DESERT VALLEY PEDIATRICS

Patient Registration

Patient Name: _____ DOB: _____ Sex: Male/Female

Primary Address: _____

_____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Emergency Contact Name and Phone Number: _____

Primary Language: _____

Race(s): **(Circle all that applies)**

African American/Black
Alaska Native
American Indian
Asian
Native Hawaiian/Pacific Islander
White/Caucasian

Ethnicity:

Hispanic or Latino
Not Hispanic or Latino
Unknown

Primary Care Physician: _____

Contacts:

Parent/Guardian Name: _____ **DOB:** _____

Social Security #: _____ - _____ - _____ Lives with patient: Yes / No

Address (if different from patient): _____

_____

Mobile Phone: _____ Work Phone: _____

Employer Name: _____

Parent/Guardian Name: _____ **DOB:** _____

Social Security #: _____ - _____ - _____ Lives with patient: Yes / No

Address (if different from patient): _____

_____

Mobile Phone: _____ Work Phone: _____

Employer Name: _____

Other Contact: Name / Relationship to Patient / Phone Number:

_____

Patient Name: _____ **DOB:** _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes _____ No _____

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

How would you ideally prefer to be contacted regarding (circle one):
Appointment Reminders: Home Phone / Work Phone / Cell Phone / Home Email
Billing Statements: Mail to Primary Address / Home Email / Other Address
Patient Portal Notifications: Text to Cell / Home Email

Insurance Information:

Primary Insurance Name: _____

Policy Holder's Name & DOB: _____
Relation to Patient: _____
ID #: _____ Group #: _____

Secondary Insurance Name: _____

Policy Holder's Name & DOB: _____
Relation to Patient: _____
ID #: _____ Group #: _____

If there is a Tertiary (3rd) insurance, please inform our front office staff

Preferred Pharmacy Name & Phone #: _____

Pharmacy Address: _____

Other children in family: Yes/No
First & Last Name: _____ **DOB:** _____ **Sex: Male or Female**

Race(s):	**(Circle all that applies)**	**Ethnicity:**
African American/Black	Asian	Hispanic or Latino
Alaska Native	Native Hawaiian/Pacific Islander	Not Hispanic or Latino
American Indian	White/Caucasian	Unknown

Other children in family: Yes/No
First & Last Name: _____ **DOB:** _____ **Sex: Male or Female**

Race(s):	**(Circle all that applies)**	**Ethnicity:**
African American/Black	Asian	Hispanic or Latino
Alaska Native	Native Hawaiian/Pacific Islander	Not Hispanic or Latino
American Indian	White/Caucasian	Unknown

I hereby authorize release of information necessary to file a claim with my insurance company.

_____

Parent/Guardian Signature Date

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Routine or Emergency Consent for Treatment

Patient / Child _____ Birth Date _____

Address: _____

_____

Allergies: _____

Last Tetanus (if applicable): _____

Please list current medications, pertinent medical information or problems:

_____

_____

_____

_____

In the event of accident or illness to my child / dependant _____
(Name of child)

I hereby authorize _____
(any person other than biological parents or legal guardian, i.e., friend, nanny, etc.)

to secure any medical aid and/or treatment from Desert Valley Pediatrics or the nearest hospital or clinic.

Furthermore I agree to be directly responsible for all costs and expenses connected with the examination, diagnosis and medical treatment for my child / dependant.

_____ _____

Print and Sign Parent / Guardian Name Date

This form is valid for one year from date of signature

DESERT VALLEY PEDIATRICS

FOR OFFICE USE
Patient Account #
Date

Thank you for choosing Desert Valley for your child's medical care. We are committed to providing your child the best care possible to maintain his or her health.

This is our financial policy which outlines the agreement between our practice and the child's parent/guardian or if the patient is 18 years and older, themselves. Please read through this document carefully to obtain a clear understanding of the financial relationship between you and your insurance as well as the financial relationship/responsibility between you and the practice. If there are any questions, please do not hesitate to ask a member of our team.

Please Initial	FINANCIAL STATEMENT
	1. **Insurance Information** - you are responsible to provide **VALID** insurance information at the time of service. If the information cannot be verified or the services are deemed not covered by your insurance, you will be considered a self-pay patient and a deposit for the services will be required.
	2. **Deposits** - payment is required for services that will be provided to your child. In some instances, we will be unable to provide a grand total due as we cannot determine the treatment(s) that will be provided to your child prior to seeing the physician. The deposit is NOT considered payment in full if the total charges are higher than the deposit made you will be responsible for the difference of the two amounts.
	3. **Outside Services** - if your child requires any services outside of the practice (i.e., lab work or cultures) these services are billed by the appropriate lab. These services are not considered part of the physician's services and you may receive a bill from the entity for any financial responsibility after your insurance processes the claim.
	4. **Co-pays / Co-Insurance and Deductibles** - any financial exposure for co-pays/co-insurance and deductibles are contractual obligations between you and your insurance. You must pay your co-pay at the time of the office visit. Co-insurance and deductibles that are determined after your insurance processes the claim will be paid with the credit card that has been provided to remain on file to handle these instances. If a credit card is not provided payment for these amounts are required upon receipt of the statement. Co-pays, co-insurance and deductibles cannot be waived by the practice as it is a violation of our contract with the payors and would jeopardize our participation with the insurance company.

