Bright Futures Pediatrics
8352 W. Warm Springs Rd. Suite 210
Las Vegas, NV 89113
Phone (702)944-4028 Fax (702)944-4019

Patient's Name: _____ Birth Date: ____/____/____ Age: _____ Sex: M / F

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____ Primary Phone #: _____ Secondary phone # _____

How did you hear about us? _____ **Language**: _____

Race: Caucasian / Hispanic / African American / Asian / Pacific Islander / Other _____ / Refuse

Sibling(s)

Name: _____ DOB___/____/___ Name: _____ DOB___/____/___

Name: _____ DOB___/____/___ Name: _____ DOB___/____/___

Mother's Name: _____ Birth Date: ____/____/____

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____ Phone #: _____ SSN # _____-_____-_____

Employer: _____ Occupation_____ Work #_____

Father's Name: _____ Birth Date: ____/____/____

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____ Phone #: _____ SSN # _____-_____-_____

Employer: _____ Occupation_____ Work #_____

Emergency Contact Name: _____**Phone** # _____

Primary Insurance: _____ **Address:** _____

Subscriber's Name: _____ **DOB**: ____/____/____ **SSN** # _____-_____-_____

Insurance ID #: _____**Group** #: _____**Effective Date**: _____

Relationship to Patient: Self Mother Father Other: _____

Secondary Insurance: _____ Address: _____

Subscriber's Name: _____**DOB:** ____/____/____ **SSN** # _____-_____-_____

Insurance ID #: _____ **Group** #: _____**Effective Date**: _____

Relationship to Patient: Self Mother Father Other: _____

I HAVE READ AND UDERSTOOD THE FOLLOWING FINANCIAL STIPULATIONS:

1. Payment is expected at the time of service.
2. Insurance Claims will be filed only for those insurance plans we are contracted with as a participating provider.
3. Co-pay's, Deductibles, and non-covered services are to be paid at the time of service.
4. If you are unable to keep your appointment please give a 24 hour notice or there can be a $25 fee.
5. I understand that my signature is valid for the purpose of filing my insurance and authorize payment of benefits to Bright Futures Pediatrics and that the information provided above is true.

Signature: _____ Date: _____/_____/_____

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Office Policies and Procedures

Effective December 1, 2013

Newborns: **All newborns need to be added to your insurance company within the first thirty days.** If we are unable to verify eligible coverage then we must collect **cash** for the visit.
If you have insurance and we are unable to verify eligibility you will be required to pay out of pocket. Once we have received payment from your insurance company a refund will be issued. Your insurance information needs to be given to our office promptly to ensure your claim will be paid. **If your insurance plan lists a PCP (primary care provider) you must contact your insurance company prior to your appointment and change the PCP to one of our providers.**

*** No Show/ same day cancellation appointments:** If you are unable to make your scheduled appointment we ask that you call our office 24 hours prior to your appointment to avoid a **same day cancellation fee of $25**. If you **do not show up** for an appointment you will be charged a fee of **$25.00**, this needs to be paid on or before your next scheduled visit in order for your child to receive medical services.

Returned/ NSF checks: If you write a check to our facility and that check is returned from your bank for any reason you will be charged a **$25.00 return check fee**. You will be required to pay that fee along with the original amount of the returned check. Your check privileges will be revoked and you will have to pay either by **cash/debit/credit card.**

- **We no do not accept personal checks for same day in office visits.**

Insurance Issues: We are happy to **file claims with your insurance company as a courtesy**, however, if we have not received a response from your insurance company within 60 days you will be billed for the services. **Ultimately, it is your responsibility to know your coverage and follow up with your insurance company if claims have not been paid.** We will be happy to assist with questions and help you to understand what is needed from your insurance company. If there is no response to our requests from you regarding your insurance payment then we will send your accounts to collections. We reserve the right to assess fees from the collection agency as well.

Email address:_____
I agree to receive email correspondence from Bright Futures Pediatrics regarding news updates and appointments.
Signature:_____

We appreciate your cooperation in following these policies.

I/we read the above and understand and agree to the terms.

