Desert Sun
PEDIATRICS p.c.

Patient Registration

Patient: The person seeking medical care.
Last Name: _____ **First Name:**_____ **MI:**_____
Date of Birth: _____ **Sex:** M F (please circle)
Home Phone: _____ **Social Security Number (if known):** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian Information:
Mother's Last Name: _____ **First Name:** _____ **MI:** _____
Social Security: _____ **DOB:** _____ **Address:** Same as patient Y or N If no, please fill below:
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell:** _____
Employed: FT or PT Occupation: _____ **Employer:** _____
Employer Address: _____ **City:** _____ **Zip:** _____

Father's Last Name: _____ **First Name:** _____ **MI:** _____
Social Security: _____ **DOB:** _____ **Address:** Same as patient Y or N If no, please fill below:
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell:** _____
Employed: FT or PT Occupation: _____ **Employer:** _____
Employer Address: _____ **City:** _____ **Zip:** _____

Legal Guardian: (If different than parent)

Last Name: _____ **First Name:**_____ **MI:**_____

Social Security: _____ **DOB:** _____ **Address:** Same as patient Y or N If no, please fill below

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Family Member E-mail (This will be used for the patient portal): _____

Primary Insurance: The insurance company that will be billed first.

Insurance Company Name: _____ **Phone Number:** _____
Claims Address: _____
Subscriber Last Name: _____ **First Name:** _____ **MI:** _____
ID #: _____ **Group Number:** _____ **Employer** _____

Secondary Insurance: The insurance company that will be billed second.

Insurance Company Name: _____ **Phone Number:** _____
Claims Address: _____
Subscriber Last Name: _____ **First Name:** _____ **MI:** _____
ID #: _____ **Group Number:** _____ **Employer** _____

Emergency Contact: _____ **Phone Number:** _____

CONSENT:
I, acting as a guardian to the above patient, give my consent for the above patient to receive medical evaluation and treatment by the providers at Desert Sun Pediatrics. I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Signature: _____ **Date**_____

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EPSDT Health History

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

Male □ Female □

Please list all people in household:

Name:		Date of Birth	Occupation	Education
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Other:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

Have there been any recent major changes or stresses in the child's life? □ Yes □ No

If yes, explain: _____

_____

Does the child go to a babysitter, preschool or daycare regularly? □ Yes □No

Birth History

Birthweight: _____ Length: _____ Place: _____

During the pregnancy, did the mother see a doctor regularly? □ Yes □No

During the pregnancy, did the mother: (If YES, explain)			Explanation
Have any medical problems?	□ Yes	□ No	_____
Smoke or drink?	□ Yes	□ No	_____
Use any medications?	□ Yes	□ No	_____
Use alcohol or drugs?	□ Yes	□ No	_____
Have problems with labor or delivery?	□ Yes	□ No	_____
How long did the baby stay in the hospital after birth?			_____

Past Medical History

Is the child's general health: □ Good □ Fair □ Poor

			Explanation
Does the child have any allergies?	□ Yes	□No	_____
Is the child taking any medications?	□ Yes	□ No	_____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____Date:_____

_____Date: _____

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Has the child had any issues with the following? (If yes, explain)

Eyes/vision	□ Yes	□ No	_____
Feet	□ Yes	□ No	_____
Digestion/Nutrition	□ Yes	□ No	_____
Ears/Hearing	□ Yes	□ No	_____
Urine/kidneys	□ Yes	□ No	_____
Joints	□ Yes	□ No	_____
Skin	□ Yes	□ No	_____
Lungs	□ Yes	□ No	_____
Teeth	□ Yes	□ No	_____
Heart	□ Yes	□ No	_____
Seizures	□ Yes	□ No	_____
Repeated Infections	□ Yes	□ No	_____

Family History

Have any of the child's brothers or sisters passed away? □ Yes □ No
If yes, give age and cause: _____

Have any of the child's blood relatives had the following diseases? (If yes, please list family member)

			Family Member
Heart Disease	□ Yes	□ No	_____
Tuberculosis	□ Yes	□ No	_____
High Blood Pressure	□ Yes	□ No	_____
Kidney Disease	□ Yes	□ No	_____
Allergies/Asthma	□ Yes	□ No	_____
Cancer	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Mental/Emotional Problems	□ Yes	□ No	_____
Sickle Cell	□ Yes	□ No	_____
Seizures	□ Yes	□ No	_____

Development

Do you have any concerns about the following? If yes, please explain.

