Desert Shores PEDIATRICS

Patient Name_____Date of Birth_____

Past Medical History (>1 years old) <PLEASE FILL IN ENTIRE BUBBLE WITH INK>

Any complications at birth or neonatal period? O No O Yes

Was your child full term at birth? O Yes 37-40 weeks gestation O No <37 weeks gestation

Was your child adopted? O No O Yes

Any previous wheezing, chronic cough, asthma or use of albuterol?
O None O Yes asthma O Yes wheezing O Yes chronic cough O Yes albuterol use

Any developmental delay or missed milestones during childhood? O No O Yes

Any significant past medical history? O None O Yes specialist visits O Yes other Social

History

Parents O Married O Divorced O Other

Does anyone smoke at home or regularly expose child to tobacco smoke? O No O Yes

Guns in home? O No guns O Yes locked O Yes but not locked

Do you have a pool? O No pool O Yes fenced O Yes but not fenced

Pets at home? O No O Yes

Family History

Does your child's father have? O Healthy O Asthma O Cancer O Diabetes O Heart Problems
O Allergies O ADHD O Depression/Anxiety O High Cholesterol O Seizures O Other

Does your child's mother have? O Healthy O Asthma O Cancer O Diabetes O Heart Problems
O Allergies O ADHD O Depression/Anxiety O High Cholesterol O Seizures O Other

Does your child's siblings have (leave blank if only child)? O Healthy O Asthma O Cancer O Diabetes
O Heart Problems O Allergies O ADHD O Depression/Anxiety O High Cholesterol
O Seizures O Other

Surgical History

Any surgeries? O None O Yes

Hospitalization

Any hospitalizations? O None O Yes

Desert Shores Pediatrics Patient Registration

Patient Name: _____DOB: ___/____/____ Gender: M F Other

Race: (check all that apply)
- ◯ White
- ◯ Asian
- ◯ Native Hawaiian/Pacific Islander
- ◯ American Indian/Alaska Native
- ◯ Black/African American

Ethnicity:
- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Latino
- ◯ Declined to report

Language: (Primary)
- ◯ English
- ◯ Spanish
- ◯ Other:_____

Address: _____

City:_____State:_____Zip:_____

E-mail:_____

Desert Shores Patient Portal (24/7 access to patient health records): Yes, Enable OR No Thanks

Cell Phone Number:_____ Home Phone (if different): _____

MOTHER STEP-MOTHER LEGAL GUARDIAN
Please circle one

Name:_____
Cell #: _____
Work #:_____
Date of Birth:_____/_____/_____
SS#_____
Employer:_____

FATHER STEP-FATHER LEGAL GUARDIAN
Please circle one

Name:_____
Cell #:_____
Work #: _____
Date of Birth:_____/_____/_____
SS#_____
Employer:_____

If patient lives at two different addresses, please provide second address.

This address is for: Mother Father Other:_____

Address:_____

City:_____ State:_____ Zip:_____ E-mail:_____

Primary Insurance:

Policy Holder: _____

Insurance:_____

Secondary Insurance:

Policy Holder:_____

Insurance:_____

Emergency Contact:_____ Phone:_____

Relationship:_____

How did you hear about our practice (if OB/GYN, please list name):_____

Consent to treat:

I, acting as a guardian to the above patient, herby give consent for the above patient to receive medical evaluation and treatment by the provider's at Desert Shores Pediatrics. I assign all benefits and payments from my insurance company to be paid directly to Desert Shores Pediatrics. I understand that if for any reason my insurance company does not make payments, I am responsible for all services.

Signature:_____ Date:_____

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OFFICE POLICIES

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits. The insurance
company informs all participants that it is ultimately their responsibility to know and understand their policy. We do not have the capability to know each individual policy as it varies per patient. We cannot guarantee that all services will be covered. It is your responsibility to verify benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you fail to inform us, we may be unable to bill the appropriate company within these time limits. A denial from the previous insurance company is the only way we know that the insurance has changed. Denials are generally not generated until after the filing deadline. If you do not notify us and your insurance company decides not to pay, you will be held responsible for payment of these services. Please notify us of any changes to your insurance, address or phone number immediately; ultimately, you will be responsible for this bill.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do NOT have insurance.
- If you are with an insurance company that we are NOT contracted with or
- If your insurance company denies your claim for any reason that is not resolvable.

PAYMENT (COINSURANCE/DEDUCTIBLE OR COPAY) IS EXPECTED ANY TIME A SERVICE IS PROVIDED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS AND MAJOR CREDIT CARDS. CHECKS DRAWN ON INSUFFICIENT FUNDS WILL INCUR A $25.00 CHARGE.

Based on American Academy of Pediatrics Bright Futures Guidelines, DSP recommends ANNUAL well child checks for all children 2 years and older. Preventative care is of utmost importance to your child's health. Therefore, if your child has not been seen for wellness care in over 2 years, the patient will come under review by the practice. We may be unable to refill medications, fill out requested forms, or fulfill other parental requests.

Neither patients, caregivers, nor their visitors are allowed to take pictures or videotape using their cell phones and/or other electronic devices to protect the privacy and confidentiality of our patients.

