PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE **Date Completed:_____**

Patient Name: _____ Date of Birth: _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS FAMILY CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

PAST MEDICAL HISTORY:

[ ] Skin Problems [ ] Frequent Ear Infections [ ] Abdominal Pain [ ] Foot or Leg Problems
[ ] Headaches [ ] Frequent Colds [ ] Excessive Colic [ ] Joint/bone pain [ ] Hearing Problems
[ ] Head Injuries [ ] Neck Lumps [ ] Nausea/Vomiting [ ] Weakness [ ] Feeding Problems
[ ] Loss of Consciousness [ ] Cough [ ] Diarrhea [ ] Seizures [ ] Skin rashes
[ ] Visual Problems [ ] Wheezing [ ] Constipation [ ] Sleeping Problems [ ] Depression
[ ] Sinus Problems [ ] Shortness of Breath [ ] Change in Bowels [ ] Nervousness/anxiety
[ ] Nose Bleeds [ ] Chest Pain [ ] Burning with Urination [ ] Problems in School
[ ] Seasonal Allergies [ ] Heart Murmurs [ ] Blood In urine [ ] Other-_____
[ ] Food allergies -_____
[ ] Major illness-_____

Has the patient been seen by any specialists? □Yes □ No
Name and when:_____
Name and when:_____

CURRENT AND PAST MEDICATIONS:

Please list all medications patient is taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/inhalers.

Drug Name: Strength: Frequency Taken: Stopped Taking:
1._____
2._____
3._____
Are you allergic to any medications? □Yes □ No Which One:_____

PAST SURGICAL HISTORY:

Surgery: Year:
1. _____ _____
2. _____ _____

LIST FAMILY HEALTH HISTORY:

Family Member: Disease(s)/Illness:
Mother _____
Father _____
Maternal Grandmother _____
Maternal Grandfather _____
Paternal Grandmother _____
Paternal Grandfather _____
Sibling (Circle): Brother / Sister _____
Sibling (Circle): Brother / Sister _____

Anthem Hills Pediatrics

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Patient Name / *Nombre del paciente* _____ ☐ Male / *Masculino* ☐ Female / *Femenino*

Birth Date / *Fecha de nacimiento* _____ Child's SSN / *Niños sociales* _____

Phone / *Teléfono* _____ Other Children in Family / *Otros niños en la familia* _____

	Father / Padre	**Mother / Madre**
Name *Nombre*		
Birth Date *Fecha de nacimiento*		
Telephone *Teléfono*	Home Work	Home Work
	Cellular Pager	Cellular Pager
Address *La Dirección*		
City/State/Zip Code *Ciudad/Estado/ Codigo postal*		
Soc Sec Number *Numero de seguro social*		
Occupation *Ocupación*		
Employer *Empleador*		
Employer Address *Dirección de Empleador*		
City/State/Zip Code *Ciudad/Estado/ Codigo postal*		

Referred By

☐ *Friend* ☐ *Internet* ☐ *OB/GYN* _____ (please provide physician/office name)

☐ *Insurance Provider Book* ☐ *Hospital* _____ (please specify) ☐ *Other* _____ (please specify)

Preferred Language _____ ☐ *Declined to Provide*

Race

☐ *American Indian or Alaskan Native* ☐ *Black/African American* ☐ *White*

☐ *Asian* ☐ *Native Hawaiian or Other Pacific Islander* ☐ *Declined to Provide*

Ethnicity _____ ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐ *Declined to Provide*

Email Address / Email Dirección _____

Emergency Contact, other than parents**:**

Contact Name: _____ Relationship: _____

Phone: (_____) _____ - _____

Pharmacy Information

Name: _____ Phone: (_____) _____ - _____

Address: _____ City:_____

State:_____ Zip Code:_____

Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? 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, you must provide a copy of any legal paperwork that supports this restriction.

Well Check/Preventative Care Visits

Due to new insurance guidelines, preventative care and well check visits may not require you to have a copayment. However, if the Physician finds an illness, issue, disease, or you address an issue during the normal routine care exam Anthem Hills Pediatrics providers may bill an additional lower level office exam. Depending on your insurance this may generate a copayment.

