



Past Medical History (>1 years old)

Patient Name: _____ DOB: _____

Any complications at birth or during the neonatal period? No Yes

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

Was your child adopted? No Yes

Any previous wheezing, chronic cough, asthma or use of albuterol?

None Yes asthma Yes wheezing Yes chronic cough Yes albuterol use

Any developmental delay or missed milestones during childhood? No Yes

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

Social History

Parents Married Divorced Other

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

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

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

Pets at home? No Yes

Family History

Does your child's father have? Healthy Asthma Cancer Diabetes Heart Problems

Allergies ADHD Depression/Anxiety High Cholesterol Seizures Other

Does your child's mother have? Healthy Asthma Cancer Diabetes Heart Problems

Allergies ADHD Depression/Anxiety High Cholesterol Seizures Other

Does your child's siblings have (leave blank if N/A)? Healthy Asthma Cancer Diabetes

Heart Problems Allergies ADHD Depression/Anxiety High Cholesterol

Seizures Other

Surgical History

Any surgeries? None Yes

Hospitalization

Any hospitalizations? None Yes



Desert Shores Pediatrics Patient Registration

Patient Name: _____ DOB: _____

Legal Sex: Male Female Other Gender (if different from legal sex): _____

Race: ___ American Indian or Alaska Native Ethnicity: ___ Hispanic or Latino
___ Asian ___ Not Hispanic or Latino
___ Black or African American
___ Native Hawaiian or Pacific Islander Primary Language: ___ English
___ White/Caucasian ___ Other, please specify: _____

Parent #1 Name: _____ DOB: _____ SSN: _____

This is: Mother Father Step-Mother Step-Father Foster Parent Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Email: _____

Employer/Occupation: _____

Would you like access to the Patient Portal for your child? Yes, Enable No, Thanks

Parent #2 Name: _____ DOB: _____ SSN: _____

This is: Mother Father Step-Mother Step-Father Foster Parent Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Email: _____

Employer/Occupation: _____

Would you like access to the Patient Portal for your child? Yes, Enable No, Thanks

Parents are: Married Divorced Separated Living Together Other: _____

Do you have health insurance? Yes No Do you have secondary health insurance? Yes No

Primary Insurance Name: _____ ID# _____ Group #: _____

Policy Holder Name: _____ Policy Holder Relationship: _____

Secondary Insurance Name: _____ ID# _____ Group #: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

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

Authorization to treat and Assignment of Benefits

I, acting as a guardian to the above patient, hereby give consent for the above patient to receive medical evaluation and treatment by the providers 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: _____

Parent/Guardian Printed Name: _____



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. 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: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ DOB: _____



Desert Shores Pediatrics Additional Office Policies

Please initial to acknowledge:

_____ Any appointment scheduled after our normal office hours of Monday through Friday 8:00 am to 5:00 pm will be 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.

_____ Court orders regarding custody and medical decision making and/or for foster children need to be provided in hard copy to the office as soon as they are executed (or at the first visit if a new patient) or the appt will need to be rescheduled.

_____ I have read and was offered a copy of the "DSP Policy on Telehealth", which includes information about the risks and benefits of telemedicine visits. I understand and consent to the use of telemedicine when necessary. Telemedicine visits are billed similar to an in-office visit; copays or deductible may apply.

_____ 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.

_____ I have read and was offered a copy of the "Patient Consent for Use and Disclosure of Protected Health Information" (HIPAA policy), which includes information about our participation in the AZ Health Information Exchange (HIE). I understand and consent to the use and disclosure of my child's protected health information to carry out treatment, payment, and healthcare operations.

_____ I have read and was offered a copy of the "Code of Conduct for Patients, Families, and Employees/Providers at Desert Shores Pediatrics." I understand and agree to these standards to provide a safe and healthy office environment for all.

Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ 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 above-named 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, COVID-19 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 Acknowledgement

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.

Educational resources regarding vaccine recommendations and safety can be found on our website: <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: <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 at any time!

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

Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ DOB: _____



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.



Desert Shores Pediatrics Policy on Telehealth

Telehealth Informed Consent: Please read this information about telehealth. Your provider/other health care professional will talk to you about the information in this form before your visit. Ask your provider/other health care professional if you have any questions about telehealth.

What is telehealth: Telehealth is a way to see your provider when the two of you are not in the same place. You will talk to them on your phone, computer, or tablet. You will usually use video so you can see each other. You will not go to a clinic or hospital. Your provider can prescribe medication, order tests, and refer you to a specialist just as they would during an in-person visit.

