SIERRA PEDIATRICS
1546 N Parkway Drive Suite 101 Gilbert, Arizona 85234, P: 480-644-1466 F: 480-644-1063

Patient Eligibility Screening Record
Vaccines for Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC Program. The record may be completed by a parent, guardian, individual of record, or by the Healthcare provider. The same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of three years.

(Please print or type)

Date: _____

Child: _____
Last Name First Name M.I.

Date of Birth: _____

Parent/Guardian/
Individual of Record: _____

Provider: _____

This child qualifies for vaccination through the VFC program because he/she (check only one box):

a) ☐ is enrolled in Kids Care; or
b) ☐ is enrolled in AHCCCs; or
c) ☐ does not have health insurance; or
d) ☐ is American Indian or Alaskan Native; or
e) ☐ has health insurance that does not pay for vaccines.

☐ Check here if this child has health insurance that pays for vaccines. These children *do not qualify* for VFC.

Parental Signature: Date:

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Date: _____

Name: _____

LEAD SCREENING QUESTIONAIRE

Please answer the following questions with either Yes or No.

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 home of a babysitter or a relative, etc.
YES	☐	NO	☐	2. Does your child live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?
YES	☐	NO	☐	3. Does your child have a brother or sister, housemate, or playmate being followed or treated for lead poisoning?
YES	☐	NO	☐	4. Does your child live with an adult whose job or hobby involves exposure to lead?
YES	☐	NO	☐	5. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
YES	☐	NO	☐	6. Does your child live near a heavily travelled major highway where soil and dust may be contaminated with lead?
YES	☐	NO	☐	7. Do you give your child any home or cold remedies which may contain lead?
YES	☐	NO	☐	8. Does your home's plumbing have lead pipes or copper with lead solder joints?

Printed Name _____ Signature of Legal Representative _____ Date: _____

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PATIENT REGISTRATION

APPLICANT INFORMATION

Name:			Gender	☐M ☐F
Date of birth:	Phone:	Phone:		
Current address:	City:	State:	ZIP Code:	

STATTISTICAL ANALYSIS

Race: ☐Refuse ☐Asian ☐Islander ☐Black/African-American ☐White/Caucasian ☐Hispanic ☐Other

Ethnicity: ☐ Refuse ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Language: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese Other: **Interpreter Needed:** ☐Yes ☐ No

Pharmacy Name: Phone:

PATIENT PORTAL

Free & secure online service to view medical records, request for refills and new appointments. Please provide us with your personal email address to access this amazing offer!

Patient Email: @

[You will shortly receive online log in credentials via your personal email] + Be sure to download a free app called "Healow"

List members and relation who are authorized to discuss about your health info with:

FATHER INFORMATION

Name:			Gender	☐M ☐F
Date of birth:	SSN:	Phone:		
Current address:	City:	State:	ZIP Code:	
Mobil Phone:	E-mail:	Fax:		

EMPLOYER INFORMATION

Address:			
Phone: Ext:	E-mail:	Fax:	

MOTHER INFORMATION

Name:			Gender	☐M ☐F
Date of birth:	SSN:	Phone:		
Current address:	City:	State:	ZIP Code:	
Mobile Phone:	E-mail:	Fax:		

EMPLOYER INFORMATION

Address:	City:	State:	ZIP Code:
Phone: Ext:	E-mail:	Fax:	

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS)

Name:	Relationship:		
Current Address:	City:	Sate:	ZIP Code:
Phone:	E-mail:	Fax:	

INSURANCE INFORMATION **Effective Date**: **PCP:**

Primary Insurance:		Secondary Insurance:	
Address:		Address:	
City:	State:	City:	State:
Zip:	Phone:	Zip:	Phone:
ID#:		ID#:	
Group#:	Copay:	Group#:	Copay:

RESPONSIBLE PARTY (For Billing) Mother☐ Father ☐ Other ☐

ASSIGNMENT/ RELEASE AND RESPONSIBILITY

I hereby assign my insurance benefits to pay directly to SIERRA PEDIATRICS (physician). I also authorize the physician. To release medical records and any information required for the processing of claims. I do understand that I am fully responsible for non-covered services and should insurance deny claims, payment should be paid in full within 90 DAYS. TWO options will be given: full payment or 3 consecutive monthly installments with the first payment being 33% of balance due.

