CHECK LIST FOR NEW PATIENT APPOINTMENT

PLEASE REMEMBER TO BRING:

- ☐ INSURANCE CARD (**YOU MUST BRING YOUR INSURANCE CARD TO VISIT**)
- ☐ PHOTO IDENTIFICATION FOR PARENT/LEGAL GUARDIAN
- ☐ COPAY
- ☐ **WELL CHILD APPOINTMENTS:** IMMUNIZATION RECORDS
- ☐ NEW PATIENT PAPERWORK (AVAILABLE ON OUR WEBSITE)
- ☐ LIST OF MEDICATIONS CHILD IS CURRENTLY TAKING
- ☐ LIST OF MEDICATIONS YOUR CHILD IS ALLERGIC TO
- ☐ NAME AND LOCATION OF PREFERRED PHARMACY
- ☐ **ADHD APPOINTMENTS:** PLEASE BRING MEDICATION BOTTLES
- ☐ PAST MEDICAL RECORDS/ER/URGENT CARE RECORDS (IF AVAILABLE)
- ☐ **FOSTER PARENTS:** NOTICE TO PROVIDER
- ☐ COURT DOCUMENTS (IF APPLICABLE)

Pediatrics of Queen Creek

22707 S. Ellsworth Rd. H101
Queen Creek, AZ 85142
Tel: 480-792-9200; Fax: 480-792-9206

PATIENT INFORMATION SHEET

Today's Date: ____/____/____

Patient Name_____ **DOB**_____
LAST FIRST MIDDLE

SEX: **Male** **Female** Patient Social Security Number_____

Patient lives with_____ Home/Cell Number_____

Address_____ City_____ State_____ Zip_____

E-mail_____

Preferred Pharmacy_____Location_____Phone_____

How did you hear about us?_____

MOTHER **STEP-MOTHER** **FOSTER-MOTHER** **LEGAL GUARDIAN** (Please circle one)

Name_____ DOB_____SSN_____

Home/Cell Number _____ Work Number_____

Marital Status _____Occupation_____Employer_____

FATHER **STEP-FATHER** **FOSTER-FATHER** **LEGAL GUARDIAN** (Please circle one)

Name_____ DOB_____SSN_____

Home/Cell Number _____ Work Number_____

Marital Status _____Occupation_____Employer_____

IF PATIENT LIVES AT TWO DIFFERENT ADDRESSES, PLEASE PROVIDE SECOND ADDRESS.

This address belongs to: (please circle one) MOTHER FATHER OTHER_____

Address_____ City_____ State_____ Zip_____

PRIMARY INSURANCE:

INSURANCE_____POLICY HOLDER_____

POLICY ID #_____GROUP #_____

CLAIMS ADDRESS_____PHONE_____

SECONDARY INSURANCE:

INSURANCE_____POLICY HOLDER_____

POLICY ID #_____GROUP #_____

CLAIMS ADDRESS_____PHONE_____

Emergency Contact (not living with you)_____Phone_____

Relationship to patient_____Address_____

Name of person completing this form_____ Relationship to Patient_____

Signature_____ **Date**_____

PEDIATRICS OF QUEEN CREEK PAYMENT POLICIES

CONSENT FOR TREATMENT

I HAVE READ AND UNDERSTAND THE PATIENT POLICIES AND AGREE TO ABIDE BY ITS GUIDELINES. I give permission to PEDIATRICS OF QUEEN CREEK to care for and treat my child. I understand my child cannot be treated without my presence unless I have given written consent to an adult OVER THE AGE OF 18 to seek such care or treatment.

_____ _____

SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PARTY **DATE**

_____ _____

PATIENT'S NAME (please print) **PATIENT'S DATE OF BIRTH**

Consent to voice messages regarding patient test results (Ex: "We are calling to inform you that your recent lab results came back negative.") No check here means that if you are not available to speak with, you must return the office's call in order to receive your results.