We kindly ask for at least 48 hours to complete any necessary paperwork for your child.

At times, you may send or bring in pictures of your children and family. We love to display these photos but we need your permission to do so. You can opt out at any time. Please initial: Yes_____ No _____

We may ask to take a photo of your child to be included in their confidential medical record to be used for identification, security or clinical purposes only. We need permission to do so. Please initial: Yes_____ No_____

Our staff will be happy to answer any questions you may have in reference to our office policies. We appreciate our Desert Shores Pediatrics patients and families.

_____ _____

Signature Date

_____ _____

Patient Name Patient DOB

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OFFICE POLICIES

Please initial to acknowledge:

_____ Any appointment NOT scheduled in our normal office hours of Monday through Friday 8:00 am to 5:00 pm is subject to an additional $15.00 **after-hours** charge that will be billed to your insurance. If insurance does not cover this charge, you will be held responsible for payment.

_____ If you have multiple concerns, chronic conditions to discuss, or an acute illness that you would like addressed during a well care visit we are happy to accommodate these concerns! If these services are rendered together at the same visit, it may result in both the standard well visit charge plus an additional office/sick visit charge. We take the comprehensive care of our patients very seriously. It may require a return visit to address these ongoing and chronic conditions so that the proper time and care can be given. Coverage for these services, if rendered together, varies greatly among insurance companies. Please check with your insurance company regarding how they pay for these services on your behalf. You will be financially responsible for any services not covered by your insurance.

_____ There will be a charge for missed appointments or appointments not cancelled 24 hours in advance based on the appointment duration and complexity of visit concerns. Fees are as follows: $20.00 for a 10 minute visit, $40.00 for a 20 minute visit, and $75.00 for a 30+ minute visit. It is important to notify us as soon as possible if you are unable to make an appointment.

What is the best number we can call for appointment reminders? _____ Cell_____ Home_____
Is it ok to text your cell phone for appointment reminders? Yes_____ No_____
What is the best number we can call to give lab and/or test results (if different than above): _____
Is it ok to leave a detailed message regarding confidential information (i.e. lab and test results): Yes_____ No_____

_____ _____
Signature Date

_____ _____
Patient Name Patient DOB

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my child(ren) to their appointments:

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

Name:_____ Relationship to child: _____

I attest that the above-named individuals are all 18 years of age or older as of this date.

I authorize the above-named individual(s) to consent to treatment for my child(ren). This may include but is not limited to consent for all necessary medications, immunizations, procedures, and hospitalizations. Desert Shores may relay any medical information, including protected health information (PHI) about my child that is necessary for the above names individual(s) to provide informed consent.

I understand that the provider will communicate his/her findings and treatment plan to the caregiver who brings the child and under most circumstances a follow-up call to us should not be necessary. I agree to be responsible for any fees for service requested by the above named individual(s) when permitted by my insurance carrier.

I agree to hold Desert Shores Pediatrics and its staff harmless for any disagreement between the abovenamed individuals and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following child(ren) and that I have the legal authority to consent to this agreement. I understand that I can revoke this authorization for any or all individuals at any time. I understand that authorization cannot be revoked retroactively for treatment already provided. This alternate caregiver consent will remain in effect and will **not expire** until authorization has been revoked.

Children covered by this consent (please list child's full name):

Child:_____ Date of Birth: _____

Child:_____ Date of Birth: _____

Child:_____ Date of Birth: _____

Child:_____ Date of Birth: _____

Child:_____ Date of Birth: _____

Child:_____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Parent/Guardian Signature:_____ Date: _____

Desert Shores Pediatrics Policy Statement on Immunizations

Desert Shores Pediatrics strongly believes in the effectiveness of immunizing children to prevent serious and life-threatening illnesses and certain types of cancer. We firmly recommend all infants, children and adolescents receive all recommended vaccines according to the schedule published by the American Academy of Pediatrics and Centers for Disease Control. These schedules are continually studied and revised by experts in many fields of medicine, including immunology and public health.

Vaccinating children against a multitude of infectious agents is the most important health intervention of the 20th century. The recommended vaccines and the schedule by which they are given are the result of years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians. We fully believe, based on all available data, scientific literature, current studies and evidence based medicine, that vaccines do not cause autism or developmental disabilities.

Vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers and that you can perform as parents/caregivers. Vaccines, in some respect, have become a victim of their own success. Many people have never seen a child with whooping cough, polio, tetanus, bacterial meningitis, measles, or even chicken pox. Choosing not to vaccinate is refusing one of our strongest recommendations to protect children and prevent illness.

In general, public support for the United States vaccine program remains overwhelmingly strong. However, not vaccinating your child or vaccinating your child according to your personal vaccine schedule is putting your child and other children at risk. Children who are not vaccinated are at a much higher risk of catching a vaccine preventable disease and may be contagious even before they show symptoms. This puts everyone, but especially infants or immunocompromised children, at risk.

