high desert pediatrics

8650 Alameda Blvd NE
Suite 101E
Albuquerque, NM 87122

T (505) 255-1866
F (505) 255-1852

# Patient Information

**Patient Name:** _____ **Date of Birth:** _____ /_____ /_____

**Sex:** ☐ M / ☐ F **Patient SSN:** _____

**Race:** ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native

**Hispanic/Latino Ethnicity**: ☐ Yes / ☐ No **Language:** ☐ English ☐ Spanish ☐ Other: _____

**Mailing Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

## Responsible Party Information

**Parent/Guardian #1:** _____ **DOB:** _____

**Relationship:** _____ **Phone #:** _____

**Email:** _____

**Parent/Guardian #2:** _____ **DOB:** _____

**Relationship:** _____ **Phone #:** _____

**Email:** _____

## Pharmacy

**Pharmacy Name:** _____ **Phone:** _____

**Address/Cross Streets:** _____

## Consents

**Call** ☐ **Yes** ☐ **No**
**Text** ☐ **Yes** ☐ **No**
**Email** ☐ **Yes** ☐ **No - Email:** _____
**Medication History Authority** ☐ **Yes** ☐ **No**

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# Billing / Insurance Information

**(Please give your insurance card to the receptionist to copy)**
***** If patient is Newborn, please provide Mom's Insurance *****

**Patient Name:** _____

**Primary Insurance:** _____

**Subscriber/Policy Holder Name:** _____ **DOB:** _____

**Subscriber/Policy Holder SSN:** _____

**Secondary Insurance:** _____

**Subscriber/Policy Holder Name:** _____ **DOB:** _____

**Subscriber/Policy Holder SSN:** _____

**Billing Address if Different than Patient's**

**Billing Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

_____

I authorize the release of any medical information necessary to process this claim.

**Signature (REQUIRED):** _____ **Date:** _____

I authorize payment of medical benefits to High Desert Pediatrics for services provided.

**Signature (REQUIRED):** _____ **Date:** _____

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# Past Medical History

**Patient Name:** _____ **DOB:** _____

**Please list allergies the patient may have:**

_____

_____

**Have you ever been hospitalized overnight?** ☐ Yes ☐ No If so, when: _____

**Are immunizations up to date?** ☐ Yes ☐ No *(We would like a copy of immunization records)*

**Which of the following conditions is the patient currently being treated or has been treated for in the past?**

☐ Heart disease/murmur
☐ Shortness of breath
☐ Eye disorder
☐ High cholesterol
☐ Asthma
☐ Seizures
☐ Low blood pressure
☐ Lung Problems
☐ Stroke
☐ High blood pressure
☐ Sinus problems
☐ Headaches/Migraines
☐ Heartburn/reflux
☐ Seasonal allergies
☐ Neurological problems
☐ Anemia/blood/bleeding problems
☐ Tonsillitis
☐ Depression/Anxiety
☐ Pregnancy (prior history)
☐ Ear problems
☐ Psychiatric care
☐ Diabetes
☐ Kidney/Bladder problem
☐ Liver problems
☐ Arthritis
☐ Cancer
☐ Ulcers/Colitis
☐ Thyroid problem
☐ Sexually transmitted disease
☐ Abnormal pap smear
☐ Corrective lenses/glasses
☐ Hearing loss
☐ Rheumatic fever
☐ Hernia
☐ Kidney stones
☐ Eating disorder

**Please describe any current or past medical treatment not listed above:**

_____

_____

**Please list your past surgeries:** (Include tonsillectomy, adenoidectomy, PE tubes, dental surgery, appendectomy, abdominal surgery (hernia)

_____

_____

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**Patient Name:** _____

## Family History

| | Living | Age (or age at death) | List serious illnesses |
|---|---|---|---|
| Mother | ☐ Yes ☐ No | _____ | _____ |
| Father | ☐ Yes ☐ No | _____ | _____ |
| Sister(s) | ☐ Yes ☐ No | _____ | _____ |
| Brother(s) | ☐ Yes ☐ No | _____ | _____ |

