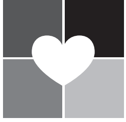


ST. ROSE
PEDIATRICS

St. Rose Pediatrics

It is a policy and requirement for this office to obtain social security numbers from the parents or individuals responsible for the child(ren). If you do not wish to provide us with your social security number, you will need to pay for the visit and will be reimbursed once your insurance company pays the claim. This policy is not negotiable. Thank you for your cooperation.

______________________	______________________
Child Name	Child Date of Birth
______________________	______________________
Parent/Legal Guardian Signature	Date

Child:

Last Name		First Name		MI
D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White
Mailing Address Street		City	State	Zip
Home Phone (________) ________ - ____________		Who lives at this household?		

Siblings: DOB:

(1)____ ________________

(2)____ ________________

(3)____ ________________

(4)____ ________________

(5)____ ________________

(6)____ ________________

(7)____ ________________

(8)____ ________________

Parent / Guardian (PG1)#1:

Last Name		First Name		MI
D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White
Social Security # ____ - ___ - ______	Lives with Patient (circle) Y N	Relation to Patient		
Home Address Street		City	State	Zip
Home Phone (________) ________ - ____________	Work Phone (________) ________ - ____________	Cell Phone (________) ________ - ____________		
Home Email		Work Email		
Employer		Occupation		

Parent / Guardian (PG2)#2:

Last Name		First Name		MI
D.O.B ____/____/______	Sex (circle) M F	Primary Language	Ethnicity (circle) Hispanic Non-Hispanic Unknown	Race (circle) Asian Black Hawaiian White
Social Security # ____ - ___ - _____	Lives with Patient (circle) Y N	Relation to Patient		
Home Address Street		City	State	Zip
Home Phone (________) ________ - ____________	Work Phone (________) ________ - ____________	Cell Phone (________) ________ - ____________		
Home Email		Work Email		
Employer		Occupation		

How would you ideally prefer to be contacted regarding (Place "x" in box):

	Home Phone		Work Phone		Cell Phone		Home Email		Work Email		Home Address	
	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2	PG1	PG2
Medical Issues												
Appointment Reminders												
Recall Notices												
Billing Statements												
General Practice Notices												
Patient Portal Notifications												

NPP-2 10/19

Signature ______________________________ **Date**________________

Insurance

Primary Policy

Policy Holder's Name		
D.O.B ______/______/_________	Sex (circle) Male Female	Social Security # ________ - ______ - ________
Insurance Carrier		
ID#	Group #	

Secondary Policy

Policy Holder's Name		
D.O.B ______/______/_________	Sex (circle) Male Female	Social Security # ________ - ______ - ________
Insurance Carrier		
ID#	Group #	

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No / __________

If parents are divorced or separated; fill out this section:

Who has custody? ____

Are there any legal restrictions that restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?

Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

____

____

Emergency Contacts, other than parents**:**

Contact #1: ____ Relationship: ______________________

Phone: (_____) ______ - _________

Contact #2: ____ Relationship: ______________________

Phone: (_____) ______ - _________

Pharmacy Information

Name: ____ Phone: (_____) ______ - _________

Address: ____ City:___________________________

State:_____________________ Zip Code:______________

Signature ____ **Date**_____________________

PLEASE COMPLETE ALL THE INFORMATION SO WE CAN BILL YOUR INSURANCE

I here by authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to *St Rose Pediatrics* and I understand that I am responsible for charges for medical services rendered to the above-named patient regardless of insurance coverage, including amount not limited to, any and all immunizations.

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION REGARDING MY CHILD OR MYSELF AS DESCRIBED BELOW FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).

Patient Name____
(Nombre paciente)

Patient DOB____
(Paciente fecha del nacimiento)

A. Person(s), Organization(s) authorized to Provide, Use or Disclose the information, i.e, Family Members, Physicians or Others Person(s), Organization(s) authorized to Receive the information, i.e. Schools, Daycare Centers of Others

1. ____

2. ____

3. ____

4. ____

5. ____

B. Specific description of the information, i,e,, Lab, X-ray and/or all Medical Records. ______________________________

____

____

C. This authorization will expire on __________________________ (leave open or enter a date)

I authorize that I may revoke this authorization at any time by notifying *St. Rose Pediatrics*. I understand that I can refuse to sign the authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits_________ . I may inspect a copy of any information used or disclosed under the agreement and I have the right to receive a copy of this form. I understand that if the person or organization that receives the information is not a health care provider by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. I understand that this form does not constitute legal advice and covers only federal, not state, law.

