Kiddies' Pal
Pediatrics

New Patient Registration

(FILL OUT COMPLETELY)

Date of Birth _____ Sex: _____
Patient's Name_____ SSN _____
Home address: _____Zip _____

Preferred Phone Number : _____ home/cell/work (please circle one)

Alternate Phone Number: _____ home/cell/work (please circle one)

Email address: _____

Preferred contact method: phone text email mail fax (please circle one)

May we leave a message at preferred contact? Yes / No

Mother's Name _____DOB_____ SSN _____

Address: _____City_____Zip_____

Employer: _____ Position: _____

Father's Name _____ DOB_____ SSN _____

Address: _____City_____Zip_____

Employer: _____ Position: _____

Parents are: Married/Divorced/Separated/Single (please circle one)

Who has legal custody? _____ Insured Name: _____

Insurance Carrier: _____

Group ID: _____ Subscriber ID: _____

Siblings:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Preferred Pharmacy: (specific address)_____

Emergency Contacts:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

List any other person that has permission to bring your child in to be seen in our office. Indicate whether they may consent for all care including immunizations and lab work.

Name : _____ Care: all /other _____

Name : _____ Care: all /other _____

Name : _____ Care: all /other _____

* any person accompanying your child is responsible for charges incurred on the day of service including copayments.

* I hereby authorize Kiddies' Pal Pediatrics to furnish information to insurance carriers concerning my child's illness and/or treatment. I also assign Kiddies' Pal Pediatrics all payments for medical services rendered to my child. I understand that I am responsible for any amount not covered by insurance or other implied payors.

Acknowledgment of Receipt of Privacy Practices

I have received a copy of the Notice of Privacy Practices. This notice describes how my health information may be used or disclosed. I understand that the Notice may change at any time.

Signature: _____ Date: _____

How did you hear about us: _____

Kiddies' Pal Pediatrics (KPP)
FINANCIAL POLICY

KPP believes providing and maintaining a positive and communicative physician-patient relationship with our families is important. We want to make sure you understand all KPP financial policies relating to your responsibility as well as the responsibility of your insurance company. Please read this carefully. We will be happy to provide further clarification if needed. After your review, please see the Financial Policy, Credit Card on File Policy, Annual Administrative Fee and Permission to Treat. If you have any questions, please do not hesitate to ask a member of our billing staff.

Billing/Payment Policy

We participate in many insurance plans. Insurance plans are complex and differ even within the same insurance company. It is your responsibility to fully understand your plan and any health savings accounts you may have. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at ***the time of your visit. Before*** every visit, you ***MUST settle your account*** by check, cash or credit card.

We require a credit card on file. Having a credit card on file allows flexibility for payment and can extend the time you need to pay the balance - in some cases as long as 90 days from the time of the visit. When we receive payment from your insurance company, any balance due from you will be applied to your credit card. If your credit card has expired or we are unable to run the balance through your credit card, then the balance will be billed to you via mail immediately. Your credit card information is stored in an encrypted merchant services company called BluePay. KPP only has access to the last 4 digits of your account number.

Please be assured if there are financial circumstances that prevent you from settling your account at the time of your visit we are more than willing to work with you, ***but you must communicate this with our patient accounts coordinator so arrangements can be made and noted in your account.***

The adult accompanying your child is responsible for payment at the time of service unless you have a credit card on file. Unless previous arrangements have been made, adolescents who come alone should be prepared to settle their visit if you have chosen not to leave a credit card on file. In the case of non-joint custody, please note the documented guarantor is responsible for payment.

We pride ourselves on providing exceptional, state-of-the-art medical care and extended services for our patients. Sometimes insurance companies choose not to pay for recognized service codes. ***Any non-covered service (like instrument based vision screen or hearing test) is your responsibility.*** Please refer to our website for the health maintenance schedule for services provided at each visit. Most times if your insurance does not cover a service and it is your responsibility, we will offer a discount at the time of payment. Please note, after normal business hours, most insurers recognize after hour codes and we charge for these. Urgent care centers and ERs have significantly higher copays and deductibles. Please take time to understand the insurance plan you have. If your insurance does not cover these after hour codes you will be responsible.

Appointment Cancellation Policy

All specialty appointments (like Lactation Consultation) require a 48-hour cancellation notice and well care appointments require a 24 -hour cancellation notice to avoid a fee. Depending on the complexity of the appointment, fees range from $25 to $50. Medicaid/State insurance patients will be discharged for no-shows, as government rules prohibit this fee.

Records Release

There is no charge for releasing records if the patient is current with their yearly administrative fee.

Non-Payment Policy and Overdue Accounts

We realize some families from time to time experience financial difficulties and we want to always be here to care for your children. Communicating any hardships with us ensures uninterrupted medical care. It is of utmost importance to discuss these issues and make financial arrangements with our patient accounts' manager. However, if you ignore or fail to respond to your financial obligation, we will have no choice but to enforce our non-payment policy.

If your credit card is not valid, we will notify you and payment will be expected 10 days from receipt. You **MUST check out personally and settle your account at each visit.** As with an invalid credit card, you will receive a letter and payment is due within 10 business days from receipt.

Any accounts over 90 days will receive a certified letter and will need to be settled in 7 business days. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at KPP. Your account will be sent to collection, and all legal fees and collection expense will be added to your balance. By law, we will continue to provide emergency care for 30 days from date of notice. Should a patient need non-emergent medical attention in those 30 days, you will be required to settle your account prior to the visit.

Yearly Administrative Fee

The modest annual fee of $10 for all children and adolescents, with a maximum of $30 per family is for non-covered and administrative services. Payment of this fee entitles the patient to participate in all the services provided by KPP.

Kiddies' Pal Pediatrics
FINANCIAL POLICY SIGNATURE PAGE

Please complete and return by mail or bring to the front desk.

Guarantor's Name: _____

Guarantor's Email: _____

Patient Names: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Financial Policy

I have read and understand the office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined on Financial Policy Page.

× _____ Date: _____

Guarantor Signature

Credit Card on File Policy

For your convenience we accept debit cards and credit cards (Visa, MasterCard, Discover)

(Please print name) _____ authorizes Kiddies' Pal Pediatrics to charge my credit card for the following reasons: *Office visits, Deductibles, Coinsurances, Copays, Non-Covered Services, Administrative Services, Cancellations and No Show Fees.*

NOTE: If the credit card you are using for the Patient Service Plan payment is NOT the card you would like saved on file for co-payments, balances or any other charge, please give the staff your preferred card.

× _____ Date: _____

Guarantor Signature

Yearly Administrative Fee

I have read, understand and agree to the yearly administrative fee. I authorize Kiddies' Pal Pediatrics to charge this mandatory administrative fee to my credit card. This card will be saved on file for the year. I understand it is a $10.00 /patient and $30/family. I understand that if I do not provide a credit card, I will pay the mandatory administrative fee either online or mail it to Kiddies' Pal Pediatrics at 851 S Rampart Blvd, Ste 130, Las Vegas, NV 89145.

× _____ Date: _____

Guarantor Signature

Permission to Treat

I _____ (or my legal guardian or parents) authorize Kiddies' Pal Pediatrics to provide medical care reasonable by today's standards.

× _____ Date: _____

Parent/Guardian Signature

Kiddies' Pal
Pediatrics

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

_____

To release healthcare information of the patient named above to:

Name: Kiddies' Pal Pediatrics_____

Address: 851 S Rampart Blvd, Ste 130 _____

City: Las Vegas_____ State: NV_____ Zip Code: 89145

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: _____

□ All healthcare information

□ Other:

As the person signing this authorization, I understand that I am giving my permission to the above named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless specific circumstances under which such conditioning is permitted by law are applicable and set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to the records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included in my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

Patient *Signature:*_____ Date: _____

Relationship to Patient: _____

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003

Kiddies' Pal Pediatrics

851 S Rampart Blvd, Suite 130, Las Vegas, NV 89145

702-823-1333

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Tal A Minuskin, MD	702-823-1333	kiddiespalpediatrics@cox.net
HIPAA Compliance Officer	phone	email

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" section on the 2nd page of the registration form. Please note that by signing the Acknowledgment you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Kiddies' Pal Pediatrics

851 S Rampart Blvd, Ste 130
Las Vegas, NV 89145

Phone 702-823-1333
Fax 702-823-1190

Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement

Kiddies' Pal Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kiddies' Pal Pediatrics does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kiddies' Pal Pediatrics:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Limor Minuskin

If you believe that Kiddies' Pal Pediatrics has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Limor Minuskin, Office Manager, 851 S Rampart Blvd, Las Vegas, NV 89145, phone: 702-823-1333, fax: 702-823-1190, email: kiddiespalpediatrics@cox.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Limor Minuskin is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.