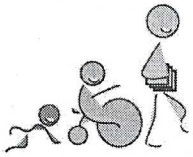

Marcella A Frausto MD PA 12430 Montwood Dr. El Paso TX 79928 (915) 849-9733

PATIENT INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____ Age:_____ Circle Male Female

Address: _____

City/State:_____ Zip:_____ Cell Number:_____

PARENT/LEGAL GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____

Cell Number: _____ Email Address: _____

Address (if different from patient's) _____

Father's Name: _____Date of Birth: _____

Cell Number: _____ Email Address: _____

Address (if different from patient's) _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth:_____

Policy ID # _____ Group #_____ Effective date: _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Name: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth:_____

Policy ID # _____ Group #_____ Effective date: _____

PATIENT'S SIBLINGS UNDER OUR CARE

Name: _____ Date of Birth: _____

Circle: Male Female

Name: _____ Date of Birth: _____

Circle: Male Female

Name: _____ Date of Birth: _____

Circle: Male Female

Name: _____ Date of Birth: _____

Circle: Male Female

Name: _____ Date of Birth: _____

Circle: Male Female

MEDICAL CONSENT FOR SICK VISITS ONLY

(Only individuals listed are permitted to bring patient to office for sick visits)

Name: _____ Cell number: _____

Relationship to patient: _____

Name: _____ Cell number: _____

Relationship to patient: _____

Name: _____ Cell number: _____

Relationship to patient: _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth ____/____/____ *Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Telephone ____ - ____ - ____

Child's Address _____ Apartment # _____ Email address _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The 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 ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized 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 state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, 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;
- 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 to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

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 _____

Date _____ Signature _____

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)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac DC

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.
DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____
   Last Name First Name MI
2. Child's Date of Birth: ____/____/____
   MM DD YYYY
3. Parent, Guardian, or Individual of Record: _____
   Last Name First Name MI
4. Primary Provider's Name: _____
   Last Name First Name MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Marcella A. Frausto, MD. PA.

Notice Of Privacy Acts

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment plan for future care or treatment and billing related information.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction.

Uses and Disclosures

How We May Use and Disclose Health Information About You.
The following categories describe examples of the way we use and disclose medical information:
For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or others who are involved in taking care of you. We may also provide your specialist or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

For Payment: We may use and disclose information about your treatment and services to bill and collect payments from you, your insurance company, or a third-party payer. We may need to give your insurance company information about your surgery or treatment so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatments you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. For example, A case manager or others may combine medical information about many parties in order to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other providers to see where we may make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

We may also use and disclose medical information:

-To business associates we have contracted with to perform the agreed upon service and billing for it.
-To remind you that you have an appointment for medical care.
-To tell you about possible treatment alternatives.
-To tell you about health-related benefits or services.
-To inform funeral directors consistent with applicable laws.

Business Associates:
There are some services provided in our office through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a dictation service we use. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your insurance for services rendered. To protect your health information, however, we require business associates to appropriately safeguard your information.

Individuals Involved In Your Care or Payment For Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps you pay for your care.

Organized Health Care Arrangement: This office and its staff has organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and health care. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time period. Please contact the office manager for further information on the specific sites included in the affiliated covered entity.

As Required By Law: We may also use and disclose health information for the following types of entities, including but not limited to:

-Public health or legal authorities charged with preventing or controlling disease, injury, or disability.
-Workers compensation agents.
-Organ and tissue donation organizations.
-Military command authorities.
- Health oversight agencies.

- Funeral directors, coroners, and medical directors.
- National security and intelligence agencies.
- Protective Services for President and others.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Your Health Information Rights: Although your healthcare record is the physical property of the health care practitioner or office that compiled it, you have the right to:

Inspect and copy: you have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes. We may deny your request to inspect and copy in certain and very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Amend: If you feel that the medical information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us. We may deny your request for an amendment, and if this occurs, you will be notified the reason for the denial.

An Accounting of Disclosures: you have the right to request an accounting of disclosures. This is a list of disclosures we make of medical information about you.

Request Restrictions: you have the right to request a restriction of limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit of the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request Confidential Communications: you have the right to request that we communicate with you about medical matters in a certain way or a certain location, i.e. hospital or at home. We will agree to the request to the extent that it is reasonable for us to do so.

A Paper Copy of This Notice: you have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To exercise any of your rights, please obtain the required forms from the office manager and submit your request in writing.

Changes to This Notice:
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you, as well as any information we receive in the future. The current notice will be posted in the office and include the effective date.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us by contacting our office and asking for the office manager, or you may file with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Other Uses of Medical Information:
Other uses and disclosures of medical information that are not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Revised June 22, 2021

Marcella A Frausto MD PA 12430 Montwood Dr. El Paso TX 79928 915-849-9733

CONSENT TO TREATMENT: I voluntarily consent to receive medical health care services provided by MARCELLA A. FRAUSTO MD PA, employees and such associates, assistants, and other health care providers, as my physician deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the office of MARCELLA A. FRAUSTO MA PA unless revoked by me in writing such written notice provided to each clinic attended by me.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at MARCELLA A FRAUSTO MD PA, including but not limited to information concerning mental illness (except for psychotherapy notes, use of alcohol or drugs or communicable diseases, laboratory test results, medical histories, treatment progress or any other such related information.