Development	□ Yes	□ No	_____
Behavior	□ Yes	□ No	_____
Eating Habits	□ Yes	□ No	_____
Sleeping Habits	□ Yes	□ No	_____
School Experience	□ Yes	□ No	_____
Bathroom/Toilet Habits	□ Yes	□ No	_____
Discipline	□ Yes	□ No	_____
Other (Please explain)	□ Yes	□ No	_____

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Privacy Policy

The office of Desert Sun Pediatrics, P.C. is dedicated to protect your "nonpublic health information". This notice is to tell you how and why we collect that information, and who has access to that information.

How We Collect Your Information
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This insures you that the information we collect is correct. If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office we will ask you to bring our information sheet to insure that the information we received from the hospital is correct.

Why We Collect This Information
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

Maintaining Accurate And Timely Information
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical records, and those entities that need your information to process health care claims and obtain payment for services have access to your Protected Health Information.
Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

How We Protect Your Information
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claim processing have access to your Protected Health Information.

Your Rights
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your record.
If you leave this practice, your Protected Health Information will continue to receive the protection outlined in this notice.

Complaint/Comments:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services as 200 Independence Avenue, S.W. Room 509 F, HHH Building, Washington, D.C. 20201. You also may contact the Privacy Officer of this practice at (480) 563-1111.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

Patient's Name: _____ DOB: _____
Parent or Legal Guardian: _____ Date: _____

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Consent Form

THIS FORM ALLOWS PARENTS/LEGAL CUSTODIAN TO DESIGNATE WHICH OTHER ADULTS WILL MAKE MEDICAL DECISIONS FOR A CHILD IN THE ABSENCE OF PARENTS/LEGAL CUSTODIAN. PARENT'S/GUARDIAN'S DELEGATION OF AUTHORITY TO CONSENT TO MEDICAL TREATMENT OF MINOR CHILD.

I, the undersigned parent, legal guardian, or person having legal custody of _____, a minor child, do hereby authorize the individuals listed below to act as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and/or hospital care to be rendered to said minor child under the supervision of a physician and surgeon licensed or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a physician.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the said agents to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician and surgeon in the exercise of his or her best judgment may deem advisable.

INDIVIDUALS AUTHORIZED TO CONSENT TO MEDICAL TREATMENT OF MINOR CHILD (LIST INDIVIDUALS <u>OTHER THAN</u> PARENTS OR GUARDIANS OF MINOR)

1._____ Relationship _____
2._____ Relationship _____
3._____ Relationship _____
4._____ Relationship _____
5._____ Relationship _____
6._____ Relationship _____

This authorization shall remain in effect for 1 year from below date, unless sooner revoked in writing and delivered to Desert Sun Pediatrics, P.C.

Dated: _____

At, Phoenix, Arizona

_____
SIGNATURE of Legal Guardian/Person Having Legal Custody

_____
Print Name

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We do not double book appointments If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $25 for missed appointments.**
2) If you are late for your appointment, you may be asked to reschedule.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (Well-child) visit.
Initial: _____

