Desert Shores
PEDIATRICS

18 years old and Older Patient Registration

☐ Patient has legal guardianship by another adult and does not make autonomous decisions about his/her medical care. Legal documentation of guardianship is required. If checked, do not fill out information below.

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____State: _____Zip: _____

Patient E-mail: _____

☐ Ok to transfer my Patient Portal Account ☐ I prefer my Patient Portal Account to be disabled

Patient Phone Number: _____ Cell Home

Is it ok to leave a detailed message regarding confidential information (i.e. lab and test results): Yes No

Emergency Contact Information (Parent, Spouse, Friend)

Full Name: _____ Relationship: _____

Emergency Contact Phone Number:_____

Can we discuss your medical records with this person? Yes No Case-By-Case

Please list all people who you authorize to discuss your medical records (leave blank if no one is authorized)

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Signature: _____ Date: _____

Desert Shores Pediatrics 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, your address, or your phone number immediately; ultimately, you will be responsible for charges.

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. INSUFFICIENT FUNDS WILL INCUR A $25.00 CHARGE.

Based on the 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 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:_____

Printed Name: _____

Desert Shores Pediatrics 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 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

Is it ok to leave a detailed message regarding lab and/or test results: 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 _____

Printed Name: _____

Patient Name: _____ DOB: _____

Desert Shores
PEDIATRICS

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.

Signature: _____ Date _____

Printed Name: _____

Patient Name: _____ DOB: _____