PATIENT REGISTRATION FORM

Today's Date: _____

Section I: Patient Information

Legal Name of Patient: _____

Date of Birth: _____

Nickname of Patient: _____

Gender: ____ Male ___ Female

Race/Ethnicity:
___White/Caucasian ___Asian ___Southeast Asian ___ African ___African-American
___Middle East ___ Hispanic/Latino ___Native American ___Pacific Islander
___Mixed Race Other:_____
___Prefer not to answer

Which languages are spoken at home?: _____

Religion:
___Christian (All) ___Jewish ___ Hindu ___Muslim ___Buddhist ___No Religion
Other: _____
___Prefer not to answer

School Information:

Current grade: _____

Name of School: _____

Section II: Family/Parent/Legal Guardian Information

Mother/Legal Guardian:

Name: _____ Date of Birth: _____

Phone: _____ Alternate phone: _____

Mailing Address: _____

Social Security Number: _____

Email address: _____

Employer: _____

Work phone (for emergencies only): _____

Father/Legal Guardian:

Name: _____ Date of Birth: _____

Phone: _____ Alternate phone: _____

Mailing Address: _____

Email address: _____

Social Security Number: _____

Employer: _____

Work phone (for emergencies only): _____

Are both parents married to each other and living in the same household?

- ☐ **Yes**
- ☐ **Other (Explain): _____**

If parents are divorced or not married, who is the custodial parent?

Name: _____

Phone: _____ Alternate phone: _____

Email address (for web portal): _____

Mailing Address: _____

<u>Siblings:</u>

Are any siblings already established patients with Southern Nevada Pediatric Center?

Sibling #1: _____

Sibling #2: _____

Sibling #3: _____

Sibling #4: _____

Section III: Insurance Information

Responsible Party Information (If person listed above then write your name only):

Name: _____ Date of Birth: _____

Relationship to Patient: ___ Mother ___ Father Other: _____

Phone: _____ Alternate phone: _____

Mailing Address: _____

Email address: _____

Social Security Number: _____

Employer: _____

Primary Insurance Information:

Name of Policyholder: _____

Date of Birth of Policy holder:_____

Relationship to Patient: ___ Mother ___ Father Other: _____

Group #: _____ ID#: _____

Insurance Company: _____

Insurance Phone #: _____

Social Security Number: _____

Employer: _____

Do you have a secondary insurance?

- ☐ **Yes (see below)**
- ☐ **No**

Secondary Insurance Information

Name of Policyholder: _____

Date of Birth of Policy holder:_____

Relationship to Patient: ___ Mother ___ Father Other: _____

Group #: _____ ID#: _____

Insurance Company: _____

Insurance Phone #: _____

Social Security Number: _____

Employer: _____

PATIENT RIGHTS AND RESPONSIBLITIES
BILL OF RIGHTS

The goal of **SOUTHERN NEVADA PEDIATRIC CENTER** is to provide all patients with outstanding and confidential health care. In order to effectively accomplish this goal, we must work as a team to develop and maintain optimum health.

As a Patient You Have The Right to:

1. Receive care that is respectful of your personal beliefs, cultural and spiritual values.
2. An explanation in terms that you can understand and to have any question answered concerning your symptoms, diagnosis, prognosis, and treatment.
3. Appropriate assessment and management of your symptoms, including pain.
4. Know your: diagnosis; prognosis; testing and treatment to be used; risks of treatment and common side effects of medications; financial considerations associated with medical care
5. Know the contents of your medical records through interpretation by the provider.
6. Know your health care team.
7. Develop a collaborative plan to prevent your medical problem from recurring.
8. Choose or change your provider.
9. Refuse to be examined or treated and to be informed of the consequence of such decisions.
10. Be assured of the confidential treatment of disclosures and records and to approve or refuse the release of such information, except when release of specific information is required by law or is necessary to safeguard you or the university community.
11. Be informed and provide consent to participate in research conducted at Health Services.
12. Participate in the consideration of ethical issues that may arise in the provision of your care.
13. Provide feedback on the services you receive.