Insurance Plans

Please understand
1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, **you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been notified that we are your primary care physician, **you may be financially responsible for your current visit.**
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
   a) Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment at the time of service. Please notify our office for financial arrangements if you are not able to pay at time of service before the appointment.
   b) For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment at the time of service. Please notify our office for financial arrangements if you are not able to pay at time of service before the appointment.
4) It is your responsibility to know if a written referral or authorizations is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.
5) It is your responsibility to notify us of primary and secondary insurance policies. If you have both a commercial private and State AHCCCS insurance, you are to use the AHCCCS policy as a secondary and commercial as primary, for further questions you may contact State AHCCCS insurance for information. If both policies are commercial insurances, it is your responsibility to contact both policies to update coordination of benefits (which one is to be billed first). This will make billing your insurance companies a much easier process and avoid unpaid visits by your plan.
Initial: _____

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve all referrals before they are issued.
Initial: _____

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Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments deductibles and co-insurances at time of service.
2) Co-payments are due at the time of service. A **$20** fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Self-pay patients are expected to pay for services in **FULL** at the time of the visit. Please notify our office for financial arrangements if you are not able to pay at time of service before the appointment.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6) If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged **a $20 re-bill fee** for each 28-day cycle. Any balance outstanding longer than **90 days** will be forwarded to a collection agency and patients will be dismissed from the practice.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa, MasterCard, American Express, Discover, and Debit cards.
10) A **$25** fee will be charged for any checks returned for insufficient funds.
Initial: _____

Forms

1) There is no charge for immunization records, additional school, camp or sports forms given at the time of your child's visit. This is considered part of the visit. However, should you lose your forms there will be a $15 charge to complete them.
2) Any additional school, camp or sports forms are subject to a **$15** per form fee that is requested after your child's well-check visit. Family and Medical Leave Act Forms are **$20**. Payment is due when the forms are dropped off. We require **3- day turn around time**.
Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunizations record and your last visit to your physician, free of charge, as a courtesy to you. We need 30 day notice.
2) A copy of your complete record is available for a $25 fee.
3) We provide records of your child for visits (including consultations from specialists) rendered here at Desert Sun Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).
Initial: _____

Prescription Refills

For monthly medication refills, we require **48 hour's notice**, during regular business hours. Please plan accordingly.
Initial: _____

Well-Child Services Policy

Good health care for newborns, infants, children, and adolescents begins with the well-child visit (checkup) and other services that help keep children healthy. These are *preventive* services. Our doctors and staff provide these services based on a plan called Bright Futures. The American Academy of Pediatrics (AAP) made this plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests (developmental, hearing, vision), and advice about staying health and safe. This plan can be altered to suit each child as needed. We also follow the AAP vaccine schedule for newborns, infants, children and adolescents.

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Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care reform law) includes a rule that all preventive care screenings and services included in the Bright Futures plan and vaccine schedule must be covered by most health plans. This is not always true though, as some older plans, galled grandfathered plans do not have to pay in full for preventive services.

There may also be times when a child needs a service that is not considered preventive on the same day as well-child visit. If a child is not well or a problem is found or needs to be addressed during the checkup, the physician may need to provide an additional office visit service (called a sick visit) to care for the child. This is a different service and is billed to your health plan *in addition* to the preventive services provided on that day. If you have a co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.

We value your time and want to make the most of each appointment for the child. This is why we will address any problem that needs a doctor's care during well-child visits so that only one trip is needed. Some services that may be provided and billed in addition to preventive services include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (eg, if the doctor gives a prescription, orders tests, or changes care for a known problem)
- Medical treatments (eg, breathing treatments)
- Any surgery (eg, removing splinters or something the child put in his or her nose or ear)
- Tests performed in the office that are not included in the Bright Futures Plan

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health plan on the day of your visit. It is our pleasure to help.
Initial: _____

I have read and understand this office policy and agree to comply. I also understand that I am financially responsible for all charges not covered by my insurance. In the event of default, I agree to pay any/all additionally fees' that require a collection agency. I also agree to pay court costs, Interest allowed by law and attorney fees incurred because of the default.

Patient Name _____

Responsible Party Member's Name _____**Relationship**_____

Responsible Party Member's Signature _____**Date**_____