By signing this form you consent to MARCELLA A FRAUSTO, MD PA use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our notice of Privacy practices provides information about how the doctor and its workforce may use and/or disclose protected health information about you for treatment, payment, health care operations, and as otherwise allowed by law.

RELEASE FROM LIABILITY: I release and agree to hold harmless MARCELLA A FRAUSTO MD PA and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand MARCELLA A FRAUSTO MD PA cannot be held responsible for the use or re-disclosure of information by third parties.

FINANCIAL REPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicaid, Medicare, or other third-party payer benefits for medical or health care services otherwise payable to me, to MARCELLA A FRAUSTO MD PA, and/or medical practice income plan. I also authorize direct payments to be made by Medicare, Medicaid, ,and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges to MARCELLA A FRAUSTO MD PA and /or medical practice income plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be pain or actually paid by Medicare/Medicaid, my insurance company, or other third party payer and agree to make payments as requested by MARCELLA A FRAUSTO MD PA.

I certify that this form has been fully explained to me, that I have read it or had it read to me* and that I understand its contents.

ADVANCE DIRECTIVE

I have signed an Advance Directive ____YES____NO

If yes, Is it still in effect? ____YES ____NO

I have provided a signed copy to MARCELLA A FRAUSTO MD PA ____YES ____NO

Date:_____

Patient Name:_____ Date of Birth: _____

Parent/Legal Guardian Name: (print)_____

Signature: _____

OFFICE POLICIES

To provide you child with the best care in an efficient manner, we ask you follow a few simple policies.

- All doctor visits are by appointment only. There are daily appointments available, but it is necessary to call first and inquire.
- Please arrive **15 minutes** prior to your scheduled appointment time with **photo ID, insurance card, and vaccine record**. If you arrive late or do not have the proper items on hand, your appointment will need to be rescheduled.
- All appointments are to be cancelled in advance.
- Referrals will not be faxed to the specialist's office; if you need a referral, please call at least 48 hours in advance of your appointment
- There is a $5 fee for lost referrals
- Exam rooms are small, therefore, a parent/guardian and patient in the room only.
- Please silence cell phones in office
- **No** food or drink (except infant formula) allowed in waiting area or exam rooms
- For all well child check-ups or vaccine only visits, only the parent/legal guardian may accompany patient to visit.

POLITÍCAS DE LA OFICINA

Con el fin de proporciónale a su hijo la mejor atención de un amanera eficiente, le pedimos que siga algunas regalas sencillos.

- Todas las visitas medicas son solo con cita previa. Hay citas diarias disponibles, pero es necesario llamar primero y preguntar.
- Por favor, llegue a tiempo **15 minutos** antes de su cita con su **identificación fotográfica, tarjeta de seguro, y registro de vacuna**. Si llegas tarde, su cita será reprogramada.
- Todas las citas deben ser canceladas por adelantado.
- Las referencias no serán enviadas por fax a lo oficina de un especialista. Si necesita un referido por favor llame 48 horas antes de la cita.
- Habrá una tarifa de $5 para cualquier referidos perdida.
- Las salas de examen son pequeñas. Por lo tanto, un padre/tutor y un paciente solo en la habitación.
- Por favor, silencio teléfonos celulares en la oficina
- **No** hay comida ni bebidas permitido en la zona de espera y salas de examen.
- Para todos los exámenes físicos anuales y cita para vacunas, solo los padres pueden traer la paciente.

THANK YOU/GRACIAS

Marcella A Frausto MD PA 12430 Montwood Dr. El Paso TX 79928 (915) 849-9733

RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

This release of information may be used to permit a covered entity (as defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read in entirety before signing and complete the sections below relating to their decision to use or release their protected health information.

Patient for Whom Authorization is Made

Patient name: _____ Date of Birth: _____

Address: _____

Cell Number: _____ Email address: _____

Health Care Provider or Health Care Entity Authorized to Disclose Health Information

Name of Medical or Health Care Facility: _____

Address: _____

Office Number: _____ Fax Number: _____

Requested items: Medical Records, including all notes, histories, lab results, radiology studies

Other: _____

Please send requested information to:

Marcella A Frausto MD PA 12430 Montwood Dr. El Paso TX 79928

SIGNATURE AUTHORIZATION: I have read this form and agree to uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by las without my specific authorization or permission. I understand that information disclosure pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient/Legal Representative: _____ Date: _____

Telemedicine Informed Consent

Texas Medical Association
Physicians Caring for Texans

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

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 will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my 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 health care 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 a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Marcella A Frausto MD PA at 915-849-9733.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my 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 my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

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 my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.

THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association