PATIENT INFORMATION

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PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____SSN: _____ SEX : M F

WHO DOES PATIENT LIVE WITH: FATHER MOTHER BOTH STEPPARENT GUARDIAN OTHER: _____

WHO HAS LEGAL CUSTODY OF PATIENT: FATHER MOTHER BOTH STEPPARENT GUARDIAN OTHER: _____

PRIMARY CARE PHYSICIAN (PCP): _____ PCP's PHONE: (_____)_____

PARENT INFORMATION

	FATHER	MOTHER
NAME:	_____	_____
BIRTH DATE:	_____	_____
ADDRESS:	_____	_____
CITY, STATE, ZIP:	_____	_____
HOME:	_____	_____
CELL:	_____	_____
WORK:	_____	_____
EMAIL:	_____	_____
SSN:	_____	_____
EMPLOYER:	_____	_____
OCCUPATION:	_____	_____

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PH: (_____)_____

SUBSCRIBER'S NUMBER (ID#): _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE): FATHER MOTHER SELF STEPPARENT GUARDIAN OTHER : _____

GROUP NAME: _____ GROUP NUMBER: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PH: (_____)_____

SUBSCRIBER'S NUMBER (ID#): _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE): FATHER MOTHER SELF STEPPARENT GUARDIAN OTHER: _____

GROUP NAME: _____ GROUP NUMBER: _____

Patient's Name_____ Date of Birth_____
Pediatrician_____ Parent completing this form _____
Other doctors this patient sees: _____

CHILD'S MEDICAL HISTORY

ALLERGIES ☐ None ☐ Yes:_____

MEDICATIONS ☐ None ☐ Yes:_____

VITAMINS/ SUPPLEMENTS ☐ None ☐ Yes:_____

BIRTH HISTORY ☐ Term Birth weight_____

☐ Premature. Born at ____weeks, stayed in _____NICU for _____weeks

Complications _____

IMMUNIZATIONS ☐ Up to Date ☐ Not up to date

HOSPITALIZATIONS ☐ None ☐ Yes, for these reasons:_____ _____

SURGERIES ☐ None ☐ Yes, these operations:_____

HAS YOUR CHILD HAD, OR DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS: (circle all that apply, check "none" if none)

GENERAL Fever Night sweats Excessive Weight changes

SKIN ☐ none skin infections/MRSA eczema rashes acne hemangiomas

EYES ☐ none pain blurred vision

NEUROLOGIC ☐ none bleeding in brain stroke headaches developmental delay seizures brain injury ADHD

EAR/NOSE/THROAT/MOUTH ☐ none Sinus problems Frequent sore throat swollen lymph nodes Ear infections

ENDOCRINE ☐ none thyroid problems diabetes overweight underweight tired/sluggish Excessive thirst

HEART ☐ none murmur fainting congenital heart defect poor exercise tolerance

DOES YOUR CHILD SEE A HEART DOCTOR? ☐ Yes ☐ No

BLOOD ☐ none anemia easy bruising poor blood clotting jaundice transfusions

IMMUNE ☐ none environmental allergies

LUNG ☐ none asthma wheezing RSV shortness of breath pneumonia synergis shots tracheomalacia

PSYCHOLOGICAL ☐ none Depression Anxiety

INTESTINAL ☐ none liver disease obstruction constipation acid reflux poor growth bleeding diarrhea indigestion/heartburn nausea/vomiting chronic abdominal pain

URINARY ☐ none hydronephrosis urinary reflux kidney problems undescended testicle urine infections

MUSCULOSKELETAL ☐ none broken bones weakness joint pain

CANCER ☐ none ☐ Yes Type: _____

FAMILY HISTORY ☐ none diabetes anesthesia problems easy bleeding sickle cell cancer heart disease

ANY OTHER MEDICAL PROBLEMS NOT MENTIONED ABOVE _____

Date_____ Reviewed by_____

FINANCIAL POLICY AND AGREEMENT

THIS DOCUMENT DESCRIBES OUR BILLING AND COLLECTIONS POLICY. PLEASE REVIEW THIS DOCUMENT CAREFULLY! WE APPRECIATE THE OPPORTUNITY TO SERVE YOU AND PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

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INSURANCE POLICY:

As a courtesy to you, we will be happy to submit your claims to most insurance carriers if you have provided us with policy numbers, address, social security numbers, place of employment and any other needed information. **Please keep in mind that your insurance policy is an agreement between you and your insurance company, and it is <u>your</u> responsibility to understand your policy**. Likewise, we have agreements with most insurance companies, and we are bound by our contracts with them to collect co-pays, deductibles, and co-insurances directly from you. **<u>You are responsible for these charges, and we are not allowed to waive them.</u>** Additionally, please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is your responsibility.

OFFICE POLICY ON PAYMENT :

It is our policy to require payment of all *office* charges at the time they are given and payment of *surgical* charges before the day of surgery. Based on the information your insurance company provides us about your individual policy, we will ESTIMATE your responsibility to the best of our ability and collect this amount. After receiving a claim from us, the insurance company will determine (based on your individual policy) their payment to us and the EXACT amount you must pay. This information will be sent to both you and us in an *Explanation of Benefits (EOB)* document. We will then send you statements for *or* refund to you the difference between the EXACT and ESTIMATED amounts.