10105 Banbury Cross Dr. #370 • Las Vegas, Nevada 89144
6850 N. Durango #406 • Las Vegas, Nevada 89149
9140 W Post Rd • Las Vegas, Nevada 89148
Telephone (702) 260-4525 • Fax (702) 869-0133

5. **No-Show Appointments** - if you are unable to keep an appointment, we require notification per the times indicated below or you will be assessed a missed appointment fee:

Appointment Type	Timeframe to Cancel to Avoid No-Show Fee	No-Show Fee
Well Visit / Check Up	24 Hours	$30.00
Sick / Same Day	2 Hours	$30.00
Behavioral Health (i.e., ADHD, Autism)	24 Hours	$50.00
Well Woman	24 Hours	$50.00

6. **Returned Check** - a $30.00 non-sufficient fund fee will be charged if your check is returned. If the same check is returned unpaid a second time, the account will be referred to an outside collection agency.

7. **Primary Care Provider Selection** - if your insurance requires you to choose a primary care provider, you must contact your insurance and select our office and/or one of our providers as soon as your medical records are transferred. In accordance with carrier guidelines, we cannot schedule any appointments or write any referrals until we receive notice that you have been added to our roster.

8. **Credit Card On-File** - we prefer credit card information be kept on file in a secure encrypted fashion to resolve any and all outstanding balances once your insurance has processed your claim. We will only charge your credit card without prior notice if a Promissory Note has been signed OR you provide authorization for the transaction to be completed once your insurance has processed the claim. If the claim is denied, we will contact you to resolve the situation prior to collecting any amounts indicated as per the Explanation of Benefits (EOB) from the insurance.

9. **Newborns and Newly Adopted Child(ren)** - your new child is covered for the first 30 days by the mother's insurance policy, regardless of which parent will provide ongoing coverage. You should contact your carrier as soon as possible to add the new child to your policy. Permanent coverage must be in place prior to the termination of the automatic newborn coverage. This MUST be completed prior to the child's one-month well-visit and a VALID insurance card must be presented at the time of the visit. If these steps are not completed prior to the visit your visit may be rescheduled/delayed and you may be personally responsible for the bill.

10. **Submission of Claims** - we will submit a claim for adjudication to the insurance provided. If there is an issue with the insurance company processing your claim you may be contacted to assist with the processing (i.e., incorrect/invalid subscriber ID, coordination of benefits, custodial indication, nonpayment of premium, etc.). If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. After 90 days the account will be considered delinquent and may be placed with an outside collection agency.

11. **Collection Agency** - we reserve the right to place your account with our collection agency after all internal efforts to obtain payment have been exhausted. Any and all accounts placed with the collection agency are subject to all fees incurred with the referral of your account. In addition, this may cause you to be discharged from the practice, resulting in your child having to seek treatment from another pediatrician.

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	12. Divorce and Court Orders - Desert Valley Pediatrics will not participate in disputes between custodial and noncustodial parents. The individual who signed the financial policy will be the individual who is responsible for any payment due to the practice.

The undersigned agrees with the terms and conditions listed above within this financial policy. Should I refuse to sign this financial policy, I am ultimately agreeing to pay in full at the time of service. I certify that the information provided is accurate.

Printed Name	*Signature*	*Date*

I hereby authorize Desert Valley Pediatrics to furnish my insurance company with any medical information requested directly associated with the processing of the claim.

Printed Name	*Signature*	*Date*

I hereby assign to Desert Valley Pediatrics all benefits for services rendered (payments from your insurance company will go directly to the treating physician).

Printed Name	*Signature*	*Date*

I hereby give consent to Desert Valley Pediatrics to treat the above-named child and agree that I will be directly responsible for all costs and expenses connected with the examination, diagnosis and medical treatment for my child/dependant.

Printed Name	*Signature*	*Date*

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Authorization to Disclosure Protected Health Information (PHI)

-Patient Request

Patient Name: _____

Patient DOB: _____ Social Security Number: _____

Address: _____ City_____ State _____ Zip _____

I authorize the use or disclosure of the above named individual's PHI to be released as follows:

☐ All Medical Records ☐ Lab/X-ray ☐ Immunizations ☐ Other _____

Reason for Request:

☐ Medical Care ☐ Personal ☐ Insurance ☐ Attorney ☐ Other _____

There will be a "Fee" of 60 cents per page when releasing records directly to a patient.

This request will not be processed without all of the following information completed.

Transfer Records From:

Name: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

Send Records To:

Name: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

Signature if Parent, Guardian or Personal Representative:

(If guardian or representative, attach supporting documentation and identification)

_____ _____

Signature Date

_____ _____

Print Name of Above Relationship to Patient

Within the limitations of the law, we will make every effort to accommodate your request and I understand that Desert Valley Pediatrics has 30 days to respond, however our goal is 3 to 5 days. Please contact the Medical Records Department if you have any questions at (702) 260-4525.

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Authorization for Disclosure of Protected Health Information (PHI)

-General

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION REGARDING MY CHILD/OR MYSELF AS DESCRIBED BELOW FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

Patient Name: _____ Date of Birth: _____

A. Person(s) authorized to bring the above named child to Desert Valley Pediatrics and Provide, Use or disclose the information, i.e.: Family Members, Nanny, Step-Parents.

1. _____
2. _____
3. _____

B. Person(s) or Organization(s) authorized to **Receive** the information, i.e.: Clark County School Districts, Daycare Centers or Others.

1. _____
2. _____

C. Specific description of the information, i.e.: Labs, X-rays and/or all Medical Records.

_____

D. This authorization will expire on _____ (leave open or enter a date)

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 Valley Pediatrics in writing.

I may inspect or copy any information used or disclosed under this agreement and I have the right to receive a copy of this form.

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 no longer be protected by these regulations.

I understand that this form does not constitute legal advice and covers only federal, not state laws.

_____ _____

(Signature of Patient or Patient's Representative / Relationship to Patient) Date

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).

Signature _____ Date _____