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
___ Asian
___ Black or African American
___ Native Hawaiian or Pacific Islander
___ White/Caucasian

Ethnicity: ___ Hispanic or Latino
___ Not Hispanic or Latino

Primary Language: ___ English
___ 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. ANY ACCOUNTS SENT TO COLLECTIONS WILL INCUR A $25 PROCESSING FEE.

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 and may be discharged from 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: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ DOB: _____

Sibling(s) Name & DOB: _____

Desert Shores Pediatrics Additional Office Policies

Please initial to acknowledge and accept:

_____ Any appointment scheduled outside our normal office hours of Monday-Friday 8:00 am to 5:00 pm will be subject to an additional $15.00 charge that will be billed to your insurance. If insurance does not cover this charge, you will be held responsible for payment. This includes early morning, after-hours or weekend appts.

_____ 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. 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. Missed appointments (or ones not cancelled timely) will be classified as a No-Show visit. Multiple No-Show visits will result in a fee assessed and potential discharge from the practice.

_____ For best care and efficiency, we ask that all patients arrive EARLY for their scheduled appointment time. Late patients will be rescheduled. New patients must arrive prior to the appointment time. Established patients are late if the arrival time is 10 or more minutes after your scheduled appointment time. Please arrive early.

_____We are a by-appointment-only office and do NOT accept walk-ins. There will be a strict $150 fee if you walk-in without an appointment and are seen by a provider.

_____ Paperwork Fees: FMLA = $25, Sports/School/Camp Forms = $10 (completed in 48-72 hrs), if needed within 24 hrs = $25. Forms presented for completion during an office visit do not incur a charge (except FMLA $25).

_____ Court orders regarding custody and medical decision making and/or foster children orders 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 "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.

I give permission to leave detailed voicemail messages at this number #: _____ for:
_____ appointments, _____ billing, and/or _____ medical information on my child, including lab results.
please initial each category or leave this section blank if you do not give permission to leave a detailed voicemail

Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ DOB: _____

Sibling(s) Name & DOB: _____

Desert Shores
PEDIATRICS

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: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Parent/Guardian Signature: _____ Date: _____

Future Acknowledgement (initial and date): _____ _____ _____ _____

_____ _____ _____ _____

Desert Shores Pediatrics Vaccine Policy

Our providers take great pride in providing excellent care for our patients. This includes detailed knowledge and understanding of the research and scientific data supporting vaccines and helping you to understand that information. We recognize that the choice to vaccinate may be very emotional for some parents, and that it is your right to make decisions regarding the vaccination of your child. However, we believe in the safety and effectiveness of vaccines to prevent serious illnesses and save lives. We also feel it is our right, as pediatricians, to practice medicine in a way that we believe follows the evidence-based recommendations regarding vaccines, as published by the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC). When choosing not to follow these recommendations, we feel we are implicitly supporting the practice of non-vaccination. We do not want to continue to encourage trends that leave children vulnerable to severe illnesses. Having mutual trust in each other is crucial as we work together to raise healthy children. Non-vaccination is not representative of our views in keeping children and our community healthy.

Effective September 1, 2024, we have made the decision to no longer accept NEW patients to our practice who are unimmunized or whose parents are not planning to immunize, in the case of newborns. This includes new siblings of patients that are established at the practice.

Although it is rare, there are medical conditions that prohibit vaccinations, for example children diagnosed with cancer undergoing chemotherapy treatment as well as children with severe immunodeficiency. New patients with these conditions would be exempt from this new policy.

While we do not encourage alternate vaccine schedules, we will work with new patients who have chosen an alternate schedule. We have a minimum vaccine timeline requirement for those new patients who elect to receive an alternate schedule:

DTaP, Hib, Prevnar: 1 dose of each by 4 months, 4 doses of each by 18 months, 5 doses of DTaP by 6yrs old

IPV: 1 dose by 18 months, 3 doses by 6yrs old

MMR and Varicella: 1 dose of each by 18 months and 2 doses of each by 6yrs old

Tdap: 1 dose by 12yrs old

Meningitis A, C, W, Y: 1 dose by 12yrs old , 2 doses by 17yrs old

We will continue to see our existing patients who are unimmunized, but they will be required to follow specific infection control protocols to better protect our most vulnerable patient populations and will be required to sign a vaccine refusal, accepting responsibility, each time vaccines are recommended. Patients must also maintain all recommended AAP well visits on schedule (NB, 1mo, 2mo, 4mo, 6mo, 9mo, 12mo, 15mo, 18mo, 24m, 30mo, 3yr and then annually). The infection control guidelines are as follows: notifying the front office when scheduling an appointment that their child is not fully immunized, waiting in the car until their room is ready, entering the practice through a different door when necessary, following through with recommended labs and/or imaging studies when their child is ill, and ensuring all other healthcare providers are made aware of their child's unimmunized status.

Since trust in your health care provider is a fundamental component of the physician/patient relationship, families that cannot accept or adhere to our minimum vaccination requirements or our infection control guidelines will be asked to find a new healthcare provider for their children. We understand that our new policy will not be acceptable to some families. Please know that we did not come to this decision lightly.

Desert Shores Pediatrics Vaccine Policy Acknowledgement Form

We are so grateful to all our families that entrust us with the care of their children. It is our privilege to be on your team and to work with you to raise healthy, strong, resilient children. We would be happy to discuss this policy further and answer any questions you may have.

I have read and I understand the Desert Shores Pediatrics Vaccine Policy, effective 9/1/2024.

Parent Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

Patient Name: _____ DOB: _____

Sibling(s) Name & DOB: _____

Rev 9/2024

Desert Shores
PEDIATRICS

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 it 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.

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: _____

Desert Shores
PEDIATRICS

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).