

# 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

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## 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

YES  NO

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship to Child)

YES  NO

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship to Child)

YES  NO

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(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: \_\_\_\_\_

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## **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.

\_\_\_\_\_  
Patient Name (Type or Print)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Signature of Patient or Parent/Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of parent/legal guardian if signing for patient

**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 be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- Communications barriers prohibited obtaining acknowledgement
- Other (please provide specific details)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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 result back to your provider. Tests ordered to be done same day “STAT” should be result within 24 hours.

REFERRAL INFORMATION:

- We will contact you with referral information by email using the email address provided at the time the referral was generated.
- Most referrals are done within 7 business days.
- If you do not have an email address, we will only give referral information to the parent/guardian using the most recent phone number.
- 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  
CASH PAY CONTRACT**

PATIENT NAME: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

Initial all to acknowledge understanding:

\_\_\_\_\_ I do not have insurance coverage of **any kind** for my child, not private or Medicaid.

\_\_\_\_\_ I will be given a 40% discount off the usual charges and agree to pay for the entire visit at the time of service. Office staff will do their best to calculate your charges at the time of check-in, however, if a charge is missed, you will be billed with the appropriate discount.

\_\_\_\_\_ Because my child has no insurance coverage, I am eligible for immunizations provided By the Vaccine for Children Program. The vaccine is free. I am responsible for the Administration fee.

\_\_\_\_\_ If it is later determined that there was medical coverage in place for this child at the time of service, the insurance will be billed and I will be responsible for any patient responsibility determined by the insurance carrier. If there is a refund due, Medicaid patient's will be refunded when eligibility has been proven. Private insurance patients will be refunded when the insurance has paid the claim.

**Returned checks: a \$30.00 fee will be charged for the checks initially returned unpaid by your bank.**

**No Show Policy: Please notify us at least 2 hours prior to your appointment time if you are unable to keep the appointment. Failure to do so may result in discharge from the Practice.**

**I have read, understand and initialed Desert Pediatrics' Cash Pay Contract.**

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 late fees and additional fees imposed by collections. 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.

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: \_\_\_\_\_

UPDATED 9/2021

DESERT PEDIATRICS

2150 S. EASTERN AVENUE  
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**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 schedule a same day appointment and do not show for that appointment, you may be discharged along with all family members.

If you do not show for three appointments that were scheduled in the course of a year, you may 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: \_\_\_\_\_



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: \_\_\_\_\_

It is the policy of this office not to accept or retain patients that refuse to vaccinate their children in accordance with the American Academy of Pediatrics and the United States Center for Disease Control.

We will not participate in alternate vaccine schedules.

If your child is not current with vaccines and you wish to remain a patient at Desert Pediatrics, you will be required to follow the catch up schedule recommended by the American Academy of Pediatrics. Your child will be scheduled to return for any missing vaccines at appropriate intervals. If you fail to show for this appointment, your child and any other children in your family, will be discharged from the practice.

If your child is being treated for an acute condition and the provider postpones administering the recommended vaccines, an appointment will be scheduled within the following 4 week period. If you fail to show for this appointment, your child and any other children in your family, will be discharged from the practice.

If your child has a chronic condition and the administration of vaccines is contraindicated, the chart will be reviewed by Dr. Richard Weiner.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_  
Printed Name if Parent/Guardian have read the above Immunization Policy and agree to all.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT MEDICAL QUESTIONNAIRE AGE NEWBORN – 4 YRS OF AGE**

**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Mother's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Father's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**A. PREGNANCY AND BIRTH**

1. Mother's age at birth: \_\_\_\_\_
2. Any illnesses during this pregnancy?      Y      N
3. During pregnancy history of smoking, alcohol, or drug use?:  
\_\_\_\_\_      Y      N
4. Any medication other than vitamins?      Y      N
5. Was the baby born on time?      Y      N
6. What was the birth weight? \_\_\_\_\_
7. Did the baby have any trouble while in the hospital?  
(infection, jaundice, breathing)      Y      N
8. 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      Y      N  
immunizations?  
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. Type of diet: (Circle) Formula, Baby Food, Table Food?
3. Was there severe colic or any unusual feeding problems  
during the first three months?      Y      N

4. Do any foods disagree with your child?      Y      N  
Explain: \_\_\_\_\_  
\_\_\_\_\_
5. During the first 6 months was your child breast or bottle fed?  
\_\_\_\_\_
6. Is your child still on formula? Which one? \_\_\_\_\_
7. 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
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
9. Any concerns regarding vision or hearing?      Y      N

**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
6. Are there pets in the home?      Y      N
7. Is there a swimming pool?      Y      N
8. Is the swimming pool secure?      Y      N

Signature: \_\_\_\_\_

Date: \_\_\_\_\_