Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name____________________ Sex M____ F____ Date of Birth____________________

Patient's HomeAddress____ Home Phone(____)-_____-______
Street City ST Zip

Marital status of child's parents (Please Check One):
Married_____ Single _____ Separated _____ Divorced _____

PARENT'S INFORMATION

Please Circle (Natural, Step, Guardian)
Mother's Name____________________(Maiden Name)________________ SS# ______-_______-________

HomeAddress____ Home Phone(____)-_____-________
Street City ST Zip

Employer ____________________ Cell or Work (_____)-______-_________ Email ____________________

Occupation ______________________________ Date of Birth ________________

Please Circle (Natural, Step, Guardian)
Father's Name ________________________________ SS # ______-_______-________

Home Address ____ Home Phone(____)-_____-________
Street City ST Zip

Employer ____________________ Cell or Work (_____)-______-_________ Email ____________________

Occupation Date of Birth

INSURANCE INFORMATION

Primary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number
Secondary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number

Other Children in our Practice: Name ____________________ DOB ________________ Sex: M____ F____
Name ____________________ DOB ________________ Sex: M____ F____
Name ____________________ DOB ________________ Sex: M____ F____
Name ____________________ DOB ________________ Sex: M____ F____

Name of Nearest Relative: Name ____________________ Phone ____________________
(Not living with you)
Name ____________________ Phone ____________________

How did you hear about our practice? ____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physician's of Great Destinations Pediatrics for Medical treatment(s) provided to my Child.
I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and all other costs.
I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child.
FINANCIAL/OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the notice of Privacy Practices.

____ Date _____/_____/_______
Responsible Party Signature

Updated 6/5/2009/skf

Great Destinations Pediatrics, P.C.
7757 W. Deer Valley Rd • Suite 275 • Peoria, AZ 85382
Telephone: (623)-878-2800 • Fax: 623-878-9150
www.gdpeds.com

Authorization to Release Medical Information to Great Destinations Pediatrics, PC

Patient Information:

Patient's Name: ______________________________ DOB: ____________

Patient's Name: ______________________________ DOB: ____________

Patient's Name: ______________________________ DOB: ____________

Address: ____

Phone: __________________

I hereby authorize Great Destinations Pediatrics, PC to **RECEIVE** photocopies of medical records concerning the above named patient (s) **FROM:**

Practice/ Company or Person(s) authorized to release records:
Name: _________________________
Address: _________________________
____
____
Phone: _________________ **Fax:** _______________
For the purpose of:

(Check all that apply)
Records to be included:

_____ All Medical Records
_____ Copies of Medical Records for the Period: ___/___/___ to ___/___/___ (Mo Day Year Mo Day Year)
_____ Copies of Information described below for the Period: ___/___/___ to ___/___/___ (Mo Day Year Mo Day Year)
_____ Immunization Record
_____ Consult Reports
_____ Lab, X-Ray
_____ Other (Please Specify) ______________________________
_____ The following information should **not** be released (Please Specify) ____________________

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

______________________________ ____________________ __________
Signature, Parent/Legal Guardian Relationship to Patient Date

Great Destinations Pediatrics, P.C.

Patient Name: ______________________________ DOB: ___________________

Parent/Legal Guardian Name: ____

CONSENT FORM FOR MEDICAL CARE

The following persons have my permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent(s) responsibility to notify Great Destinations Pediatrics of any changes with the list of authorized caregivers in writing.

1. Name ____

   Phone ____________________________ Relationship __________________________

2. Name ____

   Phone ____________________________ Relationship __________________________

3. Name ____

   Phone ____________________________ Relationship __________________________

THIS CONSENT WILL BE VALID FROM ____/_____/_______ TO _____/_____/_______
(Today's Date) (Future Date)

AUTHORIZATION FOR TEST RESULTS

Parent/Legal Guardian Contact Information (please choose preferred method):
By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail for your child's test results if you cannot be reached at the time of the call.

Abnormal	Normal	
☐	☐	Home Telephone: ______________________________
☐	☐	Cell/Work Telephone: __________________________
☐	☐	Email Address: ________________________________
☐	☐	Other Contact Name: ___________________________

Relationship: ________________________________

Telephone Number: ____________________________

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. I UNDERSTAND GDP CONTACTS ALL PATIENTS WITH NORMAL AND ABNORMAL TEST RESULTS AND IT IS MY RESPONSIBILITY TO CONTACT GDP IF I HAVE NOT RECEIVED THE RESULTS. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.

BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

______________________________________ ____________________

Parent Signature Date

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 the parent, guardian, individual of record, or by the healthcare provider. <u>This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed</u>. 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: Great Destinations Pediatrics, P.C.

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

(0) [ ] is enrolled in KidsCare; or

(1) [ ] is enrolled in AHCCCS; or

(2) [ ] does not have health insurance; or

(3) [ ] is American Indian or Alaskan Native; or

(4) [ ] has health insurance that does not pay for vaccines

[ ] Check here if this child has health insurance that pays for vaccines.
These children <u>do not qualify</u> for VFC.

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make Vaccines For Children Program retroactive and you are only eligible for Vaccines For Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You

Signature:____ Date:____________________

GREAT DESTINATIONS PEDIATRICS P.C.
FINANCIAL/OFFICE POLICIES

Dear Parents/Guardians,

Welcome! Please take the time to review the following policies and procedures that we at Great Destination Pediatrics have set in place to better serve you. We look forward to establishing a long and wonderful relationship.

