DESERT PEDIATRICS

2150 S. Eastern Avenue
Las Vegas, Nevada 89104
Phone (702) 641-2150
Fax (702) 641-8667

7180 Cascade Valley Ct. #180
Las Vegas, Nevada 89128
Phone (702) 641-2150
Fax (702) 228-1043

PLEASE PRINT & FILL OUT COMPLETELY
PATIENT/PARENT INFORMATION

EMAIL ADDRESS: _____

Child's Name
Last: _____ **First**: _____ **MI:** _____
Has the child been known by any other name: _____
Sex: _____Birthdate: _____ Preferred Language: _____
Race: _____Ethnicity: ( ) Hispanic ( ) Non-Hispanic ( ) Other _____
Home Phone Number: ( ) _____Alternate Phone Number: ( ) _____
Street Address: _____Apt #: _____
City:_____ State: _____ Zip: _____

Mother's Name
Last: _____ **First:** _____ **MI:** _____
Home phone number: ( ) _____ Alternate phone number ( ) _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ **Birthdate:** _____
Employer: _____ Employer Phone: ( ) _____
Occupation: _____

Father's Name
Last: _____ **First:** _____ **MI:** _____
Home phone number: ( ) _____ Alternate phone number ( ) _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ **Birthdate:** _____
Employer: _____ Employer Phone: ( ) _____
Occupation: _____

Name and Phone # of Nearest Friend or Relative not Living with You to Contact in Case of an Emergency:
Name: _____ Phone #: ( ) _____
Relationship: _____

How Were You Referred to Desert Pediatrics?
Friend: _____ Family: _____ Other: _____ Yellow Pages: _____

INSURANCE AUTHORIZATION FOR BENEFIT ASSIGNMENT AND INFORMATION RELEASE

I AUTHORIZE DESERT PEDIATRICS, ALL MEDICAL PROVIDERS LISTED ABOVE TO PROVIDE MEDICAL CARE FOR MY CHILD AS NECESSARY. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE PLAN. I ALSO AUTHORIZE DESERT PEDIATRICS TO RELEASE MY INSURANCE COMPANY INFORMATION CONCERNING ADMINISTERING CLAIMS FOR BENEFITS, INFORMATION REQUESTED FOR ANY OTHER PURPOSE WILL REQUIRE MY SIGNATURE FOR RELEASE.

SIGNED: _____ **DATE:** _____
PARENT/GUARDIAN/RESPONSIBLE PARTY

DESERT PEDIATRICS

2150 S. Eastern Avenue	7180 Cascade Valley Ct. #180
Las Vegas, Nevada 89104	Las Vegas, Nevada 89128
Phone (702) 641-2150	Phone (702) 641-2150
Fax (702) 641-8667	Fax (702) 228-1043

TREATMENT AUTHORIZATION

THE FOLLOWING PEOPLE, OTHER THAN THE PARENTS, ARE AUTHORIZED TO BRING:

_____ TO DESERT PEDIATRICS FOR
(Child's/Children's Names)

TREATMENT.

	HAS AUTHORIZATION TO ACCESS MEDICAL RECORDS	
_____ (Name)	☐YES ☐NO	_____ (Relationship to Child)
_____ (Name)	☐YES ☐NO	_____ (Relationship to Child)
_____ (Name)	☐YES ☐NO	_____ (Relationship to Child)

PLEASE BE ADVISED THAT ALL INDIVIDUALS LISTED ON THE TREATMENT AUTHORIZATION WILL BE REQUIRED TO PROVIDE IDENTIFICATION AT EVERY OFFICE VISIT.

THIS TREATMENT AUTHORIZATION WILL SUPERCEDE ALL PREVIOUS AUTHORIZATIONS. ONLY PERSONS LISTED ON THIS MOST RECENT DOCUMENT WILL BE ABLE TO SEEK TREATMENT FOR CHILD/CHILDREN.

Date: _____ Parent/Guardian: _____

Witness: _____

DESERT PEDIATRICS

2150 S. Eastern Avenue	7180 Cascade Valley Ct. #180
Las Vegas, Nevada 89104	Las Vegas, Nevada 89128
Phone (702) 641-2150	Phone (702) 641-2150
Fax (702) 641-8667	Fax (702) 228-1043

WAIVER FOR NON-COVERED SERVICES

There may be times during the treatment of your child, that the provider may render or prescribe a medication not covered by your insurance.

On those occasions when a non-covered service is provided, you will be responsible for those charges attached to that service. Payment in advance may be requested.

It is your responsibility to know your insurance benefits. We will assist you in this as much as possible.

I have read the above information and agree to be responsible for any services or medications not covered by my insurance.

Signed: _____
(Parent or Guardian)

Patient's Name: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print Your Name Here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not by obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (please provide specific details)

Employee Signature

Date

DESERT PEDIATRICS

COMMUNICATION PERMISSIONS

APPOINTMENT CONFIRMATIONS:

- We make every attempt to remind you of your upcoming appointment and receive confirmation of your intent to keep the appointment, reschedule the appointment or cancel.
- We will call the primary phone number listed on the patient's demographic form.
- We will leave appointment information with the person answering the telephone or on the answering machine.
- The only information given will be the child's name, provider's name, appointment time and location.

