WEST VALLEY PEDIATRICS

Patient Name:_____M____F_____DOB:_____/_____/_____

Residential:_____ APT:_____

City:_____ State:_____ Zip:_____

Race: CAUC AFR/AMER ASIAN NTV/AMER OTHER Ethnicity: HISPANIC OTHER REFUSED

PREFERRED COMMUNICATION

How do you wish to receive communication/reminders? (Select all that apply) : VOICE TEXT EMAIL

Primary Phone Number:_____ ☐ CELL PHONE ☐ HOME PHONE

Contact Email:_____ LANGUAGE: ENGLISH SPANISH

RESPONSIBLE PARTIES

Relationship to Patient: Mother Father Guardian

Name:_____DOB_____/_____/_____ SSN:_____

Mailing:_____APT:_____City:_____State:_____Zip:_____

Home:_____Cell:_____ Work:_____

Employer:_____

Relationship to Patient: Mother Father Guardian

Name:_____DOB_____/_____/_____ SSN:_____

Mailing:_____APT:_____City:_____State:_____Zip:_____

Home:_____Cell:_____ Work:_____

Employer:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Name:_____ ID#:_____ Group#:_____

Cardholder Name_____ DOB:_____/_____/_____

SECONDARY INSURANCE:

Insurance Name:_____ ID#:_____ Group#:_____

Cardholder Name_____ DOB:_____/_____/_____

PHARMACY INFORMATION

Pharmacy Name:_____ Cross Streets:_____/_____

PLEASE READ AND SIGN BELOW:

MEDICAL CONSENT/ASSIGNMENT/RELEASE: I hereby agree to medical treatment rendered under control of West Valley Pediatrics, PC. I hereby assign my insurance benefits to be paid directly to West Valley Pediatrics, PC and I am financially responsible for any non-covered services. I also authorize West Valley Pediatrics, PC to release information as necessary to process all claims for services rendered. Rev 11/14

_____ _____ _____

Parent/Guardian Name Printed Parent/Guardian Signature Date

HEALTH HISTORY FORM

Child's Name: _____ □ M □ F Date of Birth: _____

Previous Pediatrician/Doctor: _____ Phone: _____

I. PREGNANCY HISTORY

During your pregnancy with this child did you:

1. Have high blood pressure?.....□Yes □ No
2. Have diabetes or sugar in your urine?.....□Yes □ No
3. Have albumin or protein in your urine?.....□Yes □ No
4. Have a urinary infection?.....□Yes □ No
5. Have German (3day) Measles?.....□Yes □ No
6. Have chicken pox or receive immunization?.....□Yes □ No
7. Take any medications?.....□Yes □ No
8. Smoke cigarettes?.....□Yes □ No
9. Get tested or treated for STD's?.....□Yes □ No
10. Drink alcohol? .....□Yes □ No
11. Street drugs? _____
12. How many weeks was your pregnancy?_____weeks
13. How early did you start seeing your doctor? _____ months
14. Deliver multiples?..□Yes □ No How many? _____
15. Was the delivery... □ vaginal □ cesarean □ breech

II. CHILD'S MEDICAL/NUTRITIONAL HISTORY

1. Did your baby breathe/cry immediately at birth...□Yes □ No
2. Was the baby jaundiced at birth?.....□Yes □ No
3. Did the baby receive a blood transfusion?.....□Yes □ No
4. At birth, did the baby appear normal?.....□Yes □ No
5. Was Newborn screening testing done at birth?...□Yes □ No
   What state? _____
6. During baby's FIRST year, did you breastfeed?.....□Yes □ No
7. During baby's FIRST year, did you formula feed?.□Yes □ No
8. If feeding problems, explain: _____
   _____
9. Weaning from breast completed at what age? _____
10. Whole milk started at what age? _____
    Problems/Allergies? _____
11. Solid food started at what age? _____
    Problems/Allergies? _____

III. SURGERY/HOSPITALIZATION INFORMATION

Please list any overnight hospitalizations or surgeries with reasons and dates.

