pediatric surgery associates

**Demographics Form**

1. Full Name _____
2. Date of Birth _____
3. Gender _____
4. Language _____
5. Ethnicity/Race _____
6. Home Phone _____
7. Other Phone _____
8. Email _____
9. Address _____

## Welcome to Our Practice!

Please notify the staff if you have any questions or need help in filling out this questionnaire.

It is important that we have accurate medical information for your child.

today's date:_____

Child's name:_____

Who is filling out this form? (circle all that apply):

mother father grandmother grandfather

other:_____

What health concerns are to be addressed during this appointment?

_____

**My child is allergic to (circle all that apply):**

no allergies

environmental allergies:_____

food allergies:_____

medications:_____

**My child takes these medications:**

_____

My child takes no medications

By checking this box I give consent to access my child's prescription medication history.

Are your child's immunizations up to date? Yes No

**Birth History**

Is this child yours by: (circle one)

birth adoption stepchild foster child

Delivery method

C- section Vaginal

Premature

Yes- born at_____ weeks (full term is 38 weeks)

No- born after 38 weeks

Child's birth weight was _____pounds and _____ounces

Did your child require admission to the NICU? yes no

How long did the child stay in the NICU? _____weeks

Which NICU?

Sunrise Children's Hospital

Summerlin Hospital

UMC

Centennial

Spring Valley

Southern Hills

Mountainview

St Rose Siena or San Martin

Other:_____

## Nutrition and Feeding History

If your child is an infant, please indicate feeding:

breast milk only
formula only — formula name: _____
breast mild and formula

All patients:

Is your child on a special or restricted diet? yes no

If yes, please explain: _____

## Child's Medical History

*Please circle all that apply*

No past medical history

abdominal pain-frequent
ADD/ADHD
Anemia or Easy Bleeding
Asthma
Anxiety or Depression
Bladder or Kidney Infection
Blood Transfusion
Bronchitis, Bronchiolitis, RSV
Cancer
Colic
Congenital Heart Disease
Constipation
Bleeding in the Brain/other neurologic problems
Croup
Diabetes
Feeding or swallowing Problems
Diarrehea-frequent
Eczema
Fracture of bone
Heart Murmur
High Fevers
Pneumonia
Seizures
Sickle Cell Disease or Trait
Skin Problmes- chronic or recurrent
Thyroid or Endocrine problems
Urinary tract infections
Vision problems

other: _____

## Hospitalizations/Surgical History

*circle all answers*

Never hospitalized overnight
My child has stayed in the hospital for these problems: _____

My child has had these surgeries:

None
Circumcision
Umbilical or Epigastric hernia repair
Appendectomy
Inguinal hernia or hydrocele repair
Ear tubes, tonsis, or dental surgery
Undescended testicle
Fundoplication and/or g tube
Other procedure: _____

## Developmental Milestones

*circle answers*

Is your child physically developing as expected: Yes No Mild delay
Is your child developing mentally as expected: Yes No Mild delay

**Health Maintenance and Prevention**

| | | |
|---|---|---|
| Do you always use a care seat or seat belt? | Yes | No |
| Do any household members smoke? | Yes | No |
| Does your child smoke? | Yes | No |
| Has your child visited the dentist? | Yes | No |

**Family History** *Please circle if your child's parents, siblings, or grandparents wer diagnosed with any of the following*

No family problems known

There is a family history of severe problems under anesthesia

There is a family history of bleeding or blood disorders

| | |
|---|---|
| ADD/ADHD | diabetes |
| Alcohol/drug abuse | genetic disorder |
| allergies | heart disease |
| anemia | hepatitis/liver disease |
| asthma | learning disability |
| birth defects | psychiatric problems |
| deafness/hearing problems | seizure disorder |
| depression | social problems |
| developmental delay | speech problems |
| cancer: _____ | stroke |
| | thyroid disease |
| | tuberculosis |

other: _____

Is there anything else we need to know in order to care for your child?

_____

**My child currently is a patient of these specialty providers:**

*Please circle so that we can send them records and keep them up to date with your child's care.*

GI
- PGNA- Drs Baron, Rhee, Mileti, Carroll
- Dr Sheikh
- GI clinic at UMC

Endocrinology
- Dr Saad
- Dr Dewan
- Dr Darukhanavala

Pediatric Urology
- Drs Genesan, Plaire, Feng, Casey
- Dr Close
- Dr Hwang

Neurosurgery
- Dr Schmidt
- Dr Blum

Neurology
- Drs Johns, Halthore, Maller
- Dr Raja

Children's Heart Center

Pulmonary: Dr Nakamura

Children's Specialty Clinic- Hematology/Oncology

Are there any other specialty doctors not mentioned above that care for your child?

**You have reached the end. Thank you for completing this form.**

## Family Demographic Information and Insurance Information

PATIENT NAME: _____

DATE OF BIRTH: _____

Patient Lives With (circle all that apply):

- Father
- Mother
- Siblings
- Foster Family
- Grandparents
- Domestic Partner/Significant Other
- Other: _____

Who has custody of this child? (circle all that apply)

- Mother
- Father
- Both Parents
- Grandparent
- CPS/State
- other: _____

Who is financially responsible for this patient's account?

- Name: _____
- Street Address: _____
- City, State, Zip: _____

Mother's Information

- Mother's Name: _____
- Mother's Date of Birth: _____
- Mother's Social Security Number: _____
- Mother's best contact number: _____
- Mother's employer: _____

Father's Information

- Father's Name: _____
- Father's Date of Birth: _____
- Father's Social Security Number: _____
- Father's best contact number: _____
- Father's employer: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

**Insurance companies require that you share ALL insurance information for your child.**
**If there is information that you do not share, you might be at risk for ALL charges.**
**Please do not take this risk!**

Please select the option that describes your child's insurance coverage:

*Please bring all insurance cards to your visit.*

- Commercial Insurance- only one policy
- Commercial Insurance- dual coverage
- Commercial Insurance with Medicaid secondary insurance
- Medicaid only ( Smartchoice/Amerigroup/State Medicaid)
- No insurance/No Medicaid

We would like to remind you of future appointments by text or email.
Please indicate your email address or cell number:

- Cell for texts: _____
- email: _____

**Thank you for your cooperation!**

# 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 your 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. **You are responsible for these charges, and we are not allowed to waive them.** 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** _____

## Consent to Treatment

I hereby give my permission for **Pediatric Surgery Associates (including physicians, nurse practitioners, and medical assistants)** to give my child medical treatment.

I allow Pediatric Surgery Associates to file for insurance benefits to pay for the care I receive.
I understand that:

- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my provider
- The practice will have to send my medical record information to my insurance company
- I must pay my share of the costs
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance

Patient Name _____

Signature of Patient or Legal Guardian _____

## Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illnesses properly and to avoid potentially dangerous drug interactions

It is very important that you and your provider discuss all your medications in order to ensure that your recorder medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers

Patient Name _____

Signature of Patient or Legal Guardian _____

**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!

pediatric surgery associates

**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 _____