Welcome to Sapphire Pediatrics!

To better serve you, please fill out the following paperwork completely.

Patient Information:

Today's Date: ______________

Name (First, Middle, Last)			Male Female
Date of Birth		Hospital where child was born	
Address			
City	State		Zip
Home Phone		Other Phone A	
Preferred Pharmacy (Please specify cross streets)			

Siblings

Name/DOB	Name/DOB
Name/DOB	Name/DOB

Mother/Guardian Information:

Name (First, Middle, Last)			Male Female
Date of Birth		Social Security	
Address			
City	State		Zip
Home Phone		Other Phone	
Employer		Employer Phone	
E-mail address:			

Father/Guardian Information:

Name (First, Middle, Last)			Male Female
Date of Birth		Social Security	
Address			
City	State		Zip
Home Phone		Other Phone	
Employer		Employer Phone	

Person to contact in case of an emergency: (someone who does not live in your home)

Name		Relationship to patient
Address		
City	State	Zip
Home Phone	Work Phone	Other Phone

Insurance Information

Primary Insurance Company		Co-Pay
Claims Address		
Insured's Name	Social Security #	
Employer	Employer Address	
ID/Policy Number	Group #	

Race/Ethnicity

	White – Non-Hispanic	
	Hispanic	
	African American	
	Native American	
	Asian/other	Language

HIPPA Consent: (if you did receive a copy of our privacy practices, please ask the front desk)

I, ____________________________________, Guardian for this patient have received a copy of Sapphire Pediatrics notice of privacy practices. I understand that if I have any questions about HIPAA or my child's privacy, I may contact the office manager.

Telephone/E-mail Consent:

By providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails; using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Providing your phone number(s) is not a condition of receiving our services. I/We have read this disclosure and agree that we may be contacted as described above.

____________________ ____________________

Signature Date

Consent and Disclosure:

I hereby voluntary agree to diagnostic procedure and medical and surgical treatment which may be administered to or performed on the patient under the general or special instructions of the attending practitioner's care and service of the practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at this office. I understand that my physician encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care.

*also, get an extended copy of our privacy practices, available upon request.

* we will also need an authorized release form if any other person besides the parent or guardian should bring this child in for care.

______________________________ ______________________________

Guardian Signature Relationship to Child

____

Date

Patient Name: ____DOB:__________________________

Sapphire Pediatrics is a pediatric MEDICAL HOME, that is:

- **Accessible:** Families can easily reach us or a nurse advice line 24/7. Families know how to contact us, which insurance plans are accepted and that we give a 20% discount to our uninsured patients to be paid at the time of service.
- **Family Centered:** Families are recognized as the principal caregivers and centers of strength, knowledge and support for the children. Our families' voices are valued.
- **Continuous:** A team of healthcare professionals are available from infancy through adolescence and help transition young adults into the healthcare system.
- **Comprehensive:** The child's medical, educational, developmental and psychological needs are identified and addressed including limited dental care and *behavioral health services.
- **Coordinated:** A plan of care is developed with the healthcare provider, child and family and is shared with other involved providers, agencies and organizations that work with the child and family.
- **Compassionate:** We make efforts to understand and empathize with the feelings and perspectives of both the child and the family. We strive to help families be comfortable, satisfied participants in their healthcare.
- **Culturally responsive:** The child and family's cultural background including beliefs, rituals and customs are recognized and incorporated into care planning.

I HAVE READ THE ABOVE INFORMATION AND GIVE SAPPHIRE PEDIATRICS CONSENT TO TREAT

Signature: ____

Relationship to patient: _______________________

Date: ____________________

Sapphire Pediatrics
Notice of Privacy Practices

-This notice describes how your child's health information may be used and disclosed and how you can access this information. Please review it carefully.
-At Sapphire Pediatrics, we have always kept your child's health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
-The law permits us to use and disclose your child's health information to those involved in your treatment. For example, a specialist doctor whom we may involve in your care may review your file.
-We may use or disclose your child's health information for payment of your services. For example, we may send a report of your child's progress to your insurance company.
-We may use and disclose your child's health information for our normal healthcare operations. For example, one of our staff will enter you information into our computer.
-We may share your child's health information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
-We may use your information to contact you. For example we may send you test results or other health information.
-In an emergency, we may disclose your child's health information to family members or other persons responsible for your child's care.
-We may release some or all of your child's health information when required by law.
-If the practice is sold, your child's information will become the property of the new owner.
-Except as described above, this practice will not use or disclose your child's health information without you written prior consent.
-You request in writing that we not use or disclose your child's health information as described above. We will let you know if we can fulfill your request.
-You have the right to know how your child's health information is being disclosed.
-As we may need to contact you from time to time, we will use any numbers and addresses that you would like us to.
-You have the right to transfer copies of your child's health information to another practice.
-You have the right to see and receive a copy of your child's health information, with few exceptions. Give us a written request regarding the information that you wish to see and will do our best to get the information that you are requesting within 3-5 business.
-You have the right to request an amendment or change to your child's health information, please give us a written request. We may not make the requested changes, but we will keep a copy of your request in your child's file.
-You have a right to receive a copy of this notice.
-If we change any of the details of this notice we will notify you in writing.
-You have the right to file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., room 509F, Washington DC 20201.
-However, before filing a complaint, or for further information regarding your child's health information please contact our Privacy Officer – Andrea Norman at 720-941-1778.
-This notice goes into effect April 14, 2003.