As a Patient You Have The Responsibility to:

1. Provide Health Services with information about your current symptoms, including pain and medications.
2. Provide Health Services with information about your medical and mental health history.
3. Ask questions if you do not understand the directions or treatment being given by a provider.
4. Keep appointments or notify Health Services within a reasonable time frame if you need to cancel.
5. Be respectful of others and others' property while at Health Services.
6. Limit the use of mobile devices

I understand and agree to the terms above,

_____

WRITTEN NAME OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

RELATIONSHIP TO PATIENT: _____ DATE: _____

OFFICE NO SHOW POLICY

EFFECTIVE February 15th, 2019

WE RECOMMEND COMING 10-15 MINUTES EARLY FOR YOUR APPOINTMENTS.

- We reserve the right to charge $25 for regular appointments cancelled without advance notice of at least one (1) business day. We reserve the right to charge $35 for appointments that are scheduled for the same day and then cancelled and for no-show appointments scheduled the same day. Please be aware that your insurance will not pay for this fee.
- **THE RESPONSIBLE PARTY WILL BE REQUIRED TO PAY THE NO SHOW FEE BEFORE FUTURE APPOINTMENTS WILL BE SCHEDULED.**
- Each patient will be given three no show or short notice cancellations per year. The year begins at the time of the first no show or short notice cancellation violation
- After each violation you will receive a letter reminding you that you have made such a violation. The letter will state whether it is the 1st, 2nd or 3rd violation.
- After the 3rd violation you will receive a letter stating that you will no longer be able to schedule visits. From that point forward you will only be able to obtain an appointment in person and on a standby basis. The standby basis will remain effective for one year.
- You will be given to option to appeal the decision and will remain in good standing and able to make appointments during the appeals process.

IT IS THE PATIENT'S RESPONSBILITY AND THE RESPONSIBLE PARTY WILL BE REQUIRED TO PAY THE NO SHOW FEE BEFORE FUTURE APPOINTMENTS WILL BE SCHEDULED.

I understand and agree to the terms above,

_____

WRITTEN NAME OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

RELATIONSHIP TO PATIENT: _____ DATE: _____

CHAPERONE POLICY

EFFECTIVE FEBRUARY 15TH, 2019

EVERY PATIENT HAS THE RIGHT TO HAVE A CHAPERONE PRESENT IN THE ROOM DURING THEIR MEDICAL VISIT. SOUTHERN NEVADA PEDATRIC CENTER REQUIRES THAT A CHAPERONE BE PRESENT FOR ALL VISITS THAT REQUIRE AN EXAMINATION. IF YOU ARE NOT ABLE TO BRING A CHAPERONE TO THE VISIT THEN YOU CAN REQUEST THAT ONE OF OUR CLINICAL STAFF SERVE AS YOUR CHAPERONE FOR THE VISIT. PLEASE NOTIFY OUR FRONT DESK AND ONE WILL BE PROVIDED FOR YOU.

I understand the terms above,

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

COMPLAINT PROCESS POLICY AND PROCEDURE

PATIENTS OR THEIR REPRESENTATIVES WHO HAVE A COMPLAINT OR GRIEVANCE OR WOULD LIKE TO EXPRESS CONCERNS ABOUT THEIR CARE AND SAFETY WHILE IN OUR CLINIC MAY DO SO BY CONTACTING OUR OFFICE MANAGER IN ANY OF THE FOLLOWING WAYS:

- ASK TO SPEAK WITH THE DOCTOR OR OFFICE MANAGER DIRECTLY
- EMAIL: INFO@SNPCLASVEGAS.COM
- SEND A SECURE MESSAGE USING THE PATIENT PORTAL
- USING OUR "CONTACT US" TAB ON OUR WEBSITE: WWW.SNPCLASVEGAS.COM

I understand the instructions above,

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

Financial Agreement, Assignment of Benefits & Release

In Accordance with the Federal Truth in Lending Act, please be advised of the following financial policies which apply in the office.

