Desert Valley Pediatrics

Phone: 623-877-7337 Fax: 623-772-0686

Patient Account #________________

Child's Last Name ________________ First ________________ MI ________

Birth Date ________ Age ____ Sex: F M Primary Language ________________

Race ________________ Ethnicity ________________

Please list names of family members seen by DVP physicians: ________________

Pharmacy: ________________ (Name) ________________ (Location)

Guardian's/ Father's Name ________	Guardian's/ Mother's Name ________
Address ________	Address ________
City ____ State ____ Zip ____	City ____ State ____ Zip ____
Home/Message Phone ________	Home/Message Phone ________
Business Phone ________	Business Phone ________
Cell Phone ________	Cell Phone ________
E-mail ________	E-mail ________
SS# ____ Date of Birth ____	SS# ____ Date of Birth ____

Insurance Information

Insurance Co.Name ________	Insurance Co.Name ________
Patient's Insurance ID #: ________ *Include member number if applicable (01, 02, 03, etc.)*	Patient's Insurance ID #: ________ *Include member number if applicable (01, 02, 03, etc.)*
Group: ________	Group: ________
Insurance Policy Holder Name: ________	Insurance Policy Holder Name: ________
Insurance Policy Holder DOB: ________	Insurance Policy Holder DOB: ________
Relationship: ________	Relationship: ________
Address To Send Claims:	Address To Send Claims:

Release of Benefits and Information: I consent for medical treatment and I have verified the insurance listed on this form and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize Desert Valley Pediatrics to release any information required for this claim.

Signed: ________________ **Date:** ________

DE28-121 Rev. 06/17

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally-assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
   Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

Financial and Office Policy

Thank you for choosing Desert Valley Pediatrics (DVP) for the care of your child. This Financial and Office Policy is an important part of your child's care. Due to increased insurance company demands, we ask you to read and agree to the following DVP policies.

Self-Pay Patients: If you have no insurance coverage, full payment is expected at the time of service. Please contact an office staff member for fees.

Commercial Insurance: As a courtesy, DVP will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay **CANNOT** be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted through our patient portal. Knowing and understanding your insurance benefits is your responsibility. If you have any "Out of Network Benefits" with a plan we are not contracted with, we will bill your insurance as a courtesy. Any patient responsibility will be billed to the guarantor on file. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify DVP if there is a change to your insurance coverage, residence or phone number. Ultimately, it is up to you to know your insurance benefits.

Lateness: If you are late for your appointment time, please call to inform the staff. They will review the schedule to determine if the appointment will need to be rescheduled to another day or work you in behind other scheduled appointments.

No Shows/Cancellations: A missed appointment leaves an open appointment that could have been used by a patient in need of medical care. A no-show appointment occurs when a parent or legal guardian fails to give adequate notice that the appointment cannot be kept. The parent or legal guardian's failure to cancel or reschedule an appointment by 8:00am the day of the scheduled appointment will result in a no-show. If three (3) no-shows are accrued during a calendar year (Jan-Dec) the family will be dismissed from the practice and unable to receive further treatment at DVP.

Appointments: Walk-in and sibling add-on appointments are not accepted. We want to take care of your child's illness; however, it is unfair to ask our patients who have a scheduled appointment to wait while someone without a pre-scheduled appointment is seen. If you feel that your child cannot wait to be seen, ask to speak to a triage nurse for evaluation and they will make a recommendation.

Visits: The provider is required to code the visit based on all care provided and if a preexisting problem is addressed in the process of performing a Well Child Check and the problem is significant enough to require additional work (either during the visit or after), additional billing for the problem visit may occur. With this in mind, while the appointment may have been scheduled for a Well Child Check or just for a problem(s), if both types of services are provided during the exam then both types of services may be billed.

Laboratory Fees: You will receive a separate laboratory fee for outside lab services. Any lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go to a contracted lab. Desert Valley Pediatrics is not affiliated with any labs.

Circumcisions: Circumcisions are elective and some insurances do NOT cover this procedure. Full payment is due at the time of service if it is not a covered benefit.

Return Check Fees: There is a $35 fee for any checks returned by the bank. Non-Sufficient Funds checks must be paid in full with certified funds (money order, certified check, or cash). You will no longer be able to make payments on your account with a check. Instead, future payments will need to be cash, credit card or money order only.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt from you. You will receive several statements with letters and a final phone call in an attempt to collect. If we have to refer your account to a collection agency, there will be at $25 surcharge fee imposed on your account and you agree to pay all of the collection costs which are incurred.

Divorce/Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings the child in for medical treatment responsible for payment at time of service.

Privacy Consent: We are concerned with protecting your privacy. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

By signing the form provided, you consent to our use and disclosure of protected health information about your child for treatment, payment, and healthcare operations as described in our Notice. The Practice may condition receipt of treatment on this consent.

You have the right to request, in writing, that we restrict disclosure of health information about your child. We are not required to agree to this restriction but if we do, we will honor our agreement.

By signing this acknowledgement, you agree to DVP's Privacy Policy as well as acknowledge the receipt of the Health Current's Notice of Health Information practices.

You understand that this consent will remain in force from the time forward and that it may be revoked by providing written notice.

I have read and understand DVP's Financial and Office Polices and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by DVP. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name and DOB: ____

Responsible Party Name (Please Print): ____

Your signature: _______________________________________ Date: ______________________

Consent to Treat

Date: _________
(Valid for 1 calendar year, must be updated every year)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _______________________________________, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to:

- **Treatments**
- **Vaccines**
- **Referrals**
- **Medical Records**
- **All medical history pertaining to my child**

______ **Initials**

Please list person(s) here	**Relationship**
_____________________________________	__________________________________
_____________________________________	__________________________________
_____________________________________	__________________________________

<u>Consent to leave voicemail</u>

I am granting permission Desert Valley Pediatrics to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.
_____ **Initials**

Parent/Guardian Signature Date