NEW PATIENT DEMOGRAPHICS FORMS

Please fill in all spaces below & return to front office staff when it is completed.

Patient's Name: _____ Date of Birth: _____ M____F____
First Middle Last

Home Address: _____City: _____ State: ____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Nearest family friend's name & address: _____ Phone #: _____

Nearest relative's name & address: _____ Phone #: _____

Emergency contact's name: _____ Phone #: _____

Parent's Information:

Father's Full Name: _____ DOB: _____ SSN (must provide): _____

Father's employer name & address: _____

Father's insurance plan name & ID #: _____

Is this the primary or secondary policy for the patient: _____

Father's email: _____ Father's cell #: _____

Mother's Full Name: _____ DOB: _____ SSN (must provide): _____

Mother's employer name & address: _____

Mother's insurance name & ID #: _____

Is this the primary or secondary policy for the patient: _____

Mother's email: _____ Mother's cell #: _____

Are you: Legally Married_____ Single____ Divorced____ Widowed____

Did you have a prenatal consultation with one of our provider(s)? _____

Are any of your other children seen in our office? Please list them below:

Sibling's Name: _____DOB: _____M_____F_____

Sibling's Name: _____DOB: _____M_____F_____

Sibling's Name: _____DOB: _____M_____F_____

Race: _____ Language(s) Spoken: _____

What school does the child attend: _____

What pharmacy do you use? (Please provide the name & phone number or cross streets): _____

PLEASE INITIAL NEXT TO EACH STATEMENT BELOW:

_____ I authorize ABC Pediatrics to provide any emergency care for my child(ren) including hospitalization, medication in office if necessary OR in my absence.

_____ I authorize_____ to bring my child(ren) to ABC Pediatrics for medical care.

_____ I understand that if failure of my insurance company to pay any portion of changes to ABC Pediatrics for my child(ren) will result in these charges becoming my responsibility. (If any balances are sent to collections, I am responsible for the collection fee).

_____ I authorize the release of medical records to any specialist that my child(ren) appointments prior to an office visit.

_____ I authorize ABC Pediatrics to confirm my child appointment prior to office visit.

_____ I authorize the release of any medical information necessary to process my child(ren) claims.

_____ I authorize payment of government benefits to ABC Pediatrics.

_____ I authorize payment of medical benefits to undersigned physician and/ or facility for services me child will receive.

*THIS IS A LEGAL DOCUMENT, YOUR SIGNATURE STATES THAT YOU AGREE WITH THE ABOVE ITEMS AND THE INFORMATION YOU PROVIDED IS TRUE, CORRECT AND UNDERSTOOD. ANY QUESTIONS OR CONCERNS YOU HAVE ME BE ADRESSED TO ABC PEDIATRICS OFFICE STAFF DURING YOUR VISIT. **THIS FORM WILL BE VALID UNTIL WRITTEN REVOCATION IS PROVIDED**

PRINTED NAME OF PARENT: _____**DATE:** _____

SIGNATURE OF PARENT: _____**DATE:** _____

Please fill in all spaces below & return to front office staff when it is completed.

Patient's Name: _____ DOB: _____ Today's Date: _____

Mother's Labor History (please **circle** from the choices below):

- Was the child delivered as: Vaginal or C-section
- Was the pregnancy: Full Term or Premature / How many weeks was the duration? _____
- Breast or Bottle
- Condition at birth? _____
- Birth Weight? _____
- O.B. Doctor? _____
- Birth Hospital? _____
- Previous Pediatrician? _____
- Smoking History: _____

Developmental History (When did your baby...):

- Hold his/her head up? _____
- Roll Over? _____
- Sit Up? _____
- Stand? _____
- Walk? _____
- Talk? _____

Pregnancy History:

- Any disease and / or injury during pregnancy? _____

Medical History (for child):

- Any chronic illness? Yes or No. If yes what was the duration: _____
- Any hospitalizations? Yes or No. If yes please provide the date and facility: _____
- Any operations? Yes or No. If yes, please provide the date and reason: _____
- Any poisoning or accidents? Yes or No. If yes please list date and reason: _____
- Is the child currently taking any medications? Yes or No. If yes, please list them by name, dosage and frequency taken:
  _____
  _____

Allergy History (does your child have any allergies to...):

- Medications? Yes or No. If yes please list type: _____
- Food? Yes or No. If yes please list type: _____

Social History:

- How long have you lived her in Las Vegas/Henderson? _____
- How did you hear about our office? _____
- Do you have any family members who are currently established with ABC Pediatrics? _____
- Do you live in a house or apartment? How many bedrooms? _____
- Do you have any pets? If yes please list what type and how many? _____
- Are both parents currently together? _____
- How many siblings does child have? _____
- Is there a smoker in the home? _____

Family History: (Diseases/Conditions):

Medical Conditions on Mother's Side: _____

Medical Conditions on Father's Side: _____

Please fill in all spaces below & return to front office staff when it is completed.

Authorization to Release Medical Records:

I hereby authorize to use or disclose the specific information below, only for the purpose and parties also described below.

Description of the specific information to be used or disclosed: ****ALL RECORDS****

****(If this is a newborn visit, please put the hospital information of where baby was born.) ****

Office or Facility Name: _____

(Hospital/Previous pediatrician and or specialist)

Address: _____

City: _____State: _____

Phone Number: _____ Fax Number: _____

Name and information of the entity requesting and receiving the information:

ABC Pediatrics – 10950 S. Eastern Ave, Suite 100, Henderson, NV 89052 – Ph: 702-614-2192, F:702-614-2190

This information is being requested for the purposes of continuation of care of the patient listed below.

