high desert pediatrics

8650 Alameda Blvd NE
Suite 101E
Albuquerque, NM 87122

Phone: (505) 255-1866
Fax: (505) 255-1852

BILLING and REGISTRATION FORM

CHILD'S NAME:_____ DATE OF BIRTH ____ /___/____ SEX (M / F)
(Last, First, Middle Initial)

SOCIAL SECURITY #_____ -___-_____ RACE- ☐Asian ☐Native Amerian/Alaskan Native ☐Black/African American ☐White

Latino or Hispanic Ethnicity ☐yes ☐no LANGUAGE- ☐English ☐Spanish ☐Other_____

HOME PHONE #: _____ CELL/WORK# _____ CELL/WORK# _____

MAILING ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

PARENT 1: _____ RELATIONSHIP: _____ DOB: _____

PARENT 2:_____ RELATIONSHIP: _____ DOB: _____

EMAIL ADDRESS:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE#:_____

PARENT'S EMPLOYER INFORMATION:

COMPANY NAME: _____WORK PHONE: _____EXT: _____

ADDRESS: _____CITY:_____STATE:_____ ZIP CODE: _____

BILLING/INSURANCE INFORMATION:

(Please give your card to the receptionist to copy)

IF PATIENT IS NEWBORN, PLEASE NOTE WHAT INSURANCE PATIENT WILL HAVE

☐ **Check if same as above**
NAME OF RESPONSIBLE PARTY (Guarantor): _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH _____/___/_____ PHONE NUMBER _____

INSURANCE _____**CO-PAY AMOUNT: WELL $** _____**SICK $** _____

SUBSCRIBER NAME _____ RELATIONSHIP_____

MEMBER ID # _____ GROUP # _____

I authorize the release of any medical information necessary to process this claim. (***REQUIRED***) Signature _____Date _____	I authorize payment of medical benefits to my physician for services provided. (***REQUIRED***) Signature _____Date _____

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Past Medical History Form

PREFERRED PHARMACY & LOCATION_____

Patient Name: _____ Today's Date: _____ Date of Birth: _____

Please list allergies you may have: _____

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

Are immunizations up to date? _____ (*We would like a copy of your immunization records*)

Which of the following conditions is patient currently being treated for 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/cough	☐ Stroke
☐ High blood pressure	☐ Sinus problems	☐ Headaches/migraine
☐ Heartburn/ reflux	☐ Seasonal allergies	☐ Neurological problems
☐ Anemia/blood or bleeding problems	☐ Tonsillitis	☐ Depression/anxiety
☐ Pregnancy (prior history)	☐ Ear Problems	☐ Psychiatric care
☐ Diabetes	☐ Kidney/bladder problem	☐ Liver problem/hepatitis
☐ 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)

_____

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐ Yes ☐ No	_____	_____
Father	☐ Yes ☐ No	_____	_____
Sisters	☐ Yes ☐ No	_____	_____
Brothers	☐ Yes ☐ No	_____	_____

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

Illness	Which family member? Maternal or paternal side of family?
Allergies	_____
Anemia or blood disease	_____
Asthma	_____
Bleeding Disorder	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
Lupus	_____
Mental Illness/depression	_____
Stroke	_____
Other serious illness	_____

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PAYMENT POLICY FOR SERVICES RENDERED

1. **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 the HDP office for payment. If the payment is sent to me, I shall forward this payment to the HDP office immediately. If payment is not received by the HDP office 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 this entire balance is at all times my responsibility , and that I am strictly liable for the entire amount of my balance and that I will pay the entire balance to the HDP office promptly if my insurance company does not timely do so.**
   INITIAL _____

2. **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 your visit, **please ask to speak to our Billing Department prior to the time of your visit.**

3. **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.

4. **"I understand that if my account becomes delinquent and High Desert Pediatrics refers the account to a collection agency that I am responsible for and hereby agree to pay to the HDP office the principal balance, in addition to all reasonable sums charged by the collection agency, along with interest on any balance more than 30 days past due, at the rate of 15% per annum. Should the account become litigated I understand that I am responsible for and agree to pay to the HDP office the principal balance in addition to, but not limited to, all reasonable sums charged by the collection agency, attorney fees, court costs, expert witness fees, and interest on any balance more than 30 days past due at the rate of 15% per annum. "**

_____ _____

Parent or Guardian Signature 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 ACIP (Advisory Committee on Immunization Practices) and adopted as standard of care by the CDC (Center for Disease Control) and AAP (American Academy of Pediatrics). The 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 http://www.immunizenm.org/sched.shtml. Please note that NM “law does not grant immunization exemptions for philosophical or personal reasons”.

NOTICE OF HEALTH INFORMATION PRACTICES SUMMARY

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, treatment, 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 a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations:
High Desert Pediatrics will use your health information in order to treat you. Treatment means the provision, coordination, or management of health care 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. We will also use and disclose health information about you to make appointments with you.
High Desert Pediatrics will use your health information for 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.
High Desert Pediatrics will use your health information for regular health operations to assess the quality of your care. 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; medical reviews; legal services; auditing functions; and 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.

Uses and Disclosures that We May Make Unless You Object: You have the right to object to certain situations in which *High Desert Pediatrics* may disclose information from you medical record.

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.

Uses and Disclosures Specifically Authorized by You: *High Desert Pediatrics* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem: You have the right, under Federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *High Desert Pediatrics* or to the Secretary of Health and Human Services in Washington, D.C.

FRONT & BACK

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE

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 *Notice of Privacy Practice* to help you better understand our policies in regards to 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 *Notice of Privacy Practice.*

I consent to allow *High Desert Pediatrics* to disclose my protected health information for treatment activities of another health care provider.

I consent to allow *High Desert Pediatrics* to disclose my protected health information to another physician or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow *High Desert Pediatrics* to disclose protected health information to another medical facility for health care operations 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 or 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 on Signature Line and List Relationship to patient)

Date: _____

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Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

OR

☐ I authorize the High Desert Pediatrics **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

☐ I authorize the High Desert Pediatrics **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Specific information (Select one or more, as applicable)

☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results
☐ X-ray reports ☐ Other _____
(Please describe.)

☐ Entire copy of the record checked above. **PLEASE INCLUDE SHOT RECORDS**

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.

☐ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____