Additionally, we are an international country with people traveling in and out daily from around the world. Children who are unvaccinated could be exposed to travelers with vaccine preventable diseases like measles, mumps, rubella, chicken pox, whooping cough, polio, haemophilus and pneumococcal illnesses including meningitis. This exact scenario is what led to the 2019 outbreak of measles across the United States. These preventable outbreaks resulted in countless sick children and adults as well as an incredible amount of time and money for health departments to contain the outbreak. Not only can unvaccinated children easily contract these diseases, but they can then expose partially vaccinated younger children resulting in significant disease, disability, or death. Not vaccinating or partially vaccinating puts your child and those around you at risk for these preventable diseases.

As your child's health care provider, we at Desert Shores Pediatrics would never recommend immunizations for your child that we would not be willing to give to our own children. As medical professionals and your trusted partners in the care of your children, we feel strongly that vaccinating on schedule with currently available vaccines is the right thing to do for all children and young adults. We will continue to recommend vaccinating based on the CDC immunization schedule and will address this at all visits, regardless of the family's desire to immunize. Families who continue to refuse vaccinations will still be required to attend all recommended well visits and sign both our vaccine policy and vaccine refusal forms. Please feel free to discuss any questions or concerns you may have with any of the health care providers at Desert Shores Pediatrics.

Desert Shores Pediatrics Immunization Policy

Please review the Desert Shores Pediatrics Policy Statement on Immunization which can be found on our website and/or a copy can be provided to you in the office.

Educational Resources regarding vaccine recommendations and safety can be found on our website at http://desertshorespediatrics.com/immunizations.php

Desert Shores reserves the right to discharge families from our medical care for noncompliance with medical recommendations including, but not limited to, failure to be seen for routine well care visits as recommended by the American Academy of Pediatrics. This schedule can be found on our website at http://desertshorespediatrics.com/wellness.php

If your child is under-immunized for any reason it is your responsibility to ensure that all medical providers (including urgent care and emergency room medical personnel) and daycare/schools are informed regarding your child's immunization status. Lack of protection from vaccine preventable diseases often warrants more detailed and extensive evaluation and puts other patients at risk.

Our providers are happy to discuss immunizations and our policy with you – just ask!

Please acknowledge and sign below that you have been provided the opportunity to review our Policy Statement on Immunization and are aware that recommended vaccines will be discussed regardless of the parent/guardian's desire to immunize.

_____ _____

Patient Name Patient DOB

_____

Parent/Guardian Printed Name

_____

Parent/Guardian Signature

_____ Date

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Patient Consent for Use and Disclosure of Protected Health Information

I understand that as part of my child's health care, Desert Shores Pediatrics originates and maintains health records. These records describe history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment.

I have been provided with the Notice of Privacy Practices that describes use and disclosures of my child's Protected Health Information (medical records). I understand that I have the right to review the notice prior to signing this consent.

With my consent, Desert Shores Pediatrics may call (including leaving voice mail messages), mail, text or email regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, laboratory results, and insurance items.

I understand that Desert Shores Pediatrics has the right to change the terms of its notice and practices. The changes will apply to all health information about your child. The new notice will be available in our office and on our website.

I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Desert Shores Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Desert Shores Pediatrics has already taken action. If I do not sign this consent or revoke it, Desert Shores Pediatrics may decline to provide treatment to my child.

I acknowledge that I received and read the Notice of Health Information Practices. I understand that Desert Shores Pediatrics participates in Health Current, Arizona's Health Information Exchange (HIE). I understand that my child's health information may be securely shared through the HIE, unless I complete and return an Opt-Out Form to my healthcare provider.

I fully understand and I consent to Desert Shores Pediatrics' use and disclosure of my child's Protected Health Information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient Name Patient DOB

_____

Parent/Guardian Printed Name

_____ _____

Parent/Guardian Signature Date

Authorization for Disclosure of Health Information (Incoming Records)

Patient Name: _____ DOB:_____

Phone: _____ Address: _____

City: _____ State: _____ Zip:_____

Authorization to Release From: Name/Facility:_____

Phone: _____ Fax: _____

Address:_____

City: _____ State: _____ Zip:_____

Authorization to Release To: **Desert Shores Pediatrics, PC**
6285 S Higley Rd
Gilbert, AZ 85298
Fax: 480-460-5858

Please send only the following:

_____ Medical summary, last 2 well visits, growth charts, immunization record, labs and imaging, most recent specialist reports, and any ADHD/behavioral health records

_____ Newborn Hospital Records: H&P, discharge summary, pertinent labs, imaging or specialist reports
DO NOT SEND NURSING NOTES or VITAL CHARTS, PLEASE

_____ Other (specify): _____

- I understand information in my health record may include information relating to sexually transmitted infections (STI), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment, including alcohol and drug abuse.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

- If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rule. Exp date (optional):_____

- I understand that there is no cost to me for requesting to send medical records to another medical facility. I understand that if I want a copy of medical records for personal use, there will be a fee associated with this request and I agree to be responsible for that charge. Please inquire about our medicals records release fee policy for additional information.

Signature:_____ Date: _____

Printed Name: _____ Relation to patient:_____

Please note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law (42CFR, part II).