TELEHEALTH SHOULD NOT BE USED IN EMERGENCIES. IF YOU ARE EXPERIENCING A MEDICAL EMERGENCY, PLEASE DIAL 9-1-1 OR GO TO YOUR CLOSEST EMERGENCY DEPARTMENT.

Why use telehealth: You can visit with your provider from any location when an in-person visit is not convenient. However, you must be in the state of Arizona.

How much will a telehealth visit cost: You will be billed for the telehealth visit. Your share of the cost of a telehealth visit depends on your individual insurance coverage. Telehealth appointments must be cancelled at least 24 hours before your appointment time. You may be charged if you do not cancel and do not show up for your scheduled appointment.

Are there risks to telehealth: Your provider may not be able to see or hear you during the encounter if there are technical difficulties. Your provider cannot physically examine you during your telehealth visit. It is possible that they will miss a sign or symptom that would be easier to see in-person. You should share as much information about your medical condition as possible. During your telehealth visit, your provider may decide you need an in-person visit. If so, they will ask you to make an appointment to come to the office. You may have to pay for the telehealth visit and the office visit. Your visit may be interrupted because of technical problems. Information could be lost because of an interruption. If your appointment is interrupted, you may need to call the office to set up a new appointment. An interruption or technical problem may delay your treatment. You may have to pay for both visits.

Are there privacy concerns: Your private health information is protected by federal and state law, but it may be released to your insurance for billing purposes. If you have given this office written permission to release your health information to anyone, that release applies to telehealth and in-person visits. Your provider will take reasonable steps to protect your privacy. They will tell you if there is someone else in the room with them who can see or hear you. You should make sure you are in a private place where others cannot hear you. Use a private and secure internet connection. Do not use the internet in public places such as coffee shops and libraries.

Am I required to use telehealth: You are not required to use telehealth. You may withdraw your permission to participate in telehealth at any time during your visit or by calling your provider's office at (480) 460-4949. You may request an in-person visit. There may be rules for in-person visits due to extenuating circumstances or community outbreaks. Our office staff will tell you about any rules for in-person visits when you call to make an appointment.

1. My health care professional talked to me about the information in this form.
2. My health care professional answered my questions about telehealth.
3. I understand the risks, benefits, and alternatives to telehealth visits.
4. I will be in the state of Arizona during my telehealth visit.
5. I want to have telehealth visits with my provider.



Code of Conduct for Patients, Families, and Employees/Providers

To provide a safe and healthy environment, we expect all patients, families, visitors, and all DSP employees/providers to refrain from unacceptable behaviors that are disruptive or pose a threat to anyone's rights or safety.

- If you have any questions about the care or are unhappy with the service(s) received in our office, please contact our practice manager before you leave our office so that any clarifications about your child's care or the services you received can be made. We will make every attempt to help resolve the issue or clarify any misunderstandings in a respectful manner.
- Please communicate all issues that you wish to discuss with the provider at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not disclose additional concerns in advance, another visit may be necessary so that the provider can give all their patients the time and quality of care they deserve.
- Please direct all billing questions to the billing department with the understanding that the front staff is simply a messenger in this process. Respectful discussions with our billing team are encouraged and employees are to address any problems in an understanding and kind manner.
- Our practice follows a zero-tolerance policy for aggressive behavior. This includes aggressive behavior directed by families against our staff and vice-versa. Aggressive behavior is unnecessary and cannot be tolerated for any reason.
- We will not tolerate social media posts or reviews that are derogatory, disparaging, or slanderous.
- Please be courteous with the use of cell phones and other electronic devices. When interacting with any of our employees, please put your devices away. Avoid scheduling appointments during conference calls or at times when you expect to get an important phone call. Set the ringer to vibrate before storing away. Your appointment will be delayed or may even be rescheduled if your phone call is not immediately concluded when the staff calls your child's name for their appointment or when the provider enters the room. Our employees should also refrain from all cell phone use while interacting with patients. Video recording is prohibited to protect everyone's privacy.
- Please supervise your children and keep them in their designated exam room. There are safety and confidentiality issues with patients, families and visitors wandering in the halls.

The following behaviors are prohibited by all patients, families and employees/providers:

- Possession of firearms or any weapons
- Intimidating or harassing behaviors, including on social media platforms
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Physical assault or threatening to inflict bodily harm
- Making verbal threats to harm another individual or destroy property
- Damaging business equipment or property
- Making menacing or derogatory gestures
- Racial, cultural or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report this immediately. Violators are subject to removal from the facility and/or discharge from the practice.



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).