- As the guarantor/patient (18 or older), you are the responsible party, and as such, you are responsible for the payment of the bill, regardless of your insurance type-including Medicaid and Workman's Comp, or any other third involvement.
- As the responsible party, you agree to pay the doctor at the time service is rendered, unless other financial agreements have been made with the business office. If our Physician is a preferred provider with your insurance company, all deductible amounts and copays are due at time of service.
- The responsible party will cover the balance of this account within 90 days from the date of service in the event the insurance company does not pay the entire balance within that time. A late fee will be added of 25% of any unpaid balance after a 90 day period.
- A $35.00 fee will be added in the event of a returned check.
- The responsible party agrees to pay for all attorney fees, court costs, and filing fees of the principal balance as well as any collection fees that a collections agency may charge in the event that the account must be referred to a collection agency.

Note: Certain services are not billed through our facility, and will results in a billing statement from another company (i.e. outside lab work, MRI's, x-rays and other radiology tests).

I understand the above financial policy and agree to the terms,

_____

WRITTEN NAME OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

RELATIONSHIP TO PATIENT: _____ DATE: _____

OTHER DISCLOSURES

Credit Cards on File: Southern Nevada Pediatric Center is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number in a secure and compliant location in your medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file can be used to pay copays and other charges (such as toward the deductible or for non-covered services) at the time of the visit.

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

Informed Consent: I hereby authorize the physician and/or such associates or assistants he/she may designate to perform a physical examination and to advise me in further appropriate care as he/she may deem necessary or advisable to my medical treatment. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with treatment procedures, routing immunizations or other medical treatments in hopes of obtaining the potential desired results, which may or may not be achieved, as no medical benefit is guaranteed.

Note: Failure to complete this form will results in delays with insurance, therefore you may be billed in full if we do not have all necessary information.

_____

WRITTEN NAME OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

RELATIONSHIP TO PATIENT: _____ DATE: _____

Assignment of Insurance Benefits: I, the undersigned, give permission to release information to third party carrier(s) and do assign all insurance benefits for treatment to be paid directly to my provider. I certify that a copy of this assignment shall be as valid as the original.

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

EMERGENCY CONTACT

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Phone: _____ Alternate phone: _____

Mailing Address: _____

Email address: _____

Employer: _____

Work phone (for emergencies only): _____

TELEHEALTH CONSENT FORM

Patient Name: _____ Medical Record No: _____ DOB: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    (1) omit specific details of my medical history/physical examination that are personally sensitive to me;
    (2) ask non-medical personnel to leave the telemedicine examination room: and or
    (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of telehealth type visits
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

☐ CHECK HERE IF YOU DO NOT CONSENT AND WOULD LIKE MORE INFORMATION ABOUT TELEHEALTH

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

APPOINTMENT REMINDER
TEXT MESSAGE/VOICE CALL/VOICEMAIL POLICY

If you would like to be reminded of your appointment via text message or email, please sign and fill in the phone number you would like to be reminded through.

Please write the phone number in the space provided for which you would like to be reminded below:

Email address: _____

Voice Call: _____

Text message: _____

Is it okay to leave a voicemail message?

- ☐ Yes
- ☐ No

By signing this, you are agreeing to our appointment reminder system and by doing so you agree we will not be held responsible for liabilities regarding charges incurred by your service provider.

Signature: _____

Date: _____

Print Name: _____

Patient Name: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any significant new right to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may also contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with your respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of your legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights. Our office will in no manner retaliate against you for filing a complaint.

SIGNATURE: _____ DATE: _____

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 or Toll Free: (877) 696-6775

Preferred Pharmacy

E-PRESCRIPTIONS

Please tell us which pharmacy you would like your prescriptions electronically sent to. This way your prescription will be ready when you arrive at the pharmacy and you will not have to wait. We will be sending almost all prescriptions electronically. If you do not want your prescriptions sent electronically then please let your doctor know during your visit.

Name of Patient: _____

Name of Pharmacy: _____

Zip code of Pharmacy: _____

Address of Pharmacy (if known): _____

Cross Streets: _____