Signature of Patient or Patient's Representative ______________________ Date ______________________

Print Name Above ______________________ Relationship to Patient ______________________

FINANCIAL RESPONSIBILITY

Patient ____ Birth Date ___________________________________

I understand that I am financially responsible for any balance not covered by my insurance carrier, including immunization and well care, co-pays, and all amounts applied to deductibles, or insurance claims that are not paid within 60 days of the date of service.

____ ____

Parent / Guarantor of Patient Signature Date

I authorize the release of any medical information to my insurance company necessary for processing of the claim.

____ ____

Parent / Guarantor of Patient Signature Date

I authorize payment of medical benefits to the treating physician for services provided directly from my insurance carrier.

____ ____

Parent / Guarantor of Patient Signature Date

FINANCIAL POLICY

Thank you for choosing us as your health care provider for your child. Our main concern is that your child receives the proper medical care needed to maintain his or her health. If you have any questions, please do not hesitate to ask our staff and/or doctors.

All co-pays and deductibles are due at the time of your visit. Payment for services for cash visits are due IN FULL at the time of visit. We accept cash, checks, Visa and Mastercard. For those with temporary hardships, we have payment options we can offer.

We will submit insurance claim on your behalf if we have a provider contract with your insurance company. However, it is your responsibility to follow-up with your insurance company in the event that your claim is unpaid. If your insurance company changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately.

PLEASE READ THE FOLLOWING CAREFULLY:

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
2. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.
3. If you have Managed Care insurance, please make sure you have contacted them and named us as your primary care physicians or you will be responsible for payment of services.
4. Our office bills are for doctor services only. Fees for lab work or cultures are billed separately by the appropriate lab.
5. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collections and court costs.
6. Returned checks will be subject to a $30 fee.

We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any problems so that we can assist you in the management of your account.

____ ____

Parent / Guardian Signature Date

COLLECTION POLICY

Patient Name: ____

I, ____, hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Returned checks: A $30.00 Non-Sufficient Fund fee will be charged for checks initially returned unpaid by your bank. If the same check returned unpaid a second time, it may be referred to collection service for recovery.

____ ____

Parent Signature or Responsible Party Date

____ ____

Witness Signature Date

ROUTINE or EMERGENCY CONSENT for TREATMENT

Patient / Child ____ Birth Date _________________________

Address: ____

Allergies: ____

Last Tetanus: ____

Please list current medications, pertinent medical information or problems:

____

____

____

In the event of an accident or illness to my child/dependent ______________________________________

I hereby authorize ____

(any person other than biological parents or legal guardian, i.e., friend, nanny, etc.)

to secure any medical aid and/or treatment from St. Rose Pediatrics or the nearest hospital or clinic.

Furthermore, I agree to be directly responsible for all costs and expenses connected with the examination, diagnosis and medical treatment for my child/dependent.

____ _________________________________

Parent / Guardian Signature Date

____ _________________________________

Parent / Guardian (Printed Name) Date

This form is valid for one year from date of signature

PARENT INTAKE FORM

Your Child's Name ____ Date of Birth ____________________

Where was your child delivered? ________________________________ No. of Pregnancies ___________

Delivery Problems? ____

No. of Deliveries ____________ Miscarriages ___________ Abortions ___________ Deaths ___________

Prenatal Care _____Yes _____No Any Problems? ____

Childhood Illnesses ____

Family History ____

State of Nevada Minor Laws

Unemancipated Minor Consent in Nevada: In Nevada, it is clear that unemancipated minors acting alone and without the consent of their parents or guardians can give consent to treatment for the following:

1. Contraception advice, devices for supplies from a federally-funded program.
2. Treatment of a communicable disease, including HIV, AIDs, and STDs.
3. Treatment for the abuse of a controlled substance, where the minor is, or is suspected to be under the influence of a controlled substance.

Further, certain categories of minors can give consent to their health care treatment of any type, except for sterilization (and if under 18, for breast implant.) To give consent, the minor must understand the nature and purpose of the proposed examination or treatment and its probable outcome and voluntarily request it. Those categories are:

A. Minors living apart from parents or legal guardian, with or without their consent, for more than 4 months.
B. Minors who are married or have been married.
C. A minor who is a mother, or has born a child. This includes a woman in first-time pregnancy before birth. Women in this category may also consent to care of their child/children and may consent to pregnancy testing.
D. A minor, who in the physician's judgement, is in danger of suffering a serious health hazard if health care services are not provided.

I hereby authorize St. Rose Pediatrics to use or disclose mine (if 18 years or older) or my child's (if 17 years or younger) personal information to the above mentioned people for the purpose of my care or payment relating to my care. This information may also be used for the purpose of notifying the responsible parties of my location and/or conditions.