Parental Signature Date

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PEDIATRIC HISTORY FORM

CHILD'S NAME _____ AGE _____ DATE FORM FILLED OUT _____

A. BIRTH HISTORY

1. Birthplace _____
2. Birthdate _____
3. Was pregnancy normal? _____
4. Was delivery normal? _____
5. Was baby full term? _____
6. Birth weight _____
7. Birth length _____
8. Any nursery problems? _____

E. GROWTH AND DEVELOPMENT

1. Ages when first:
- Sat _____ Crawled _____
- Rolled _____ Walked _____
- First Tooth _____ Toilet Trained _____

2. School History: Year in School _____ Nursery _____
- Grades averaged _____
- School name _____
- School problems? _____
- Attends special school or classes? _____
- Discipline or behavior problem? _____
- Ever seen by a Psychologist, Speech Therapist, or special teachers?
- _____

H. PAST MEDICAL HISTORY

1. Any problems with:
- Sleeping? _____ Bedwetting? _____
- Weight/Height? _____ Nail Biting? _____
- Nightmares? _____

2. Diet
- Nursed or Bottle Fed? _____
- Any Colic problems? _____
- Use special diets? _____
- Taking Vitamins? _____
- Taking Fluoride? _____

3. Contagious Diseases (What age?)
- Measles _____
- Mumps _____
- Rubella (German Measles) _____
- Chickenpox _____
- Scarlet Fever _____
- Any other? _____

4. Immunizations (Shots) - Please give ages and/or dates
- DPT series _____ Boosters _____
- Polio series _____ Boosters _____
- Smallpox _____ Boosters _____
- Measles _____
- Rubella (German Measles) _____
- Mumps _____
- TB (Tine) Test _____
- HIB _____
- Others _____

5. Medications (Does Your Child Take Any Now?) _____

B. HOSPITALIZATIONS (When, Where, Why?)

_____

C. SURGERY (When, Where, Why?)

_____

D. SERIOUS INJURIES (When, Where, Why?)

_____

F. ALLERGIC REACTIONS-(Drugs, Asthma, Hives, Exzema**,** Hay Fever)

_____

G. FAMILY HISTORY

1. Father: Living? _____ Age now _____ Health _____
2. Mother: Living? _____ Age now _____
3. Brothers/Sisters _____ How Many? _____
   Ages _____ Health _____
4. Any Family History of:
- Diabetes _____ Allergies _____ Convulsions _____
- Heart Disease _____ JB _____ Cancer _____
- Other? _____

I. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

_____

- **WHERE DID YOU LIVE BEFORE COMING TO THIS AREA?**

_____

J. GENERAL SURVEY

1. Has your child had any unusual problems with the following?
- Head _____
- Eyes _____
- Ears/Nose/Throat _____
- Stomach _____
- Kidneys _____
- Bladder _____
- Bones, Muscles, Joints _____
- Skin _____
- Blood _____

2. When was your child's last blood test? _____
3. When was your child's last urine test? _____

K. ANY SPECIAL COMMENTS ABOUTYOUR CHILD

_____

L. YOUR LAST DOCTOR WAS

Sierra Pediatrics Office Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy. Payment is required at the time of service. We accept cash or credit card (Visa, MasterCard or American Express).

APPOINMENTS

1. Broken appointments represent a cost to us, to you, and to other patients who could have been in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. If you are unable to keep your appointment, we would appreciate a 24-hour notice. **There is a fee of $45.00 for missed or same day canceled appointments.**
2. If you are late for your appointment (> 15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5. Physicals, well-child checks, attention-deficit/hyperactivity disorder checks, and the like may be rescheduled if there are outstanding balances or if a copayment is not made at the time of service.
6. If you are experiencing financial difficulty, please let us know.

Initial: _____

INSURANCE PLANS

Please understand

1. It is your responsibility to keep us updated with your correct insurance information**. If the insurance company you designate is incorrect, you will be responsible for the payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. If we are the primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
   A. Not all plans cover annual healthy (well) physicals, sports physicals or Hearing and vision screenings.
      - *If these are not covered, you will be Responsible for payment.*

   B. For children younger than 2 years, there is a limit as to the number of Allowable well visits per year. If the number of visits is exceeded, your Insurance company will not pay;
      - *You will be responsible for payment.*
4. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

REFERRALS

1. If your plan requires a written referral for your child to see a specialist, or for procedures or laboratory test, you must allow us 3 to 5 business days to complete the appropriate form(s) prior to obtaining services.
2. You may have to reschedule your appointment if enough notice is not given to prepare your referral.
3. Only emergency referrals will be completed in the same day.
4. Retroactive referrals cannot be written and will not be honored.
5. In general, we will not agree to a referral for a problem we have not been . consulted about first.
6. If a referral form is not presented at the time of service to the provider, the patient may be responsible for payment in full at the time of service.
7. It is important that as questions arise, you contact your insurance company directly for final guidance and clarification.
8. It is your responsibility to know if a selected specialist participates in your plan.

