you are also helping to protect your entire family, your friends and your neighbors.

At Ricardo Reyna III, MD PLLC, we strongly believe in the importance of immunizations and fully support the childhood immunization schedule established by the American Academy of Pediatrics. Therefore, **our policy requires that every patient within our group receive the vaccinations listed below:**

By 18 months of age, your child will receive the following:

Type of Immunization	
Hepatitis B:	3 doses
Hepatitis A:	2 doses
Diptheria, Tetanus and Pertussis (DTaP):	4 doses
Inactivated Polio Vaccine (IPV):	3 doses
Haemophilus influenza (HIB):	4 doses
Pneumococcal conjugate vaccine (Prevnar):	4 doses
Varicella vaccine (Chicken Pox):	1 dose
Measles, Mumps and Rubella (MMR):	1 dose

By the age of 5 years your child will receive these additional vaccines:

A fifth dose of **DTaP**
A fourth dose of **IPV**
A second dose of **MMR**
A second dose of **Varicella (Chicken Pox)**

For Preteens-To be started at 11 years old:

Tetanus, Diphtheria, Pertussis (TdaP)	1 dose (Given at 10-11 yrs.)
Meningococcal Vaccine	1 dose (Given at 11 yrs.)
HPV vaccine (Gardasil)	3 doses (First dose at 11 yrs.-must be completed before 15 yrs.)

We are aware of the concerns about vaccine safety that has been voiced by a **very small** yet vocal minority. These claims have no scientific or statistical basis. To date, there have been over 30 scientific studies, which have proven, conclusively, that vaccines are safe.

By signing, I agree to follow Ricardo Reyna III, MD PLLC policy to fully immunize my child(ren) by 5 years of age. If decide to not vaccinate, Ricardo Reyna III, MD is not responsible for any vaccine preventable related complications acquired from not vaccinating.

Name _____ Date _____/_____/_____

Ricardo Reyna III, MD PLLC

Authorization to Release Patient Medical Information

I hereby authorize the release of Medical Records, excluding protected records as follows:

Please Limit to the LAST 2 YEARS Information Only:

- **Chart Notes/ Medical Summary**
- **Immunization Records**
- **Growth Records**
- **Laboratory and/or X-Ray Reports**
- **Other:**

Records to be released from:

Name: _____Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records to be released for:

Child's Name: _____ Date of Birth:_____

Child's Name: _____ Date of Birth:_____

Child's Name: _____ Date of Birth:_____

Child's Name:_____ Date of Birth:_____

Please send records to:

Ricardo Reyna III, MD PLLC
100 E Schuster Ave
El Paso, Texas 79902
(915) 317-5900
Fax (915) 975-5912

Authorization to Release Medical Information:

_____ _____
Name (please print) of Parent/Guardian Phone Number

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

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Name(s) of patient(s) in practice:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____