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

DESERT VALLEY PEDIATRICS

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.)

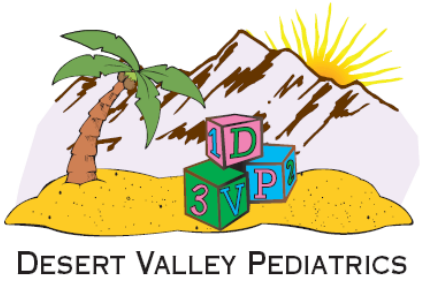
to secure any medical aid and/or treatment from Desert Valley Pediatrics or the nearest hospital or clinic.

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



STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ Date of Birth: _____

I, _____ hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event that my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. I also understand that I am financially responsible for any balance not covered by my insurance carrier, including immunizations, well-cares, co-pays, and all amounts applied to deductibles, or insurance claims that are not paid within 60 days of the date of service.

I authorize the release of any medical information to my insurance company necessary for processing of the claim.

I authorize payment of medical benefits to the treating Physician for services provided from my insurance carrier.

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

_____ _____

Parent / Guarantor of Patient Signature Date

Address: _____

Telephone: (Home) _____ (Cell) _____

DESERT VALLEY PEDIATRICS

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your health care provider for your child. Our main concern is that your child receives the proper medical care needed to maintain his or her health. If you have any questions, please don't hesitate to ask our staff and/or doctors.

All co-pays and deductibles are due at the time of your visit. Payments for services for cash visits are due "In Full" at the time of your visit. We accept cash, Visa and MasterCard. For those with temporary hardships, we have payment options we can offer.

We will submit an insurance claim on your behalf if we have a provider contract with your insurance company. However, it is your responsibility to follow-up with your insurance company in the event that your claim is unpaid. If your insurance company changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately.

Please read the following carefully:

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
2. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.
3. Our office bills for Physician services only. Fees for lab work or cultures are billed separately by the appropriate lab.
4. If your insurance company does not pay within 60 days of the date of service, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collection and court costs.
5. Returned checks will be subject to a $30.00 fee. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery. Please note that we do not accept checks as a form of payment in the office.

_____ _____

Parent / Guarantor of Patient Signature Date

DESERT VALLEY PEDIATRICS

NO SHOW POLICY

Patient Name: _____ Date of Birth: _____

There will be a fee of $30.00 for appointments that are not kept or canceled according to Desert Valley Pediatrics' policy. There will be a fee of $50.00 for Circumcision, ADD/ADHD Evaluation or Follow-up & Well Woman Exam appointments.

If you are unable to keep a scheduled appointment, we require a 24 hour notice to cancel. If you schedule a Same Day sick appointment, we require a 2 hour notice from your appointment time.

Thank you for your cooperation and understanding.

Print responsible party name: _____

Responsible party's signature: _____

Today's Date: _____

DESERT VALLEY PEDIATRICS
Phone (702) 260-4525
10105 Banburry Cross Dr. #370•Las Vegas, NV 89144
6850 N. Durango Dr. #406•Las Vegas, NV 89149
Fax (702) 869-0133

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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6850 N. Durango Dr. #406•Las Vegas, NV 89149
Fax (702) 869-0133

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 _____