This authorization shall remain in effect the date signed until: one year OR _____

I understand that:

- I may inspect or copy the health information to be used or disclosed (patients may have a printed copy for the cost of $0.60 per page)
- I may revoke this authorization in writing by contacting the privacy office at the address listed on this page.
- Information, authorized to be used, or disclosed may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment upon me signing the authorization. (Except, when the authorization is for the research-related treatment, in which case you may refuse to provide research related treatment)

Patient's full name: _____ DOB: _____

Printed name of parent or person authorizing disclosure: _____

Signature of parent or person authorizing disclosure: _____

Today's Date: _____

Please fill in all spaces below & return to front office staff when it is completed.

ATTENTION:

It is your responsibility to inform the doctor if your insurance does not cover well-visits or vaccines. If not covered, please request "state vaccines" from the doctor/staff; this will help ensure that you are not billed incorrectly.

Patient's name: _____

Parent / Legal guardian 's printed name: _____

Parent / Legal guardian printed signature: _____ Date: _____

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I _____ THE PARENT OF _____ AUTHORIZE

_____ TO BRING MY CHILD(REN) TO ABC PEDIATRICS FOR MEDICAL CARE IN MY ABSENCE. I AUTHORIZE THE ABOVE-NAMED PERSON TO MAKE MEDICAL DECISIONS AT THE TIME OF TREATMENT.

**THIS IS A LEGAL DOCUMENT, YOUR SIGNATURE STATES THAT YOU AGREE WITH THE ABOVE TERMS AND THE INFORMATION YOU PROVIDE IS TRUE, CORRECT AND UNDERSTOOD. ANY QUESTIONS OR CONCERNS YOU HAVE MAY BE ADDRESSED TO ABC PEDIATRICS OFFICE STAFF DURING YOUR VISIT. **

****THIS FORM WILL BE VALID UNTIL WRITTEN REVOCATION IS PROVIDED****

Parent / Legal guardian printed name: _____

Parent / Legal guardian printed signature: _____

Today's Date: _____

PATIENT & PARENT OBLIGATION CONTRACT

**Please initial next to each item and sign and date at the bottom of this form. **

____Upon checkout, our office staff will offer a next appointment. It is parent/guardian/patient's responsibility to schedule the next appointment. If an appointment is not scheduled at the time of check-out, it is your responsibility to call for any future appointments.

____For first-time patients: it is your responsibility to provide any immunization records or records from previous physicians. If you do not have these things available, we can assist you with this by submitting a signed medical record request to your previous doctor's office.

____ Please note, under the HIPAA (Health Insurance Portability & Accountability Act of 1996) your protected health information may be released to other health care providers and medical facilities to allow continuation of care for your treatment and other healthcare operations.

____ If you are unable to make it to your appointment, you must notify our office within 24 hours of your scheduled appointment time. Otherwise, you may be held responsible for your copay or a $10 no-show fee, whichever is greater.

____ If you are more than 15 minutes late to your appointment, you will be asked to reschedule.

____ It is your responsibility to have ABC Pediatrics assigned as your PCP (primary care physician) with your insurance if necessary, and also update the coordination of benefits with your insurance as needed. As a courtesy to you we are submitting a claim to your insurance company on your behalf. In the case of non-payment by your insurance, it is your responsibility to pay our office for any service you received.

____ It is your responsibility to know what benefits are covered under your insurance policy. Your insurance policy is a contract between you, your employer and/or your insurance company. We are not a party to this contract. Our relationship is with you as a patient, and you are responsible for any services provided, regardless of your insurance coverage.

____ It is your responsibility to add your newborn baby to your insurance policy within the specified time limit allowed by your insurance policy.

____ All copays/deductibles are due at the time of service. Please have your insurance card available for us to make a photocopy. You are responsible for any deductibles, coinsurance, and/or any other fees that your insurance applies as your responsibility.

____ You will be held responsible for all fees if your account goes into collections.

____ We have the right to discontinue anyone who insults our doctor and/or staff, anyone who uses inappropriate language, or if you miss three consecutive appointments without notifying the office.

If you have any questions or complaints please ask to speak with management.

Patient's Name and DOB: _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Today's Date: _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of privacy practices describes now we may use and disclose your **protected health information (PHI)** to carry out **treatment or health care operations (TPO)** and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographics information, that may identify you and that relates to your past, present, or future physical or mental health or condition and relation health care services.

Uses and Disclosures of Protected Health Information (PHI): Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician practice and any use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care or any related services. This includes the coordination or management of your health care with a third party. For example, you would disclose your PHI as necessary to a home agency that provides care to you for example, your protected information may be provided to a physician to whom you have been referred to ensure the physician has the necessary information to diagnosis or treat

Payment: Your PHI will be used, as needed to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Healthcare Operations: We may use or disclose as needed, your PHI in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review, and training for medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your processed health information to medical students that see patients at our office, in addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary to contact you to remind you of your appointment

We may use or disclose your PHI in the following situations without your authorization. *These situations includes as required as required by law*: Public Health issues as required by law; Communicable Disease Health Over sign Abuse or Neglect Food and Drug Administration requirements Legal Proceedings Las Enforcement Coroners, Funeral Directors, and Organ Donation "Research" Criminal Activity" Military and National Security Workers' required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500

Other Permitted and Required uses and Disclosures will be made only with your content, Authorization or Opportunity to object unless requested by law.

You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians practice has taken an action, in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information complied in reasonable anticipation of or use in civil, criminal or administrative action or proceeding and protected health information that is subject to law that promote access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us: upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of you protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will NOT retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with this notice of or legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Today's Date: _____