Check one: _____YES (Okay to leave voice messages) _____YES (Okay to communicate through the portal using email)
_____NO (**DO NOT** leave voice messages)) _____NO (**DO NOT** communicate through the portal using email)

In my absence the following adults OVER THE AGE OF 18 may seek medical attention for my minor child:

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN TO ACKNOWLEDGE YOUR UNDERSTANDING OF THE PROVIDED INFORMATION

1. **INSURANCE**: We participate in most insurance plans, including AHCCCS. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured with a plan we do business with but do not have an up-to-date insurance identification card, payment in full is required for each visit until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. **CO-PAYMENTS & DEDUCTIBLES**: ALL co-payments and deductibles must be paid at the time of service. Our office **WILL NOT** bill for any co-payments. Your payment is an arrangement which is part of your contract with your insurance company. We are not a party to that contract. Failure on our part to collect co-payments/deductibles can be considered fraudulent. Please help us in upholding the law by paying your co-payment/deductible at the time of visit. **In cases where deductible or co-insurance amount remain undisclosed until we receive your child's claim and invoice for their visit, Pediatrics of Queen Creek will then mail you a letter in which your patient balance due will be included. The balance of your child's account is expected to have been fully paid within 30-days from the date postmarked on your letter.

3. **NON-COVERED SERVICES**: Please be aware that some-and perhaps all-of the services you receive may not be covered or considered reasonable or necessary by AHCCCS or other insurance plans. If a claim has been denied by your insurance company for those reasons you will be responsible for full payment for these services.

4. **PROOF OF INSURANCE**: All patients MUST complete our patient information form before seeing the doctor. We must obtain a current valid insurance card in order to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us PRIOR to your child's next visit to assure that the appropriate changes will be made in order for you to receive your maximum benefits.

5. **CLAIMS SUBMISSION**: We submit your claims and assist in a reasonable way to ensure the payment of your child's visit. By signing below, you authorize PEDIATRICS OF QUEEN CREEK to submit your medical claims from visits at our office on the patient's behalf. I authorize release of my PROTECTED HEALTH INFORMATION required by insurance carriers for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. Your insurance company may require you to supply certain information directly. It is your responsibility to comply with their request. Please be aware the balance of your claim is your responsibility whether or not your insurance company pays your child's claim. Your insurance benefits are a contract between you and your insurance company; **we are not a party to that contract**.

6. **PRIVACY ACT**: I am aware of the **Notice of Privacy Practices** which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy Office. I understand that this authorization meets the needs of HIPPA (Health Insurance Portability and Accountability Act) guidelines set forth by the Federal government in regards to patient confidentiality.

7. **ACCOUNT BALANCES:** We require 50% of the total balance to be paid at the time of any appointment for any outstanding balance. Well child visits will be rescheduled for failure to pay the minimum payment amount of at least 50%. We offer payment plans, which must be arranged with our billing department PRIOR to your child's appointment. For any payments that are to be paid in the future we require a valid credit card to be kept on file with written authorization and instructions on how to discharge that debt owed.

8. **NON-PAYMENT**: If your account is over 60-days past-due, you will receive a letter stating that you have 15 days to pay your account in full, including a $25.00 late payment fee. Partial payments will no longer be accepted. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and you and your immediate family may be discharged from our practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. **MISSED / NO-SHOW APPOINTMENTS**: Our policy is to charge a fee of $25.00 for any/all missed appointment not cancelled within a reasonable amount of time. **(Our practice REQUIRES a 24-hour cancellation notice prior to your child's scheduled appointment – unless an emergency.)** These charges will be your responsibility and will be billed directly to you. For all patients, including those under AHCCCS insurance plans, your child will immediately be removed from our patient roster after 3 subsequent missed appointments –in which you will have 30 days to find alternative medical care.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank-you for understanding our patient payment policies. Please inform us if you have any questions or concerns.