We require a parent or legal guardian to accompany a minor patient unless prior written authorization is given to this office. The adult accompanying the minor is required to pay in accordance with our policies. We do not accept third party assignment nor do we recognize or enforce the terms of divorce decrees.

Payment is expected at each visit, may it be a deductible, co-payment, percentage, or payment in full. If you are waiting for coverage to become effective or have no insurance, payment will be expected at the time of the visit. For your convenience, we accept cash, checks, Visa, Master Card, and Discover.

There is a $30.00 charge for all returned checks. NSF checks must be redeemed with certified funds. (Cashiers check, money order, certified check, or cash.)

Our practice handles all claims and billing questions. You can reach our billing staff at (623) 878-2800 extension 16. Any accounts with outstanding balances greater than 60-days from the date of service will be subject to collection. We realize at times that there may be a financial hardship. Please communicate this with our billing staff and they will be happy to assist you.

Due to all various insurance plans in effect in the market place, it has become a very complicated process to become familiar with each plan. We therefore are requiring your cooperation so that we may better serve you and give you the proper healthcare you deserve without spending an exorbitant amount of time obtaining benefit information from your insurance company. **It is your responsibility to know all of the information required by your insurance plan to avoid any confusion or non-payment of services. (Examples being: well visit coverage, immunizations, in-house testing, contracted laboratory, radiology, durable medical equipment and sick visit coverage.)**

Please be aware that an authorization from your insurance company for treatment is not a guarantee of payment.

We require you to inform the scheduler when you make your appointment of any of the following changes: insurance, address, telephone number, and emergency contact. This will eliminate unnecessary delays in your child's care.

"Walk-in and sibling add-on" appointments place the physician and staff in a difficult and uncomfortable position. We want to take care of your child's illness; however it is unfair to our patients who have a scheduled appointment to ask them to wait while someone without a prescheduled appointment is seen. Please call to schedule your appointment. Ask to speak to the triage department if you feel your child cannot wait to be seen.

Please call to inform our staff if you are unable to arrive for your appointment on time. They will review the schedule to determine if the appointment will need to be rescheduled or if we are able to work you in behind the scheduled appointments.

Failure to cancel your child's appointment hinders another patient's ability to be seen by our physicians. Therefore we require a 24 hour notification in order to avoid a fee. This can be done by calling our office or visiting our website at www.gdpeds.com and sending a message to our staff. **A $25.00 charge will be applied for all "no-show" appointments.** Repeated "no-show" appointments may be subject to discharge from the practice.

Updated/July 2009

GREAT DESTINATIONS PEDIATRICS, P.C.

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. We might disclose your health information to a pharmacy when ordering a prescription for you.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services provided, and the medical condition being treated. We may contact your health insurer to certify that you are eligible for benefits (and what range of benefits). We may release your health information for workers' compensation and similar programs.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Great Destinations Pediatrics, P.C. For example , information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting (such as reporting child abuse or neglect). We may have to respond to a court or administrative order, if you are involved in a law suit or similar proceedings (subpoena, discovery request or either lawful process).

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Release of Information to Family

Our practice may release your health information to family members involved in your care, or who assist in taking care of you. For example, a parent or guardian may ask that a babysitter bring child into pediatric office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.

Military

Our practice may disclose your health information if you are a member of United States military forces and if required by the appropriate authorities.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. We reserve the right to require annual updates to information and authorizations.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to call/leave appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Deceased Patients. We may release your health information to a medical examiner or coroner to identify a deceased person or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. We may release your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate the donation and transplantation if you are an organ donor.

Individual rights

You have certain rights under the federal privacy standards. These include:
The right to receive confidential communications concerning your medical condition and treatment. For example, your request to be called at home, rather work (unless emergency situation).

The right to inspect and obtain a copy of your protected health information, not including psychotherapy notes. You must submit your request in writing to Medical Records Coordinator at Great Destinations Pediatrics P.C. We have forms available at reception area. We will charge a fee for the cost of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and or obtain a copy in certain circumstances (such as a court restraining order); however, you may request a review of our denial. Custodial and non-custodial birth parents have the same rights, unless we receive a copy of a signed / notarized court order directing us not to release record.

The right to ask us to amend or submit corrections to your protected health information if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to Privacy Officer / Practice Coordinator at Great Destinations Pediatrics, P.C. You must provide reason that supports your request for amendment. We will deny your request if you fail to submit request (supporting reason) in writing.

We may deny your request if you ask for us to amend information that is in our opinion: accurate and complete; not part of the health information kept by or for the practice; not part of the health information which you would be permitted to inspect and obtain copy of, such as, psychotherapy notes; not created by our practice.

The right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. We are required to agree to your request. In order to request a restriction you must make your request in writing to Privacy Officer / Practice Coordinator at Great Destinations Pediatrics, P.C.

The right to receive an accounting of how and to whom your protected health information has been disclosed. Use of your health information as part of routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim. To obtain an accounting of disclosures, you must submit your request in writing to the Business Office, Great Destinations Pediatrics, P.C. All request for an "accounting of disclosures" must state a time period, which may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but we will charge for additional list within the same 12-month period. We will notify you of the cost involved with additional requests and you may withdraw you request before you incur any costs.

The right to receive a printed copy of this notice. To obtain a copy of this notice, ask the patient service representative at reception window.

Duty of Great Destinations Pediatrics, P.C.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints.

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer / Practice Coordinator
Great Destinations Pediatrics, P.C.
18555 N. 79th Ave. Suite D-101
Glendale, AZ 85308

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can contact the Privacy Officer / Practice Coordinator if you have any questions.

Effective Date

This notice is effective April 14, 2003