Patient's Name: _____ DOB: _____/_____/_____

Parent/ Guardian Signature: _____ Date: _____

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Patient Privacy and Confidentiality Guidelines

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to not disclose to anyone any personal health or identifiable information about our patients without their authorization. We may be required to disclose health and personal information about you in your treatment, to bill for our services and to collect payment from you or your insurance company or to review the quality of services to you. We may disclose information about you for the benefit of governmental benefit programs or in response to a warrant or subpoena. We may be required to provide health information about you to outside business associates. These business associates are required to sign a contract with us stating that any information they come in contact with must be held in the strictest of confidence. We may be required to disclose personal information about you to contact you as a reminder of an appointment, to renew or prescribe medications, or for alternative treatment options. We also may need to release medical information about you to your parents and family members.

Bright Futures Pediatrics and Staff will make every effort to protect your health and personal information however many instances in medical practice require us to divulge this type of information.

Bright Futures Pediatrics and Staff have my permission to release information concerning my personal health or identifiable information for but no limited to the information listed above.

Print Patient's Name: _____ DOB: _____

Signature of Parent/ Guardian: _____ Date: _____

* We reserve the right to make changes to this notice at any time.*

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PERMISSION TO TREAT

Bright Futures Pediatrics has permission to diagnose and to treat my child.

Patient's Name: _____ DOB: ____/_____/_____

When he/she is accompanied by the following person(s):

First Name: _____ Last Name: _____

Relationship to the patient: _____ Phone # _____-_____-_____

First Name: _____ Last Name: _____

Relationship to the patient: _____ Phone # _____-_____-_____

First Name: _____ Last Name: _____

Relationship to the patient: _____ Phone # _____-_____-_____

First Name: _____ Last Name: _____

Relationship to the patient: _____ Phone # _____-_____-_____

First Name: _____ Last Name: _____

Relationship to the patient: _____ Phone # _____-_____-_____

Parent/ Guardian Signature: _____ Date: _____/_____/_____

*This document will be valid for **one year** from the date signed.*

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MEDICAL RECORDS RELEASE FORM

This form authorizes recipient to provide a copy, summary, or narrative of my child's medical records or otherwise release confidential information.

- Complete record
- Records of care for the following dates _____to _____
- Records concerning the following conditions :_____
- Other , please specify: _____

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

Please send my records to:

Bright Futures Pediatrics
8352 W. Warm Springs Rd. #210
Las Vegas, NV 89113
Phone 702-944-4028 Fax 702-944-4019

Records to be released from:

Physician's Name: _____ Phone # (_____) _____ Fax# (_____) _____

Complete Address: _____

_____

I understand the following:

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be effective for **one year** from the date signed.

Parent or Guardian Signature: _____ Date: _____

Print Name of Parent or Guardian: _____

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Please note that there will be additional charges for documents completed by **Bright Futures Pediatrics.**

Your insurance company will not pay for these forms. Payment **must** be made prior to completing the forms and they must be picked up, we **Do Not Fax forms.**

All payments are expected at the time of service. We **DO NOT** bill for patient co-pays.

Our office accepts cash and credit cards as payment **(We do not take personal checks)**

- **Health statements, daycare forms -** **$10.00(please allow 12-24 hrs for completion)**
- **Sports physicals -** **$25.00 (please allow 12-24 hrs for completion) if you have not been seen in the past 3 months.**
- **Sports physicals-** **$50.00 if you have not been seen within 3 months**
- **Immunization Records -** **$5.00/ patient**
- **Medical Records-** **$0.60/ page**
- **FMLA paperwork-** **$50.00 (please allow one week for completion)**

If you arrive more than **15 minutes late** for your appointment you will be asked to reschedule. There will be a rescheduling fee of **$25.00 .**

All cancellations **without a 24 hour** notice will be charged a **$25 fee.**

If you are scheduled for a **circumcision** a **24 hour notice** is required to avoid a **$100.00 no show or same day cancellation fee.**

Please sign below that you understand our office policies.

Patient's Name: _____ DOB: _____/_____/_____

Printed Name of Parent/ Guardian: _____

Parent or Guardian Signature: _____ Date: _____/_____/_____

* We reserve the right to adjust charges as necessary*