LABORATORY/RADIOLOGY/TEST RESULTS:

- We will contact you regarding test results by calling the primary phone number listed on the demographic form unless you have specifically given us an alternative number.
- We will only give results to the parent or guardian.
- If we are prompted to leave a voicemail message, we will only state the office we are calling from and request that the parent/guardian return our call regarding test results. No specific test information will be left on a message machine.
- If you have not received a call from our office within 7 business days, please contact the nurse line at your location. The nature of some labs require more time to be completed and resulted back to your provider. Tests ordered to be done same day "STAT" should be resulted within 24 hours.

REFERRAL INFORMATION:

- We will contact you with referral information by calling the phone number provided at the time the referral was generated. Make sure that you inform your provider of the best contact number.
- Most referrals are done within 7 business days.
- We will only give referral information to the parent/guardian.
- If we are prompted to leave a message, we will only request that the parent/guardian call the referral department.

I, _____, have read the above
Printed Name of Parent/Guardian

Communication Permissions and agree to all.

Signed: _____Date:_____

DESERT PEDIATRICS

2150 S. Eastern Avenue	7180 Cascade Valley Ct. #180
Las Vegas, Nevada 89104	Las Vegas, Nevada 89128
Phone (702) 641-2150	Phone (702) 641-2150
Fax (702) 641-8667	Fax (702) 228-1043

MEDICAID INSURANCE PAYMENT POLICY

Our medical services are provided on a cash basis until proper documentation has been presented to substantiate insurance eligibility.

A current MEDICAID card must be presented at each visit!

If you have not received your current card or have lost or left your card at home, you can:

1. Pay for the visit. We are unable to bill you. You will be reimbursed when proof of eligibility is given, or

2. Go to your caseworker and request a printout of your eligibility with PCP named, or

3. Seek treatment at UMC or the Health Department.

RETURNED CHECKS: A $30.00 fee will be charged for the checks initially returned unpaid by your bank. An additional $25.00 will be charged if the same check is returned unpaid a second time.

NO SHOW POLICY: PLEASE NOTIFY US AT LEAST TWO HOURS PRIOR TO YOUR APPOINTMENT TIME IF YOU ARE UNABLE TO KEEP THE APPOINTMENT. REPEATED FAILURE TO DO SO MAY RESULT DISCHARGE FROM THE PRACTICE.

I have read DESERT PEDIATRICS' MEDICAID INSURANCE PAYMENT POLICY, and understand my responsibilities.

PATIENT'S NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

DESERT PEDIATRICS

FINANCIAL POLICY

We are committed to providing your child with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans.

It is your responsibility to:

- **Bring your insurance card and photo I.D. to the first visit.**
- **Pay your Co-Payment and / or any deductibles at each visit.** Payment can be made by cash, check, or credit card. We accept VISA and MasterCard. We do not bill for Co-Payments.
- **Pay in full for any medical care or services that are not covered by your insurance plan.**

2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service. Your child will be a "Private Pay" patient in our office. We offer a discount to "private Pay" patients, if the charges are paid at the time of service. See Private Pay Policy.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP (primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name we will assist you in attempting to change the PCP prior to your appointment. If we are unable to verify that the PCP has been changed, you will be required to pay our "Flat Rate" fee at the time of service.
4. **You are financially responsible for any amount not covered by your child's plan.**
5. **You are financially responsible for all charges incurred in your child's care and treatment.**
6. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.
7. If you fail to make payment in full for services that are rendered to you in a timely manner, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Accounts sent to collections will lead to dismissal from the practice.
8. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Patient/Parent Information Form. We will scan your insurance card, ID, and Patient/Parent Information Form into your child's electronic medical chart. We will check these documents prior to releasing your child's records.
9. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.
10. RETURNED CHECKS: A $30.00 fee will be charged for the checks initially returned unpaid by your bank. An additional $25.00 will be charged if the same check is returned unpaid a second time.

PATIENT'S NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

STATEMENT REGARDING RETENTION AND DESTRUCTION OF MEDICAL RECORDS

I, _____, parent/guardian of

_____, acknowledge receipt of this statement regarding the retention and destruction of my child's medical records.

Pursuant to NRS 629.051, your child's medical records may be destroyed at age 23 provided your child has not been seen in the previous 5 years but in no event will they be maintained after the age of 24.

Signed:_____

Date:_____

DESERT PEDIATRICS

2150 S. EASTERN AVENUE
LAS VEGAS, NV 89104

7180 CASCADE VALLEY COURT, #180
LAS VEGAS, NV 89128

NO SHOW AND LATE ARRIVAL POLICY

Every day, these offices have 10 – 20 patients that schedule appointments and then fail to show and do not cancel. This drastically effects our ability to be able to see your child when you need a same day appointment because your child is sick.