Alternatively, you may request to place your credit card on file. If a valid credit card and authorization is on file, the payment will not be due until the EXACT amount you owe is determined by your insurance company. We will automatically charge your card once this amount is determined. Please refer to the credit card authorization agreement for full details. We are still required to collect the office visit co-pay at the time of the office visit, but any additional estimated charges will be deferred until the EOB is received.

COLLECTION POLICY:

Please understand that we need to concentrate our efforts on the care of your child and have limited resources for collecting past due accounts. Therefore, we must forward all accounts not paid within 60 days from the date of your first statement to the American Credit Bureau for reporting to your credit report. The undersigned agrees to be financially responsible for all charges incurred regardless of insurance coverage. I understand that late fees or interest may be charged if the account I'm responsible for becomes delinquent. In the event such account is referred to a collection agency due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. If referred to a collection agency, I understand I may be discharged as a patient.

MISSED APPOINTMENTS and RETURNED CHECKS :

A $45.00 charge will be incurred for appointments not cancelled within 24 hours of your appointment time. This charge will not be covered by insurance plans. A $25.00 charge will be incurred for checks returned for insufficient funds.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the release, to my insurance company, of any medical information necessary to process any claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.

I authorize Pediatric Surgery Associates to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information.

I have read and understand the above, and I accept financial responsibility in full for this account.

Signature of Parent/Guardian_____ **Today's Date**_____

Relationship to Patient_____

Patient's Name _____ **Date of Birth** _____

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY!

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USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information me be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to- day activities and management of **Pediatric Surgery Associates, Ltd.** For example, information on the services you received may be used to support budgeting and financial reporting, activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatment: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected **health information**
- the right to receive confidential communications concerning you medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected **health information**
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Pediatric Surgery Associates, Ltd Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and procedures will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Front Desk Receptionist or Office Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Pediatric Surgery Associates
653 N Town Center Dr, Suite 412
Las Vegas, NV 89144

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

I have received a copy of the Notice of Privacy Practices for Pediatric Surgery Associates

Name of Patient_____Date of Birth_____

Signature of Parent/Guardian/Representative_____

Relationship to Patient_____ Today's Date _____

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

pediatric surgery associates

Your signature on this form authorizes other doctors, hospitals, laboratories, radiology centers to send us copies of your medical records.

DATE: _____

TO:_____

ADDRESS: _____

_____

_____

I hereby authorize the release of any and all medical and/or clinical records of my child, and those records are to be sent to:

PEDIATRIC SURGERY ASSOCIATES
653 N TOWN CENTER DRIVE #412
LAS VEGAS, NV 89144
P: 702.233.8101 F: 702.242.0726

_____ _____

*PRINT PATIENTS FULL NAME *PATIENT'S DATE OF BIRTH

OTHER NAME(S) PATIENT IS KNOWN BY (for example: baby girl/boy XXXX, hyphenated last names, different birth name):

_____

_____ _____

*PARENT/LEGAL GUARDIAN (PRINTED NAME) *RELATIONSHIP TO PATIENT

_____ _____

*PARENT/LEGAL GUARDIAN (SIGNATURE) TODAY'S DATE

* = Required fields

CREDIT CARD ON FILE
AGREEMENT AND AUTHORIZATION

THIS DOCUMENT DESCRIBES OUR CREDIT CARD ON FILE POLICY. PLEASE REVIEW THIS DOCUMENT CAREFULLY! WE APPRECIATE THE OPPORTUNITY TO SERVE YOU AND PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

I understand and agree that I am responsible for payment for all office charges at the time of service and for payment of all surgical charges before the day of surgery as outlined in the Financial Policy and Agreement. In lieu of paying before my insurance company assigns the exact amount for which I am responsible, I can elect to place my credit card on file. I understand this will defer charges until my insurance company has issued an Explanation of Benefits document to Pediatric Surgery Associates indicating the amount I must pay. At that time, Pediatric Surgery Associates will charge my credit card as follows:

- charges will be made on the first day of the month or the next business day.
- unless I ask otherwise, the maximum charge to my card will be $200. If there is any balance thereafter, my card will be charged $200 monthly until the balance is paid in full.
- a receipt will be sent to me.

____ I understand my credit card information is stored securely by a third party in compliance with PCI laws. Pediatric Surgery Associates employees will only have access to the last 4 digits of my card number.

____ I acknowledge I am responsible for updating my information in the event the card expires or becomes invalid. In the event my card is declined, I agree that I am responsible for payment of the full amount immediately.

____ I acknowledge that it is solely my responsibility to resolve any disagreement about my financial responsibility directly with my insurance company.

One option must be selected:

_____I have read and understand the above. I authorize Pediatric Surgery Associates to charge my credit card for pediatric surgery services provided to my child named below in accordance with the policy outlined above.

Last 4 digits of Credit Card_____

Credit Card Expiration Date_____

Signature of Parent/Guardian/Card Holder_____

_____ I decline to place my credit card on file. Instead, I will be expected to pay for services on or before the date of service in accordance with the Financial Policy and Agreement.
I understand that Pediatric Surgery Associates will calculate my financial responsibility to their best ability and that adjustments will be made after the insurance company issues the exact amount owed.

Signature of Parent/Guardian_____

Today's Date_____ **Relationship to Patient_____**

Patient's Name _____ **Patient's Date of Birth _____**

Pediatric Surgery Associates, Ltd. (702) 233-8101
653 N. Town Center Dr. #412 Las Vegas, NV 89144