**Bright Futures Pediatrics**

**6850 N. Durango Drive Ste 202**

**Las Vegas, NV 89149**

**Phone (702)944-4028 Fax (702)826-4244**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_ Sex: M / F**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Primary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name & Major Cross streets/Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: Caucasian / Hispanic / African American / Asian / Pacific Islander / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Refuse

**Sibling(s)**

 Name: \_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_\_/\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_\_/\_\_\_

 Name: \_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_\_/\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_\_/\_\_\_

 **Mother’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN # \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN # \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN # \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: Self Mother Father Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN # \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: Self Mother Father Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HAVE READ AND UDERSTOOD THE FOLLOWING FINANCIAL STIPULATIONS:**

1. Payment is expected at the time of service.

2. Insurance Claims will be filed only for those insurance plans we are contracted with as a participating provider.

3. Co-pay’s, Deductibles, and non-covered services are to be paid at the time of service.

4. If you are unable to keep your appointment please give a 24 hour notice or there can be a $25 fee.

5. I understand that my signature is valid for the purpose of filing my insurance and authorize payment of benefits to Bright Futures Pediatrics and

 that the information provided above is true.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_**

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**Office Policies and Procedures**

**Effective September 1, 2010**

**Newborns:** All newborns need to be added to your insurance company within the first thirty days. However, you need to add the baby immediately in order for us to verify eligible coverage. If we are unable to verify eligible coverage then we must collect **cash** for the visit. We will be happy to refund the money once we receive payment for the services. If you are covered by Medicaid and the baby does not have a card then you are considered a **cash** pay patient until you have eligible number which shows active coverage for the baby. You will be refunded once we receive your payment for the services from the insurance. This must be given to our office promptly otherwise we will NOT refund the money.

\* **No Show/ same day cancellation appointments:**  If you are unable to make your scheduled appointment we ask that you call the office within 24 hours to avoid a same day cancellation fee of $25. If you no show to an appointment then we will charge a fee of $25.00, also this needs to be paid on or before your next scheduled visit in order for your child to receive medical services.

**Returned/ NSF checks:** If you write a check to our facility and that check is returned from your bank for any reason then we will charge a $25.00 fee for a returned check fee. You will be required to pay that fee along with the original amount of the returned check. Your check privileges will be revoked and you will have to pay either by **cash/debit/credit card.**

* We no do not accept personal checks for same day in office visits.

**Insurance Issues:** We are happy to file claims with your insurance company as a courtesy, however, if we have not received a response from them within 60 days you will be billed for the services. **Ultimately, it is your responsibility to know your coverage and follow up with your company to make sure payment is made.** We will be happy to assist with questions and help you to understand what is needed from your company. If there is no response to our requests from you to get payment then we will send your accounts to collections. We reserve the right to assess fees from the collection agency as well.

**Email Correspondence**: I authorize Bright Futures Pediatrics to email me on occasion’s reminders of follow up appointments and other necessary communications.

Parent Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We appreciate your cooperation in following these policies

I/we read the above and understand and agree to the terms.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Privacy and Confidentiality Guidelines**

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to not disclose to anyone any personal health or identifiable information about our patients without their authorization. We may be required to disclose health and personal information about you in your treatment, to bill for our services and to collect payment from you or your insurance company or to review the quality of services to you. We may disclose information about you for the benefit of governmental benefit programs or in response to a warrant or subpoena. We may be required to provide health information about you to outside business associates. These business associates are required to sign a contract with us stating that any information they come in contact with must be held in the strictest of confidence. We may be required to disclose personal information about you to contact you as a reminder of an appointment, to renew or prescribe medications, or for alternative treatment options. We also may need to release medical information about you to your parents and family members.

**Bright Futures Pediatrics** **and Staff** will make every effort to protect your health and personal information however many instances in medical practice require us to divulge this type of information.

**Bright Futures Pediatrics and Staff** have my permission to release information concerning my personal health or identifiable information for but no limited to the information listed above.

Print Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* We reserve the right to make changes to this notice at any time. In event there is a material change to the notice, the revised notice will be posted.

If you have any complaints concerning our privacy practices you may Contact our Office Manager, by mail at the above address or call (702)944-4028

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**PERMISSION TO TREAT**

Bright Futures Pediatrics has permission to diagnose and to treat my child.

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

When he/she is accompanied by the following person(s):

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**Parent/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

\*This document will be considered for **one year** from signed date unless otherwise specified.

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**MEDICAL RECORDS RELEASE FORM**

This form authorizes recipient to provide a copy, summary, or narrative of my child’s medical records or otherwise release confidential information.

* Complete record
* Records of care for the following dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Records concerning the following conditions :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other , please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_***

Please send my records to / from (circle one):

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**Las Vegas, NV 89149**

**Phone 702-944-4028 Fax 702-826-4244**

**\*\*NO DISCS. PAPER ONLY\*\***

Records to be released to / from (circle one):

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax# (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_

Complete Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the following:

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until **one year** from date of execution at which time this authorization

Expires.

***Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_***

***Print Name of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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Please note that there will be additional charges for documents completed by **Bright Futures Pediatrics.**

Your insurance company will not pay for these forms. Payment **must** be made prior to completing the forms and they must be picked up, we **Do Not Fax forms.**

All payments are expected at the time of service. We **DO NOT** bill for patient co-pays.

Our office accepts cash and credit cards as payment **(We do not take personal checks)**

* **Health statements, daycare forms - $10.00(please allow 12-24 hrs for completion)**
* **Sports physicals - $25.00 (please allow 12-24 hrs for completion)**
* **Immunization Records - $5.00/ patient**
* **Medical Records- $0.60/ page**
* **FMLA paperwork- $50.00 ( please allow one week for completion)**

 If you arrive more then 15 **minutes late** of you appointment time you will be asked to reschedule and will be **charged a $25.00 fee**.

All cancellations **without a 24 hour** notice will be charged a **$25 fee.**

If you are scheduled for a **circumcision** a **24 hour notice** is required to avoid a **$100.00 no show or same day cancellation fee.**

Please sign below that you read and understood our office policies.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Printed Name of Parent/ Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

\* We reserve the right to adjust charges as necessary