We will be strictly enforcing our "Late Arrival" and "No Show" policies. This is in an effort to decrease wait times and have more availability in our schedule.

"Late Arrival"

If you are late for your appointment, we will try to accommodate you. *We will not inconvenience the next patient because of your late arrival no matter the reason.* If you are sufficiently late that you cannot be seen in the time remaining of your appointment, you will be rescheduled and your account will be noted. Patients who habitually arrive late, will be discharged along with all family members. Your insurance will be notified of the reason for discharge.

"No Show"

If you do not show for three appointments that were scheduled in the course of a year, you will be discharged along with all family members.

If one of your children is a new patient, and schedules a new patient appointment and then does not show or call to cancel, you will be allowed to schedule a new patient appointment one more time. If you do not show for that appointment, you will be discharged along with all family members

I have read the above No Show and Late Arrival Policy:

Child/Children's Name(s)/DOB: _____

_____

Printed Name Parent/Guardian:_____

Signature Parent/Guardian:_____

Date:_____

Updated 10/31/2018

DESERT PEDIATRICS

2150 S. Eastern Avenue
Las Vegas, Nevada 89104
Phone (702) 641-2150
Fax (702) 641-8667

7180 Cascade Valley Ct. #180
Las Vegas, Nevada 89128
Phone (702) 641-2150
Fax (702) 228-1043

PATIENT MEDICAL QUESTIONAIRE

Child's Name: _____ Age: _____
Mother's Name: _____ Age: _____
Occupation: _____
Father's Name: _____ Age: _____
Occupation: _____

A. PREGNANCY AND BIRTH

1. Mother's age at birth: _____
2. Any illnesses during this pregnancy? Y N
3. Any medication other than vitamins? Y N
4. Was the baby born on time? Y N
5. What was the birth weight? _____
6. Did the baby have any trouble while in the hospital? (infection, jaundice, breathing) Y N
7. What kind of trouble? _____
   _____

B. PAST MEDICAL HISTORY

1. Previous Pediatrician? _____
2. Date of last check up? _____
3. Date of last dental exam? _____
4. Has your child had an allergic reaction? Y N
   To what? _____
5. Has your child had a reaction to any immunizations? Y N
   Which ones? _____
6. Any hospitalizations other than birth? Y N
   For what reason? _____
7. Any serious injuries? Y N
   What kind? _____
8. Any medications taken regularly? Y N
   What kind? _____

C. FAMILY HISTORY

1. Are the child's parents in good health? Y N
2. Circle any diseases found in the immediate family: Anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, venereal disease, cancer, AIDS
3. List age, sex, and general health of this child's siblings:
   _____
   _____
4. Have any of your children died? Y N

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Y N
2. Was there severe colic or any unusual feeding problems during the first three months? Y N
3. Do any foods disagree with your child? Y N
4. During the first six months, was your child breast or bottle fed? _____
5. Is your child still on formula? Which one? _____
6. Does your child take vitamins? Y N

E. REVIEW OF SYMPTOMS

1. Has your child had frequent ear infections? Y N
2. Any eye problems? Y N
3. Any problems with teeth? Y N
4. Frequent colds or sore throats? Y N
5. Asthma, pneumonia, or recurrent cough? Y N
6. Heart murmur or any heart problems? Y N
7. Any problems with urinations? Y N
8. Any problems with diarrhea or constipation? Y N
9. Has there been any convulsions or other problems with the central nervous system? Y N
10. Please list any other medical problems: _____
    _____
    _____

F. DEVELOPMENT/BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child speak by 1 ½ yrs of age? Y N
4. Does your child have trouble sleeping? Y N
5. What grade is your child in? _____
6. Any trouble in school? _____
7. Any trouble getting along with peers? Y N
8. Circle if your child has any of the following: Nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, nightmares, hyperactivity, speech problems, discipline problems

G. SAFETY/ENVIRONMENT

1. Do you live in a home, apartment, mobile home?
2. Is there a smoke alarm on each floor? Y N
3. Is your child always restrained in the car? Y N
4. Are there any smokers in the home? Y N
5. Does your child wear a bike helmet? Y N

H. IMMUNZATIONS

1. Do you have a record of your child's immunizations? Y N

SIGNATURE: _____

DATE: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient's Name: Patient's Date of Birth:

A. Person(s) or Organization(s) authorized to provide the information:

Phone:
Fax:

B. Person(s) or Organization(s) authorized to receive the information:

( ) Desert Pediatrics
7180 Cascade Valley Ct. #180
Las Vegas, NV 89128
Phone (702) 641-2150
Fax (702) 228-1043

( ) Desert Pediatrics
2150 S. Eastern Avenue
Las Vegas, NV 89104
Phone (702) 641-2150
Fax (702) 641-8667

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

---

1) I understand that this authorization will expire on _____ (insert date).
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Desert Pediatrics in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would not longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release (e.g. "results of a lab test performed on 01/04/03" or, if your entire medical record is included, "all health information.")
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g. the names of your health care provider(s)).
You have the right to know who is going to use it and what it is going to be used for. (e.g. John Smith,

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM