Bright Futures Pediatrics
8352 W. Warm Springs Rd. Ste 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? (Circle One)** LANGUAGE: _____
FRIEND FAMILY INSURANCE INTERNET WALK-IN PHYSICAIAN: _____

Pharmacy Name & Major Cross streets/Phone#: _____
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: _____/_____/_____

INITIAL HISTORY QUESTIONNAIRE (Page 1 of 2)

PATIENT NAME: _____DATE OF BIRTH: _____

BIRTH HISTORY:

Hospital:	Birth Weight:	Birth Length:
Age of Gestation:	Maternal Complications: NONE Other:	
Post Natal Complications: Jaundice Formula Intolerance Colic Rash		
Other Complications		

PATIENT/CHILD HISTORY:

Child have or had	Yes	No	Comment
Chicken Pox			
ADHD / ADD / LD			
Bed Wetting			
Diabetes			
High Blood Pressure			
Heart Murmur			
Mental Illness			
Deafness			
Tuberculosis			
High Cholesterol			
Anemia / Bleeding Dis			
Constipation			
Thyroid Problem			
Reoccurring UTI			
Frequent Headaches			
Ear INfections			
Allergies			
Asthma			
Other:			

SOCIAL HISTORY

Lives with: Both Parents Mom Dad Other:		
How Many Siblings: Sisters: Brothers:		
Childcare: Babysitter Daycare Home		
School:		**Grade:**
Exposure to Smoking? Yes No Who?		
Pets: Yes No	**What Kind?**	**How Many?**
Other Concerns:		

GENETIC DISEASES: Yes No

If Circled 'Yes', What Disease?

FAMILY HISTORY:

Disease	Mother's Side	Father's Side
Asthma		
Allergies		
Seizure		
Diabetes		
High Blood Pressure		
Heart Disease		
Mental Illness		
Deafness		
Tuberculosis		
High Cholesterol		
Anemia		
Bleeding Disorder		
Liver Disease		
Kidney Disease		
HIV / AIDS		
ADHD ADD / LD		
Autism		
Bed Wetting		
Other:		

SURGERIES / HOSPITALIZATION

What Type of Surgery?	Hospitalized for?

ALLERGIES

Drugs	Food	Seasonal

MEDICATIONS

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

_____ _____

SIGNATURE OF PROVIDER **DATE**

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Office Policies and Procedures

Effective September 1, 2010

Newborns: All newborns need to be added to your insurance company within the first thirty days. However, you need to add the baby immediately in order for us to verify eligible coverage. If we are unable to verify eligible coverage then we must collect **cash** for the visit. We will be happy to refund the money once we receive payment for the services. If you are covered by Medicaid and the baby does not have a card then you are considered a **cash** pay patient until you have eligible number which shows active coverage for the baby. You will be refunded once we receive your payment for the services from the insurance. This must be given to our office promptly otherwise we will NOT refund the money.

*** No Show/ same day cancellation appointments:** If you are unable to make your scheduled appointment we ask that you call the office within 24 hours to avoid a same day cancellation fee of $25. If you no show to an appointment then we will charge a fee of $25.00, also 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 then we will charge a $25.00 fee for a returned 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 them within 60 days you will be billed for the services. **Ultimately, it is your responsibility to know your coverage and follow up with your company to make sure payment is made.** We will be happy to assist with questions and help you to understand what is needed from your company. If there is no response to our requests from you to get payment then we will send your accounts to collections. We reserve the right to assess fees from the collection agency as well.

Email Correspondence: I authorize Bright Futures Pediatrics to email me on occasion's reminders of follow up appointments and other necessary communications.

Parent Email Address: _____ Parent 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. In event there is a material change to the notice, the revised notice will be posted.
If you have any complaints concerning our privacy practices you may Contact our Office Manager, by mail at the above address or call (702)944-4028

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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) (Must be 18 years and older):

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 considered for **one year** from signed date unless otherwise specified

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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 / from (circle one):

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

Records to be released to / from (circle one):

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. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein.
This authorization shall be in force and effect until **one year** from date of execution at which time this authorization Expires.

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, letters -$10.00 (please allow 12-24 hrs for completion)**
- **Sports physicals -** **$25.00 if child has been seen for a wellness visit in the past 30 days (please allow 12-24 hrs for completion)**
- **Sports physicals -** **$50 if child has not had a wellness visit in the past 30 days, child will need to be seen.**
- **Immunization Records -** **$5.00/ patient**
- **Medical Records-** **$0.60/ page**
- **FMLA paperwork-** **$50.00 (please allow 10-14 business days for completion)**

If you arrive more than 15 **minutes late** of your appointment time you will be asked to reschedule and will be **charged a $25.00 fee**.
All **No Shows** and **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 read and understood 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

Bright Futures Pediatrics

8352 W. Warm Springs Rd. Ste 210 Las Vegas, NV 89113 702-944-4028

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice or if you need more information, please contact

Bright Futures Pediatrics

Attn: Ashley Jones / Practice Manager

702-944-4028

8352 W. Warm Springs Rd #210

Las Vegas, Nevada 89113

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **Bright Futures Pediatrics.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research.** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **Bright Futures Pediatrics** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**

- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.

- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may

deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

• **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

• **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.

• **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

• **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: *www.bfpnv.com* or contact Bright Futures Pediatrics office you are receiving services from.

• Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

• Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Bright Futures Pediatrics** at the address listed at the beginning of this Notice

Bright Futures Pediatrics
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read the Patient Notice of Privacy Practices of the **Bright Futures Pediatrics. A copy may be given upon request. A copy may be obtained on our website at www.bfpnv.com.**

Date: _____

Childs Name:_____
(Please Print Only)

Guardians Signature:_____
(or Guardian, if applicable)

Please submit all requests in writing to our Medical Records Department, at Bright Futures Pediatrics 8352 W. Warm Springs Rd #210 Las Vegas, NV 89113. There may be a charge for transferring medical records.