______________________________ _______________
Parent/Guardian Signature Date

______________________________ _______________
Parent/Guardian Signature Date

______________________________ _______________
Patient Signature (if over 18 years old) Date

USING & DISCLOSING PROTECTED HEALTH INFORMATION

As per HIPAA regulations, St. Rose Pediatrics must provide with the parents of

____

Patients Name (If Patient is 17 Years or Younger)

Or the Patient ____

Patient name (18 Years or Older)

an opportunity to agree or disagree to the use or disclosure of patient health information to a Patient's family member, friend or acquaintances involved in their care.

This form will serve as a written agreement between Parent/Patients and St. Rose Pediatrics.

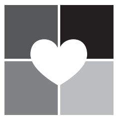
CONFIDENTIAL VOICE MAIL #: ___________________________

PLEASE BE AWARE THAT ANY AND ALL TEST RESULTS & MEDICAL INFORMATION MAY BE LEFT AT THIS NUMBER YOU HAVE LISTED.

You may also leave medical information with those designated by the Parent/Patient as having direct involvement in the Patient's care.

Name	Phone #	Relationship to Patient
____________________________	_________________	________________________
____________________________	_________________	________________________

Date: ________________________



ST. ROSE
PEDIATRICS

HIPAA Notice of Privacy Practices

______________________________ ______________________

Patient Name Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your child's protected health information. Protected Health Information is information about your child, including demographic information that may identify your child and that relates to your child's past, present or future physical or mental health or condtion and related health care services.

Uses and Disclosure of Protected Health Information

Your child's protected health information may be used and disclosed by their physician, our office staff and other's outside of our practice that are involved in your child's care and treatment for the purpose of providing health care services to your child to pay their health care bills to support the operation of the provider's practice and any other use required by law.

Treatment: We will use and disclose your child's protected health information to provide, coordinate, or manage their health care and any related services. This includes the coordination or management of your child's health care with a third party. For example, we would disclose your child's protected health information, as necessary, to a home health agency that provides your child care. For example, your child's protected health information may be provided to a provider to whom your child has been referred to ensure that the provider has the necessary information to diagnose or treat your child.

Payment: Your child's protected health information will be used, as needed, to obtain payment for your child's health care services. For example, obtaining approval for a hospital stay may require that your child's relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your child's protected health information in order to support the business activities of your child's provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student and licensing. For example, we may disclose your child's protected health information to medical school students that see patients in our practice. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your child's name and indicate your child's provider. We will also call your child's name in the waiting room when your provider is ready to see you. We may use or disclose your child's protected health information, as necessary, to contact you to remind you of your child's appointment.

We may use or disclose your child's protected health information in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as Required by Law, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Research, Criminal Activity and Required Uses and Disclosures Under the Law.

Parent/Guardian may revoke this authorization at any time in writing, except to the extent that your child's provider or the provider's practice has taken an action in reliance or disclosure indicated in the authorization.

Henderson Office: 2350 W. Horizon Ridge Parkway | Henderson, NV 89052
San Martin Office: 6980 S. Cimarron Road | Suite 100 | Las Vegas, NV 89052
Summerlin Office: 8980 W. Cheyenne Ave. | Las Vegas, NV 89129

P: (702) 564-8556
F: (702) 564-4485
www.StRosePeds.com

Other Permitted and Required Uses and Disclosures will be made only with the parent/guardian consent, authorization or opportunity to object unless required by law.

Parents/Guardian Rights: The following is a statement of your rights with respect to your child's protected health information.

You have the right to inspect and copy your child's protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your child's protected health information. This means you may ask us not to use or disclose any part of your child's protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your child's protected health information not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in the Notice of Privacy Practices. Your request may state the specific restriction requested and to whom you want the restriction to apply.

Your child's provider is not required to agree to a restriction that you may request. If the child's provider believes it is in the child's best interest to permit use and disclosure of your child's protected health information, your protection will not be restricted. You then have the right to use another Healthcare Professional for your child.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, (i.e. electronically).

You have the right to receive an accounting of certain disclosures we have made, if any, of your child's protected health information.

We reserve the right to change the terms of this notice and will inform you by mail or next appointment, whichever comes first, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your child's privacy rights have been violated by us. You may file a complain with us by notifying our management of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before August 1, 2014

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with one of our management personnel in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

______________________________	______________________________
Patient Name	Date of Birth
______________________________	______________________________
Parent/Guardian	Date
______________________________	______________________________
Parent/Guardian	Date