



# 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)*

RACE-  Asian  Native American/Alaskan Native  Black/African American  White

Latino or Hispanic Ethnicity  yes  no LANGUAGE-  English  Spanish  Other \_\_\_\_\_

PARENT#1 CELL \_\_\_\_\_ PARENT#2 CELL \_\_\_\_\_

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?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart disease/murmur              | <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Eye disorder            |
| <input type="checkbox"/> High cholesterol                  | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Low blood pressure                | <input type="checkbox"/> Lung problems/cough          | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> Sinus problems               | <input type="checkbox"/> Headaches/migraine      |
| <input type="checkbox"/> Heartburn/ reflux                 | <input type="checkbox"/> Seasonal allergies           | <input type="checkbox"/> Neurological problems   |
| <input type="checkbox"/> Anemia/blood or bleeding problems | <input type="checkbox"/> Tonsillitis                  | <input type="checkbox"/> Depression/anxiety      |
| <input type="checkbox"/> Pregnancy (prior history)         | <input type="checkbox"/> Ear Problems                 | <input type="checkbox"/> Psychiatric care        |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Kidney/bladder problem       | <input type="checkbox"/> Liver problem/hepatitis |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Ulcers/colitis          |
| <input type="checkbox"/> Thyroid Problem                   | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abnormal pap smear      |
| <input type="checkbox"/> Corrective lenses/glasses         | <input type="checkbox"/> Hearing loss                 | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Hernia                            | <input type="checkbox"/> Kidney stones                | <input type="checkbox"/> 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

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List serious illnesses</u>
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

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

<u>Illness</u>	<u>Which family member?</u>	<u>Maternal or paternal side of family?</u>
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.

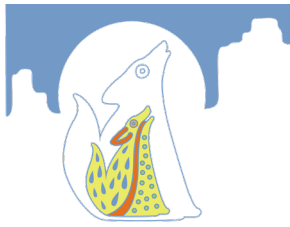
### **4. "I understand that if my account becomes delinquent and High Desert Pediatrics refers the account to a collection agency that I am responsible for and hereby agree to pay to the HDP office the principal balance, in addition to all reasonable sums charged by the collection agency, along with 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."**

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Patient or Guardian Signature

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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 your 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.

## 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)

Parent/Guardian

\_\_\_\_\_

(Signature of Person Authorizing Consent)

\_\_\_\_\_

(Print Name List Relationship to patient)

Date:

\_\_\_\_\_