Acknowledgement:

I have received a copy of the Sapphire Pediatrics notice of privacy practice.

Signed______________________________ Print name_____________________ Date_______

Please indicate the patient's name______________________________________

Financial Policy for SAPPHIRE PEDIATRICS

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Health First Colorado (Medicaid)and all other insurance benefits be made on my behalf to SAPPHIRE PEDIATRICS for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits for payable for related services.

GUARANTEE OF PAYMENT

<u>Our practice requires that you place a credit card on file to resolve any remaining balances after treatment.</u> If my insurance has a contract with SAPPHIRE PEDIATRICS, I am not responsible for amounts that are agreed to be written off. If my insurance does not have a contract with SAPPHIRE PEDIATRICS, I agree to be responsible for any amounts not paid by my insurance plan. My credit card on file will be used for these types of payments. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

ADDITIONAL CHARGES

- No Show Charge of $50, if not notified within 24 hours prior to your appointment.
- Cancelation Charge of $50, if not notified within 24 hours prior to your appointment.

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the practice's financial policy and agree to the terms of payment due.

______________________________ Patient's Name Printed	______________________________ Patient's Date of Birth
______________________________ Responsible Party's Signature	______________________________ Relationship to Patient
______________________________ Date	

Authorization for Credit Card on File Payment for SAPPHIRE PEDIATRICS

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is swiped into the ePay system for the first time.

AUTHORIZATION

Until further notice, I authorize SAPPHIRE PEDIATRICS to charge the patient-responsible balances on my account, including old balances, co-pays, co-insurance, deductibles, and non-covered services, to the following credit card:

Circle One:

- VISA
- MASTERCARD
- DISCOVER
- AMERICAN EXPRESS

Last 4 digits of my credit card: . ______ ______ ______ ______

Exp. Date (mm/yy): __________

I understand that once my insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that SAPPHIRE PEDIATRICS may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $200, I will receive a courtesy call prior to my card being charged at which time I can agree to pay in full or set up a payment plan for the balance.

Charge for the following family members:

________________________________ ________________________________

(authorized family member) (authorized family member)

________________________________ ________________________________

(authorized family member) (authorized family member)

Cardholder Information:

Cardholder Name: ____

Cardholder Signature: ____

Date: ____________________

❖ PLEASE PROVIDE YOUR CARD TO THE FRONT DESK STAFF TO SCAN TO INITIATE CREDIT CARD ON FILE!

Patient Notification Document

Sapphire Pediatrics endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

I understand and agree with the sharing of mine/my child's PHI information to the CORHIO HIE

YES **NO**

__________________________________ _________________________

Signature Date

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Relation to patient

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Missed Appointment and Cancelation Policy

Our goal is to provide quality medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed/canceled appointments.

Cancellation of an Appointment

We are committed to starting your child's appointment promptly and giving them the special time and attention they deserve. In that spirit, and out of consideration for all of our patients, we ask that you call us and kindly provide at least 24-hours' notice if you must reschedule your child's appointment.

This time will be reallocated to someone who is in need of an appointment. Appointments are in high demand, and your early cancellation will allow us to schedule another patient appointment in your time slot.

To cancel your appointment, please call our office at 720-941-1778.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice.

No Show: A "no-show", is a patient who misses an appointment without cancelling it.

For ALL "no-show" or late cancellations there will be a charge of $50.00 assessed.

After the 3rd occurrence the patient may be discharged from the practice.

All "no show" or late cancellationS will result in a charge to the credit card on file.

For late arrivals, we will consider whether enough time remains in your scheduled appointment to provide the necessary treatment. If not, we will schedule another appointment for you at your earliest convenience.

Thank you for your understanding!