Ennis Childrens Clinic 601 S.Clay Suite 101 Ennis, Texas 75119 972-875-5220

PATIENT DEMOGRAPHIC INFORMATION

Full Name: _____ Male _____ Female _____
Last First Middle

Birthdate ____/____/____

Address _____

Soc Sec ____/____/____

_____

City State Zip Code Home Phone _____

Mother _____ Father _____

Or Legal Guardian _____

Whom does patient reside with? _____

Name of other siblings under 16 years old:

_____ _____ _____

_____ _____ _____

GUARANTOR INFORMATION: Responsible Person (s)

Full Name _____ Male _____ Female _____

_____ Birthdate ____/____/____

_____ Soc Sec ____/____/____

City State Zip Code

Relationship to patient _____ Driver License _____

Employer _____ Work Phone _____

_____ Cell Phone _____

City State

INSURANCE INFORMATION

Primary Insurance _____

Pt relation to insured _____

Address _____

Ins Phone# _____

_____

City State Zip Code

Policy Holder's Name _____

Policy # _____

Policy Holder's Birth Date ____/____/____

Group# _____

Policy Holder's Employer _____

Soc Sec # ____/____/____

Employer's Address _____ Work Phone _____

Secondary Insurance _____ Pt relation to insured _____

Address _____ Ins Phone# _____

_____

City State Zip Code

Policy Holder's Name _____ Policy# _____

Policy Holder's Birth Date ____/____/____ Group# _____

Policy Holder's Employer _____ Soc Sec# ____/____/____

Employer's Address _____ Work Phone _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION TO INSURANCE

I certify the above information is correct to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the physician and I understand I am financially responsible for non-covered services. I also authorize the physician to release any medical information required in the processing of claims. I understand and agree that I am ultimately responsible for the payment of all charges on behalf of my child(ren) regardless of insurance benefits.

Signature _____ Date _____

Emmanuel E. Sackey, MD (dba Ennis Childrens Clinic)
601 S. Clay, Suite 101 Ennis, Texas 75119
Phone (972) 875-5220 Fax (972) 875-5606

TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I and my child(ren) will not be physically in the same room as my healthcare provider. I will be notified of and my consent obtained for anyone other than my child (ren) healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception and technical difficulties.
   a) If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my child(ren) healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in telemedicine visit for my child(ren) and that my refusal will be documented in my medical records. I also understand that my refusal will not affect my right to future care of treatment for my child(ren).
   a) I may revoke my right at any time by contacting Ennis Childrens Clinic at (972) 875-5220.
5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine services.
6. I understand that the healthcare information of my child(ren) may be shared with other individuals for scheduling and billing purposes.
   a) I understand that my insurance carrier will have access to my child(ren) medical records for quality review/audit.
   b) I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to the telemedicine visit for my child(ren).
7. I understand that this document will become a part of my child(ren) medical records.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during the telemedicine visit for my child(ren).

_____ _____

Name of Child(ren) **Date Signed**

_____ _____

Name of Parent/Guardian **Signature of Parent/Guardian**

Ennis Childrens Clinic
DR. EMMANUEL E. SACKEY
601 S. Clay, Suite 101
Ennis, TX 75119
972-875-5220 FAX 972-875-5606

PATIENT QUESTIONNAIRE

PATIENT'S NAME:_____

1. **Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment and health care operations):**

   _____ _____
   _____ _____
   _____ _____

2. **Please list the family members or significant others, if any, whom we may inform about medical condition ONLY IN AN EMERGENCY:**

   Name:_____ **Phone number:**_____
   Name:_____ **Phone number:**_____

3. **Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your telephone number:** _____

   ***I am fully aware that a cell phone is not a secure and private line.**

4. **Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?**

   _____ **Yes** _____ **No**

_____ _____
DATE **PARENT/GUARDIAN SIGNATURE**

Emmanuel E. Sackey, MD, PA
dba Ennis Childrens Clinic
601 S. Clay, #101 Ennis, TX 75119

CONSENT FOR TREATMENT

I consent to treatment necessary for the care of the patient _____.

I understand this facility employees Pediatric Physician Assistants.

I consent for the following to bring my child for treatment when I am not available:

_____ _____

_____ _____

_____ _____

_____ _____

Date **Signature of Parent/Legal Guardian**

PERMISO PARA TRATAMIENTO

Doy permiso de tratamiento necessario para el paciente _____.

Entiendo que esa facilidad emplea Asociados Medicos de Ninos.

Doy permiso que las siguientes personas tragan a mi nino/nina para tratamiento cuando yo no puedo venir:

_____ _____

_____ _____

_____ _____

_____ _____

Dia de Firms **Firma de Padre/Madre o Persona de Apoderado**