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 Anthem Hills 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 _____

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have reveived a copy of Anthem Hills Pediatrics Patients Rights and Responsibilities

_____ _____

Parent / Guardian Signature Date

PLEASE COMPLETE ALL THE INFORMATION SO WE CAN BILL YOUR INSURANCE

	Primary Insurance	Secondary Insurance
Name *Nombre*		
Address *Dirección*		
City/State/Zip Code *Ciudad/Estado/ Codigo postal*		
Policy & Group # *Política y número del grupo*		
Telephone *Teléfono*		
Policy Holder/DOB *(Poseedor de la política/DOB)*		
Policy Holder SS# *(Poseédor de la política SS#)*		
Policy Holder Relationship To Patient *(Relacion del poseedor de la política a paciente)*		

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to *Anthem Hills Pediatrics* and I understand that I am financially 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 del paciente)

Patient DOB_____
(Paciente fecha de 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 or Others

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

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 understand that I may revoke this authorization at any time by notifying *Anthem Hills 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, laws.

_____ _____
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. ☐Y ☐N

_____ _____
Parent / Guarantor of Patient Signature Date

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

_____ _____
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.
7. Failure to show up to an appointment and/or all visits not cancelled with at least 24 hours notice will be subject to a $35 cancellation/ no show fee. This applies to private insurance, self pay, and medicaid patients.
8. For internal labs or testing, I understand that if my insurance company does not cover Anthem Hills Pediatrics cost, I will be liable for any difference. I acknowledge that Anthem Hills Pediatrics will bill me the difference, not to exceed $35.00 per test.

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 returns unpaid a second time, it may be referred to collection service for recovery.

_____ _____
Parent Signature or Responsible Party Date

_____ _____
Witness Signature Date

Anthem Hills Pediatrics

ANTHEM HILLS PEDIATRICS

24 Hour Cancellation & "No Show" Fee Policy for Medicaid Patients, Self Pay and Private Insurance

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Anthem Hills Pediatrics reserves the right to charge a fee of $35.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Three (3) "no shows" in any 12 month period will result in termination from our practice. Please be aware that if you have other children in our practice, if one of the children gets terminated from the practice this will result in the siblings being terminated from the practice as well.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Patients Name- Printed Patients DOB

_____ _____

Parent/Guardians Printed Name **Date**

_____

Parent/Guardian Signature

Anthem Hills Pediatrics

(702) 566-2400

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices 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 protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

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

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

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your 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 protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, and conduction or arranging for other business activities, For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases. Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your 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 proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your 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 physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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 may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statements and will provide you with a copy of any such rebuttal.

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

We reserve the right to change the terms of this notice and will inform you by mail 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 privacy rights have been violated by us. You may file a complain with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with the respect to protected health information. If you have any objects to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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

Print Name:_____ Signature:_____ Date:_____

Patient Name:_____ Date of Birth:_____

Anthem Hills Pediatrics

Patients Rights and Responsibilities

Members Rights

Members have rights and associated responsibilities in the course of their health care services delivery. All contracted health plans have formal statements of member rights and responsibilities. The following represents some of the rights a member has:

1. Considerate, respectful, and compassionate care regardless of your age, race, gender, religion, national origin, sexual orientation, or physical or mental disability.
2. Privacy and confidentiality concerning your medical care and records.
3. Participate in making informed decisions about the plan of care before and during treatment, when medically possible. You may refuse a recommended treatment to the extent permitted by law, and will be informed of the medical consequences of your refusal.
4. Receive information about diagnosis, treatment and alternatives, indications for tests and procedures, risks and prognosis.
5. A copy of your medical records upon request. Please allow 72 working hours for us to process your request. There may be a fee associated with the release of your medical records.
6. Obtain information regarding pain management.
7. Assistance from a sign language translator. Patients requiring other translation assistance are asked to bring an interpreter with them to the appointment.
8. Health care services provided in a safe environment.
9. Know the identity and professional status of individuals providing services to you.

Patient Responsibilities

As a patient, you and or/your representatives are expected to:

- Know your health insurance coverage and related policies concerning required pre-approvals, co-pays covered services, hospitals, physicians and providers covered by your insurance plan.

1. Pay your clinic bills in a timely manner.
2. Provide complete and accurate information including your full name, address, home telephone number, date of birth, social security number, current insurance carrier and care, and employer when it is necessary.
3. Bring your health insurance identification card to each appointment.
4. Keep appointments, be on time for your appointments, or call as soon as possible (24 hours prior) if you cannot keep appointments.
5. Ask questions if you do not understand what your physician or other member of your health care teams informs you about your diagnosis or treatment.
6. Notify your physician, provider or nurse/medical assistant of any problems or concerns about your prescribed treatment or medications.
7. Provide complete and accurate information about your health. Including present condition, past illnesses, hospitalizations, medications, natural products and vitamin use, and any other matters that pertain to your health.
8. Follow the treatment plan, which has been developed and agreed upon by the health care provider and treatment goals to the highest degree possible.
9. Respect the rights, property and environment of all physicians, staff and patients of Anthem Hills Pediatrics.