Keirn Family Health and Pediatrics
1470 E Caluada Blvd #100
Pahrump, NV 89048
P: (775) 990-1140 F: (775) 990-1149

New Patient Registration- Pediatrics

Legal Name: _____ Date of Birth _____

Preferred Name if different: _____ Gender: _____

Race: ___ American Indian ___ Asian/Pacific Islander ____ African American ____ European/Caucasian ___Other

Ethnicity: ___ Hispanic ___ Non-Hispanic ____ Prefer not to answer

Email Address: _____

Mailing Address: _____
City: _____ State _____ Zip Code: _____

Mother/Legal Guardian 1:

Name: _____ Date of Birth: _____

Phone Number: _____ Employer: _____ Work Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Father/Legal Guardian 2:

Name: _____ Date of Birth: _____

Phone Number: _____ Employer: _____ Work Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

I also authorize the following individuals to bring my child to their appointments if I am unable to do so:

_____ _____

_____ _____

I understand that I can add additional individuals in the future so as long as I submit it in writing with a copy of my picture identification.

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Do you authorize the Keirn Family Health and Pediatrics to obtain your medication and immunization history from various state databases? _____ Yes _____ No

Emergency Contact (NOT PARENT/GUARDIANS)

Name: _____

Phone Number: _____ Relationship to patient: _____

Responsible Party

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone number: _____

Primary Insurance:

Policy Holder: _____ Date of Birth: _____

Relationship to patient: _____ Insurance Carrier: _____

Group Number: _____ Member ID: _____

Insurance Phone Number: _____ Claims Address: _____

Secondary Insurance: _____ N/A

Policy Holder: _____ Date of Birth: _____

Relationship to patient: _____ Insurance Carrier: _____

Group Number: _____ Member ID: _____

Insurance Phone Number: _____ Claims Address: _____

I agree that this form is complete and accurate to the best of my knowledge.

Patient/Responsible Party: _____ Date: _____

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Financial Policy

I _____ understand that I am financially responsible for any out-of-pocket expenses accrued as a result of the healthcare received from Keirn Family Health and Pediatrics. This includes, but is not limited to, copays, deductibles, and any out-of-pocket expenses not covered by health insurance. I understand that should I lose health insurance coverage for myself, or any minors seen for healthcare at Keirn Family Health and Pediatrics, I will be able to continue receiving medical care on a self-pay basis. I also understand that any self-pay charges will be discussed prior to receiving said healthcare service and I will have the option to accept or decline as discussed with my healthcare provider and/or the billing management team.

I also understand that by signing this form I agree to the cancellation and no-show policy. This policy states that any same day cancellation and/or no show for any scheduled appointment will incur a $25 fee per occurrence. This does not apply to any rescheduling or cancellation of appointments that may occur as a result of Keirn Family Health and Pediatrics needing to reschedule.

In addition, I understand that any financial obligations owed to third parties such as lab centers and imaging is not directly affiliated with Keirn Family Health and Pediatrics and will require reconciliation and resolution with said third party.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

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Keirn Family Health and Pediatrics

Notice of Privacy Practices- HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law that sets forth how and when covered entities can use protected health information. In addition, this law also sets forth penalties and fines for breaches of HIPAA covered entities. These entities include direct care providers such as physicians, nurses, dentists, psychiatrists, and other healthcare providers, facilities engaging in healthcare activities, health insurance companies and clearinghouses, and third part businesses such as billing services.

Protected health information includes but is not limited to patient identification such as full name, address, and social security number, medical lab results such as imaging and laboratory testing, and ongoing or past medical diagnoses.

Protected health information can be shared without the expressed consent of the patient or legal guardian in instances involving direct care and or continuation of care as well as billing matters. This includes direct referrals from the covered entity and insurance claims for reimbursement purposes. Beyond this limitation, it is required for the covered entity to receive written consent by the patient or legal guardian if a minor to allow transmission of protected health information.

In compliance with HIPAA, this practice also complies with electronic charting systems as required by federal law, secure messaging with other providers directly involved in patient care, and HIPAA compliant telehealth utilizing a zoom interface integrated in the electronic charting system.

As a patient, HIPAA also sets forth the precedence of the patient right to their own medical record. At any time can a patient request a copy of their medical records as well as request an addendum to said record if indicated. Patients have the right to limit who is authorized to receive protected health information in the form of direct patient contacts such as relatives and close friends.

This notice shall be posted within the medical office setting at all times and is available upon request. If there are any concerns about a violation of the privacy act there shall be no retaliation towards the patient regardless of how the complaint is received whether internally with the Privacy Officer or with the Office of Civil Rights. If any amendments are made to this notice of privacy act, all changes will be expressed in written form and require updated signatures to notify receipt of said changes. By signing below, you acknowledge that you have received this notice of Privacy Practices and have had the opportunity to review it thoroughly as well as have any questions or concerns answered.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

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Appointment Reminders

Please indicate your preference by signing this form and providing the phone number/email you would want to be notified through to remind you of your appointment.

Please provide the phone number/email in the designated space.

Email Address: _____

Cell Phone: _____

Home Phone: _____

Would you like to receive appointment reminders through text message: Yes or No

Would you like to receive appointment reminders through phone call: Yes or No

Would you like to receive appointment reminders through email: Yes or No

By confirming your signature, you accept our appointment reminder system and acknowledge that we won't be liable for any payments expenses that your service provider bears.

Signature: _____ Date: _____

Print Name: _____

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Permission for Release of Medical Records

Patient Name:_____ Date of Birth_____

Home Address:_____

City: _____ State: _____ Zip Code:_____

Cellphone:_____ Alternate Phone:_____

Information to Be Disclosed:

___ Physician Notes and full medical record

___ Imaging results

___ Lab reports

___ Immunization records

Information to be released from:

Facility Name:_____

Name of Provider: _____

Address:_____

Fax: _____ Phone _____

Information to be released to:

Facility Name: Keirn Family Health and Pediatrics

Name of Provider: Amanda Keirn

Address: 1470 E Calvada Blvd Suite 100 Pahrump, NV 89048

Fax: 775-491-1084 Phone: 775-990-1140

By signing below, I authorize the above records to be released to Keirn Family Health and Pediatrics.

Patient Name:_____ Date of Birth: _____

Parent/Guardian Name: _____ Signature_____