Patient Questionnaire

Today's Date:

Patient's Name:_____DOB:

Name of Person Completing This form:_____ Relationship to patient:_____

Pediatrics of Queen Creek

Pregnancy and Birth

Mother's Age at Pregnancy?				Smoking, Alcohol, Drugs during Pregnancy?	Y		N
Any Illness During Pregnancy?	Y		N				
If yes, please explain illness:				If yes, please explain:			
Medications During Pregnancy (Exclude iron & vitamins)				How many weeks of pregnancy at delivery?			
				(Doctor use only: Synagis)			
				Type of Delivery:			
				Birth weight:		Length:	
Hospital/Place of Delivery				Complications?	Y		N
Problems At Birth?				If yes, please explain complications:			
Breathing	Y		N				
Jaundice	Y		N				
Other	Y		N				
Explain:							

Patient's Past Medical History

Drug Allergies?	Y		N	Are the patient's vaccinations up-to-date?	Y		N
If Yes Please List:				Please list any hospitalizations (include year and reason)			Year
Other Known Allergies (not drug related) Please list:							
List any serious injuries (include when/where)							
Heart Problems	Y		N	Recurrent Infections			
Lung/Respiratory Problems	Y		N	Eye	Y		N
Gastrointestinal Problems	Y		N	Ears/Nose/Throat	Y		N
Kidney/Bladder Problems	Y		N	Skin	Y		N
Muscle/Bone Problems	Y		N	Other	Y		N
Seizures/Neurological Problems	Y		N				
Psychiatric Issues	Y		N				
Anemia/Hematologic Problems	Y		N	If other, List:			
Endocrine (diabetes/thyroid)	Y		N	Vision Problems	Y		N

PLEASE FILL OUT BOTH QUESTIONNAIRE PAGES

Patient Questionnaire

Today's Date:

Patient's Name:_____DOB: _____

Name of Person Completing This form:_____ Relationship to patient:_____

Pediatrics of Queen Creek

Feeding and Nutrition

Food Allergies? Please List:					Appetite Good?	Y	N
					Feeding problems in first 3 months?	Y	N
					Vitamins?	Y	N
					Colic in the first 3 months?	Y	N
Breast Fed:	Y		N	# of Months Breasfeeding:			
Formula Fed:	Y		N	Formula Brand:			
Special Diet:	Y		N		If yes above, explain:		
Explain Special Diet:							

Family Profile

Mother's Name:		Age:		Highest School Grade:	
Father's Name:		Age:		Highest School Grade:	
Please list patient's siblings and ages:		Age:			
		Age:			
		Age:			
		Age:			

Family Medical History

Anemia/Blood Disorder	Y		N	Epilepsy/Seizures	Y		N
Asthma	Y		N	Heart Disease	Y		N
Mental Retardation	Y		N	Drug/Alcohol Problems	Y		N
High Blood Pressure	Y		N	Endocrine (Diabetes/Thyroid)	Y		N
Cholesterol Problems	Y		N	Migraines	Y		N
Cancer	Y		N	AIDS/HIV	Y		N
Sudden Infant Death Syndrome	Y		N	Birth Defects	Y		N
Cystic Fibrosis	Y		N	Muscular Dystrophy	Y		N
Tuberculosis	Y		N	Arthritis	Y		N
Depression	Y		N	Psychiatric Problems	Y		N
Does anyone smoke in the home?	Y		N	If yes, who?			

Development and Behavior

Age When:			
Sat Alone		Walked	
Toilet Trained		Bicycled	
Behavioral Problems	Y		N
If yes, please explain:			
Bedwetting Problems	Y		N
If yes, please explain:			
Daycare/Preschool	Y		N
If yes, please list name and days attending:			
If no, who is responsible for care of child during the day? (list names & relation)			
Comments:			

Development When Compared to Other Children			
Circle one:	Behind	Similar	Advanced
Learning Problems?	Y		N
If yes, please explain learning problems:			
List your Child's Hobbies/Sports/Social Activities:			

Acknowledgement:

By signing below, I agree I have filled out this form truthfully and to the best of my knowledge.

Signed:	**Date:**
Official Use Only **Received by:**	**Date:**

Pediatrics Queen Creek

22707 South Ellsworth Rd.
Suite H101
Queen Creek, Arizona 85142

Phone: 480-792-9200
Fax: 480-792-9206
www.pediatricsqc.com

LEAD SCREENING QUESTIONNAIRE

Child's Name:_____ DOB:_____

_____ _____

Name of Person Completing Questionnaire | Relationship to Child

PLEASE ANSWER ALL THE QUESTIONS. THIS WILL HELP THE DOCTOR DECIDE IF YOUR CHILD NEEDS A SPECIFIC BLOOD TEST.

