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: ______________________

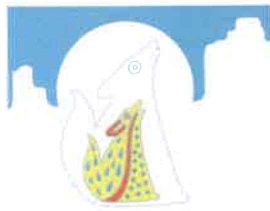
Pharmacy

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 *****

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:

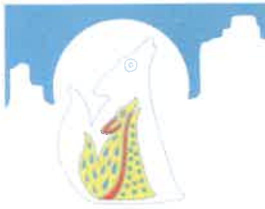
____

____

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

____

____



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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

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: ____________

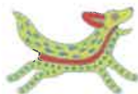
- **IF YOU ARE A CUSTODIAL PARENT:** By law, you are ultimately responsible for and strictly liable for payment of your child's medical bills, even if you are not the carrier of your child's insurance policy. Our legal agreement to care for your child is made with you only.

- **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 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 healthcare providers and should not be considered a recommendation of an alternative immunization schedule.

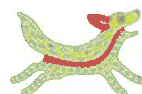
- **The risks of not following the nationally recommended immunization schedule include an increased risk of infection for the child as well as for others with whom that child may come in contact.**
- **Other consequences may also include the inability to enroll in daycare*, school*, military, or organized 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: ______________________________

Today's Date: ______________

*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."



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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.

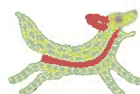
Your Health Information Rights: Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

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.
- **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.



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- **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)

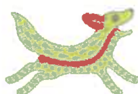
____

(Signature of Person Authorizing Consent)

______________________ / ______________________________

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

Today's Date: ______________



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Release of Medical Record Authorization

Date of Request: ____________________ **Date Needed:** ____________________

Name: ____ **Date of Birth:** ____/____/____

Address: ____

City: ____ **State:** ________ **Zip Code:** __________

SSN: _______________________________________ **Phone #:** ____________________

I authorize my medical health information be: ☐ **Obtained From** ☐ **Released To**

Name of Provider/Facility: ____

Address: ____________________________________ **City/State/Zip:** ____________________

Phone #: (_____)______________________ **Fax #:** (_____)____________________________

PURPOSE FOR THIS REQUEST: ☐ **Transfer of Care** ☐ **Healthcare** ☐ **Insurance** ☐ **Legal**

☐ **Personal** ☐ **Other:** ______________________

TYPE OF RECORDS REQUESTED: SPECIFY ILLNESS/INJURY: ______________________________

TREATMENT PERIOD: From: (Month/Year) ________________ **To:** (Month/Year) ______________

CHECK ALL THAT APPLY:

☐ **All Records** ☐ **History/Physical** ☐ **Lab Results** ☐ **Vaccine Records** ☐ **Any Radiology**

☐ **Procedure Report** ☐ **Medication List** ☐ **Other:** ____________________________________

AUTHORIZATION VALID FOR: ☐ **This request only** ☐ **One year from the date of this authorization**

I understand that:

- My right to healthcare 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/facility receiving this information is not a healthcare or 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

Signature of Patient or Parent/Guardian: ____

Relationship to Patient: ____________________________________ **Date:** ______________

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Telehealth Consent

Patient Name: ____ **DOB:** ______________

Parent/Guardian Full Name: ____

Overview

- To receive telehealth services from High Desert Pediatrics you must have access to the technological tools that are needed to engage in the telehealth services (i.e. Smartphone device with front facing camera or computer with a webcam and a reliable internet connection).
- You will need to have a designated room/area in which you are able to give your full attention and participation during the telehealth visit. They are to be treated as if it is an in-office visit.

Confidentiality

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identifiers and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth visit.

Quality of Communication for Telehealth Visits

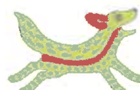
By using the telehealth service, I recognize that any transmissions over the internet are at my own risk and that third parties may unlawfully intercept or access the transmissions being sent. I also understand that despite all reasonable efforts on the part of the provider, there are risks and consequences in using telehealth services. The risks include, but are not limited to, the possibilities that the transmission of sessions could be disrupted or distorted by technical failures. In the case of technical failures, the provider will make every effort to reconnect with me through electronic means, as will I. I also understand that telehealth services may not be completely thorough as services provided via face-to-face, although there are several benefits of telehealth services that have been identified. One which includes increased access to specialized services in remote areas, lower healthcare costs, reduced travel time, minimizing time off work, decreased waiting times, and social distancing.

I have been notified by High Desert Pediatrics that if my provider believes the patient would be better served by a face-to-face visit, I will be asked to call the office to schedule an in-office appointment. I understand that the telehealth service will be billed through my insurance (if applicable) and I will be responsible for any charges that are not covered by my insurance plan (if applicable). I also understand the services I receive will be considered an office visit and my encounter notes will be kept on file at High Desert Pediatrics in the same fashion as a standard clinic visit.

I understand that if I do not contact High Desert Pediatrics to cancel or reschedule my scheduled appointment the visit will be considered a No Call/No Show.

☐ **I consent to Telehealth services** ☐ **I DO NOT consent to Telehealth services**

Today's Date: ____________________



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Notice of Medical Billing Changes Effective 09/01/2024

Dear Parent/Guardian(s),

Due to the complexity of medical billing we have found that we have not been keeping up with the industry standard changes of medical billing. As a result, we have recently discovered that we have been underbilling for quite a while. To stay in compliance with the evolving medical billing changes please note that there is a new billing process that may trigger a patient balance (Deductible/Coinsurance/Copay) when an additional problem and/or concern is addressed during a Well Check (preventative) visit.

We will address any problems or concerns you may have at the time of your visit but know that there may be an additional balance that you will be responsible for and billed to you. The Well Check visit and vaccinations (if applicable) will be covered by insurance at 100% as usual.

By signing below, I acknowledge that I have been informed of these changes and assume financial responsibility for any balance after insurance has adjudicated the claim.

Patient Name: ______________________________ **DOB:** ____________

Parent/Guardian Signature: ______________________________________

Today's Date: _____________