Initial: _____

FINANCIAL RESPONSIBILITY

1. According to your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances.
2. **Co-payment, deductibles and co-insurances** are due at the time of service.
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. If we do not participate in your insurance plan, payment in full is expected from you at the time of the visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6. If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged **a $25.00 rebill fee for each 28-day cycle.** Any balance outstanding longer than 90 days will be forwarded to a collection agency and a final $45.00 charge will be applied. If you are in collections we will see your child on an emergency basis only for 30 days.
7. For scheduled appointments, prior balances must be paid prior to the visit.

Initial: _____

FORMS

1. There is a **$15.00 prepayment fee** for the review and completion of school/child care forms not provided at the time of the well-child examination. A school/child care form is provided at no cost at every examination. Please keep the original form and photocopy for your child's school, camp, or activity. This will help you avoid additional fees.
2. If you lose your forms there will be a **$15.00 fee** to replace them,
3. Family and Medical Leave Act forms (FMLA) **are $35.00**. Payment is due when forms are dropped off.
4. All forms have a **5 day** turnaround time.
5. Only **1** Good Faith note per family at a time, balance must be paid in full in order to obtain another Good Faith note.

Initial: _____

TRANSFER OF RECORDS

1. If you transfer to another physician, we will provide a copy of your immunization record, growth chart, illness summary and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2. If you require or desire a copy of all Sierra Pediatrics provider records, there are additional charges based on the volume of records**. $15.00 for 10 or fewer pages, $35.00 for 20-50 pages, 50 pages or more is $35.00 plus .10 cents per page after 50 pages,** for the transfer/copy of Sierra Pediatrics records of the care provided for your children. This may take 7 to 10 business days.
3. We provide records of your child for visits (excluding consultations from specialists) rendered here at Sierra Pediatrics only. For any previous records, you may request them directly from your previous doctor(s).
4. Upon making your decision to transfer out please be advised once you transfer out it is office policy that you will not be accepted back into the practice; there are two exceptions to this policy and that is if your transfer was due to a move or an insurance change.

Initial: _____

PRESCRIPTION REFILLS

1. For monthly medication refills, we require a 48 hours' notice, during regular business hours. Please plan accordingly.
2. Please call your local pharmacies for refill requests.
3. We do not refill prescriptions during after-hours or weekends.

Initial: _____

THE FINANCIAL AGREEMENT

We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. When you become a patient at our office, we will ask you to sign a copy of our financial policy. Prepare for your first visit by signing our financial policy in advance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY SIERRA PEDIATRICS. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

Signature of Parent or Responsible Person:

_____

Witness: Date:

_____

Child's Name: Siblings:

Effective: Date of Notice: April 14, 2003

Sierra 'Pediatrics1
Notice of Privacy Practices

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

Sierra Pediatrics "Practice" is dedicated to maintaining the privacy of your personal health information. Each time patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights-related to the information we maintain that identifies you as a patient. Protected Information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put hi place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most .current notice at any time, Revision's to the notice will be effective loran health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization

1. **Treatment**: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment**: We may use your health information to bill and collect payment for services provided. This may include providing your insurance, company with the details of your treatment; sharing your payment information with other treatment providers, contacting, you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations**: We may use and disclose –health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state Licensing,-or to identify you byname when you visit the office.
4. **Appointment Reminders**: We may use and disclose your information to remind you of appointments: We may also mail you a reminder for follow-up visits.
5. **Treatment Options**: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public: health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain Judicial and Administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law,

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform Privacy Officer in writing.

Effective: Date of Notice: April 14, 2003

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE' IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS, WE WILL NOTIFY YOU, IN WRITING, IF YOU REQUESTS CANNOT BE GRANTED,

1. Restrictions on Use and Disclosure: You have the right to request restrictions on bow we use and disclose your health information; this includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communications; You have the right to request that we communicate with you in a particular' manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request are view of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Practice If you feel they are incorrect or incomplete we may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. Accounting of Disclosures: You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has mark of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this-notice, please contact Practice's Privacy Officer at 1546 N .Parkway Drive, Suite 101; Gilbert, AZ 85234 or (480)644 1466. If you feel-your privacy rights: have been violated, you have the right to files written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for tiling -a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

_____ _____
Printed Patient Name Name/Relationship if Signed by Individual Other than Patient

_____ _____
Signature Date

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier Care _____ Provided was Emergent

_____ Other: _____
Employee Name Date

Form 164,526-A