	YES	NO
1. Does your child live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, the house of a baby-sitter or a relative, etc.	___	___
2. Does your child live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?	___	___
3. Does your child have a brother or sister, housemate or playmate being treated for lead poisoning?	___	___
4. Does your child live with an adult or frequently come in contact with an Adult whose job or hobby involves exposure to lead? (Construction, welding, pottery, Brass/copper foundry, automotive repair shops.)	___	___
5. Does your child eat food, drink juice or punch that has been stored in pottery from Mexico or that has been stored in open cans, particularly if the cans are imported?	___	___
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (Valve and pipe fittings, pottery, chemical and chemical preparations, industrial machinery and equipment.)	___	___
7. Do you give your child any home or folk remedies or traditional medicines that may contain lead?	___	___
8. Does your child live near a heavily traveled major highway where soil and dust may contain lead?	___	___
9. Does your home's plumbing have lead pipes or copper with lead joints?	___	___
10. Do you have any questions about this survey for your doctor?	___	___

EMILIA GOMEZ, MD
GRISELDA HIGUERA, MD
EMILIANO SOL HIGUERA, MD
22707 S. ELLSWORTH RD. SUITE H101
QUEEN CREEK, AZ 85142
(P) 480-792-9200
(F) 480-792-9206

AUTHORIZATION TO REQUEST OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth:_____
Last First Middle

Name of parent/Legal Guardian:_____ Relationship to Patient:_____

Home Number:_____ Work/Cell:_____

By signing this form, I authorize PEDIATRICS OF QUEEN CREEK to (check one):

☐ **request** records **from** facility below the protected health information regarding patient above.
☐ **send** records **to** the facility below the protected health information regarding patient above.

Name of Physician/Facility:_____

Facility Address:_____

City, State, Zip_____

Phone:_____ **Fax:** _____

Reason for Request:_____

PLEASE NOTE IT MAY TAKE UP TO TWO WEEKS TO RECEIVE MEDICAL RECORDS

This authorization applies to the individual described above. Only the checked information will be disclosed in this authorization.

☐ **ALL AVAILABLE MEDICAL RECORDS**

☐ **ONLY INFORMATION PERTAINING TO THE FOLLOWING:**_____

☐ **IMMUNIZATION RECORDS ONLY**

_____ **Date:** _____
Signature of Parent/Legal Guardian

_____
Witness

This authorization will expire **1 year** from the date it was signed unless otherwise requested.

☐ **PARENT REQUEST FOR RECORDS? Y____**
☐ **REQUEST TO TRANSFER TO ANOTHER PROVIDER? Y____**
IF REQUESTING RECORDS FOR YOUR PERSONAL USE, WE CHARGE AS FOLLOWS FOR THE PREPARATION AND PRINTING OF THE RECORDS:
UP TO 50 PAGES IS .50 CENTS PER PAGE.
ANYTHING OVER 50 PAGES IS $25 PLUS .25 CENTS FOR EACH ADDITIONAL PAGE.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, AIDS or HIV, and alcohol and drug abuse. I authorize the release or disclosure of this type of information. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective August 5, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use to disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that conditions. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to you care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose your information in you health record to obtain reimbursement from you, your health insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use of disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as listed above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employee for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

(CONTINUED ON NEXT PAGE)

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, of if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying, and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site: **http://www.hhs.gov/ocr/privacy/hipaa/complaints/**

All questions concerning this Notice or requests made pursuant to it should be addressed to:

PRIVACY OFFICER, PEDIATRICS OF QUEEN CREEK
22707 S. ELLSWORTH RD., STE. H101
QUEEN CREEK, AZ 85142

BY SIGNING OUR OFFICE POLICIES (Page 2 of our New Patient Packet), YOU ACKNOWLEDGE THAT YOU HAVE READ THE PREVIOUS PRIVACY POLICY AT PEDIATRICS OF QUEEN CREEK. YOU MAY KEEP THIS COPY OF OUR POLICY FOR YOUR RECORDS.