**Has any member of your family (including children and parents) had any of the following illnesses?**

| Illness | Which Family Member? | Side of Family? |
|---|---|---|
| Allergies | _____ | ☐ Maternal ☐ Paternal |
| Anemia/Blood Disease | _____ | ☐ Maternal ☐ Paternal |
| Asthma | _____ | ☐ Maternal ☐ Paternal |
| Bleeding Disorder | _____ | ☐ Maternal ☐ Paternal |
| Cancer | _____ | ☐ Maternal ☐ Paternal |
| Diabetes | _____ | ☐ Maternal ☐ Paternal |
| Glaucoma | _____ | ☐ Maternal ☐ Paternal |
| Heart Disease | _____ | ☐ Maternal ☐ Paternal |
| High Blood Pressure | _____ | ☐ Maternal ☐ Paternal |
| Lupus | _____ | ☐ Maternal ☐ Paternal |
| Mental Illness/Depression | _____ | ☐ Maternal ☐ Paternal |
| Stroke | _____ | ☐ Maternal ☐ Paternal |
| Other Serious Illness | _____ | ☐ Maternal ☐ Paternal |

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# Assignment of Benefits & Financial Responsibility

**Patient Name:** _____

**Assignment of Benefits:** I authorize that payment of insurance or other benefits be made on the patient's behalf to High Desert Pediatrics and agree to assist in the processing of claims for benefits.

- **IF YOU DO NOT HAVE INSURANCE:** You are responsible and strictly liable for the prompt payment of your bill, in total, at the time of your visit, before the patient is seen and any services performed. We accept personal checks, credit cards, and cash. If you are unable to pay your bill in full at the time of the visit, **please ask to speak to our Billing Department prior to the time of your visit.**

- **IF YOU HAVE COVERAGE WITH AN INSURANCE COMPANY WITH WHOM WE DO NOT HAVE A CONTRACT:** **HIGH DESERT PEDIATRICS** will, at your request, submit a claim directly to your insurance company for reimbursement. Please review the following procedure and initial.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to High Desert Pediatrics. If the payment is sent to me, I will forward the payment to High Desert Pediatrics immediately. If payment is not received at High Desert Pediatrics within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that the entire balance is always my responsibility and that I am strictly liable for the entire amount of my balance and that I will pay the balance in full to High Desert Pediatrics promptly if my insurance company does not timely do so."

**Parent/Guardian Initials: _____**

- **IF YOU ARE A CUSTODIAL PARENT:** By law, you are ultimately responsible for and strictly liable for payment of your child's medical bills, even if you are not the carrier of your child's insurance policy. Our legal agreement to care for your child is made with you only.

- **COLLECTIONS:** I understand and agree that fees and charges not paid in full by the patient or insurance company may be placed with a collection agency for collection or be subject to legal action (including attorney's fees and interest) to recoup the unpaid fees. I consent to the use of any contact information I give High Desert Pediatrics (including updated information) to be provided to the collection agency on the patient's account, and further consent to the use of technology, including auto dialing, and the use of prerecorded messages on cellular/landline phones, in contacting me.

**Patient Name:** _____ **DOB:** _____

**Parent/Guardian Signature:** _____

**Today's Date:** _____

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# Immunization Policy Statement

Patient Name _____ DOB _____

The healthcare providers at High Desert Pediatrics strongly recommend following the current immunization schedule established by the New Mexico Department of Public Health which is based on what endorsed by the ACIP (Advisory Committee on Immunization Practices) and adopted as standard of care by the AAP (American Academy of Pediatrics). These current national guidelines have been shown to be both safe and effective in preventing disease. However, our providers also understand and acknowledge parental concerns regarding the safety of immunizations. When parents choose to not follow the current immunization guidelines, the providers at High Desert Pediatrics will try their best to work with the parents so that they are comfortable with the care that is received. However, any deviation from the immunization schedule is not endorsed by our providers and should not be considered a recommendation of an alternative immunization schedule. The risks of not following the nationally recommended immunization schedule include an increased risk of infection for the child as well as for others with whom that child may come in contact. Other consequences may also include the inability to enroll in daycare*, school*, military, or organized activities due to lack of immunizations. The decision to use an alternate immunization schedule or to not immunize for reasons other than established medical diagnoses is the sole responsibility of the parents.

I acknowledge that I have read this document and fully understand it.

Parent / Guardian Signature _____ Date _____

Parent / Guardian Name (print) _____

Relationship to Patient_____

* Information on New Mexico School and Daycare Immunization Requirements may be found at https://www.nmhealth.org/about/phd/idb/imp/sreq/.

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# HIPAA Notice of Privacy Practices

**Your Medical Record:** Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, and a plan for future care. The confidentiality of your medical record is protected under the State-specific and Federal Law.

**Your Health Information Rights:** Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

**Our Responsibilities:** *High Desert Pediatrics* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with notice of our legal duties and privacy practices.

**Uses and Disclosures for Treatment, Payment, and Health Care Operations:**
**Treatment:** Means the provision, coordination, or management of healthcare and related services by one or more health care providers. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary.
**Payment:** Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.
**Health Care Operations:** Health care operations means conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, underwriting, premium rating, and other activities related to health insurance contracts. This also included medical reviews, legal services, auditing functions, business management, and general administrative activities of the practice.

*High Desert Pediatrics* will disclose your health information to business associates, such as a medical transcription or billing service so that they can perform the job we have asked them to do.

**Disclosures Permitted Without Consent:** *High Desert Pediatrics* is required by State and Federal law to disclose health information from your medical record under specific circumstances.

- **U.S. Department of Health and Human Services:** *High Desert Pediatrics* must disclose your medical information upon request for purposes of determining whether we follow Federal Privacy Laws. We may disclose your medical information to a Government Agency authorized to oversee the Health Care system or Government programs or its contractors, and to Public Health authorities for Public Health purposes.

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- **Law Enforcement:** *High Desert Pediatrics* may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials.
- **Abuse or Neglect:** *High Desert Pediatrics* may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Uses and Disclosures Specifically Authorized by You:** *High Desert Pediatrics* will use and disclose your health information only based on specific written authorization forms signed by you. If you give us a written authorization, you may revoke it in writing at any time.

- **To Your Family and Friends:** We cannot use or disclose your medical information for any reason except that described in the notice. We may disclose your medical information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.
- **Persons Involved in Your Care:** We may use or disclose medical information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your medical information, we will provide you with an opportunity to object. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, or other similar forms of medical information.
- **Individual Rights:** You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot do so. You must make a request in writing to obtain access to your medical information. We may charge a reasonable fee to produce copies of your personal health information. The fee is $30 for the first 15 pages and then $0.25 for each additional page.

**To Report a Problem:** If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means you may do so directly with *High Desert Pediatrics* or with the Secretary of Health and Human Services in Washington, D.C.

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# Acknowledgement of HIPAA Notice of Privacy Practices

*High Desert Pediatrics* will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed *HIPAA Notice of Privacy Practices* to help you better understand our policies regarding your personal health information. The terms of the notice may change with time, and we will always post the current notice at our office and have copies available for distribution.

- I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices.
- I consent to allowing *High Desert Pediatrics* to disclose my protected health information for treatment activities of another health care provider.
- I consent to allowing *High Desert Pediatrics* to disclose my protected health information to insurance companies to facilitate claims processing.
- I consent to allowing *High Desert Pediatrics* to disclose protected health information to another medical facility for health care operation activities provided that the practice and the other entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations for the purpose of health care fraud and abuse detection or compliance.

**Patient Name:** _____
(Please Print Patient Name)

_____
(Signature of Person Authorizing Consent)

_____ / _____
(Print Name of Person Authorizing Consent / Relationship to Patient)

**Today's Date:** _____