_____

_____

IV. SOCIAL/DEVELOPMENTAL HISTORY

1. Mother's age? _____ Father's age? _____
2. Child has how many sisters? _____ brothers? _____
3. Child is _____ in family?
   Oldest, Youngest, Middle
4. Other children's ages' _____ / _____ / _____ / _____ / _____
5. Who lives in the home with the child? _____
6. Who spends the most time caring for child? _____
7. Does child go to day care, baby-sitter or preschool? □ Yes □ No
8. Child sat up at: _____ age
9. Child crawled at: _____ age
10. Child walked at:_____ age
11. Child started talking at: _____ age

V. FAMILY HISTORY

Has any blood relative of your child ever had or been treated for:

Allergies.....	□ Yes □ No	Heart trouble.....	□ Yes □ No
Blood disease.....	□ Yes □ No	Diabetes (sugar in urine).....	□ Yes □ No
Cancer.....	□ Yes □ No	Tuberculosis (T.B.).....	□ Yes □ No
Lung disease.....	□ Yes □ No	Mental illness.....	□ Yes □ No

Explain 'Yes" answers: _____

Parent/Guardian Signature: _____ Date: _____

West Valley Pediatrics Consent Form

Patient Name: _____ DOB:_____

The following individuals have my permission to bring my child to West Valley Pediatrics for medical care and treatment. I also authorize the same individuals to receive medical advice and information concerning my child, whether in office or over the phone. These individuals will also serve as emergency contacts for my child.

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

I give my consent for the staff at West Valley Pediatrics to relay any imperative information by:

Check all that apply

_____ Voicemail

_____ Email (If registered with the patient portal)

This statement will expire 12 months from the signed date.

Parent/Guardian Name Printed	Parent/Guardian Signature	Date

West Valley Pediatrics
10750 W McDowell Rd Ste G-700
Avondale, AZ 85392
(623) 873-0321 phone (623) 849-9623 fax

Name: _____ DOB: _____ Date: _____

LEAD SCREENING QUESTIONNAIRE

Please answer the following questions.

YES	NO	
_____	_____	1. Does your child live in, often visit, or play near a house or building built before 1978 with recent remodeling? (This could include a day care center, preschool, and the home of a babysitter or a relative.)
_____	_____	2. Does your child live in or visit often a house with peeling or chipping paint built before 1960?
_____	_____	3. Has your family or child ever lived outside the United States, or has just arrived from a foreign country?
_____	_____	4. Does your child have a brother, sister, housemate, or playmate being followed or treated for lead poisoning?
_____	_____	5. Does your child often put things in his/her mouth such as toys, jewelry, or keys? Does your child eat anything that is not food?
_____	_____	6. Does your child often come in contact with an adult whose job or hobby involves exposure to lead? (Jobs include house painting, plumbing, remodeling, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.)
_____	_____	7. Does your child live near an active company that melts lead, battery recycling plant, or another industry likely to release lead?
_____	_____	8. Does your family use cosmetics from other countries like kohl, surma, or sindoor?
_____	_____	9. Do you give your child any home remedies or traditional medicines that may contain lead?
_____	_____	10. Does your child eat food, drink juice or punch that has been stored in pottery from Mexico or that has been stored in open cans?
_____	_____	11. Does your child live near a busy roadway where soil and dust may be contaminated with lead?
_____	_____	12. Does your home's plumbing have lead pipes or copper with lead joints?

West Valley Pediatrics Policies

Patient Name: _____ DOB: _____/_____/_____

Thank you for choosing West Valley Pediatrics (WVP) as your primary care physicians. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

Please carefully read and initial by each statement and sign below.

1. _____ **I understand that I, _____, am responsible for confirming my medical benefits of my dependent with my carrier/insurance group and that I am expected to have this information ready at the time of my visit.** WVP will allow 60 days from the date of filing for my insurance company to process or pay a claim, Arizona Law allows insurance companies operating in the state no more than 30 days to process claims. **It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify WVP if there is a change in my insurance coverage, residence, or phone number.**
2. _____ I understand that I need to provide my photo I.D., insurance card and/or co-payment at every visit. If I am not able to do so, I understand that my appointment may be rescheduled until such time that I can provide the required documents or payments.
3. _____I understand that minors must be accompanied by a parent or legal guardian to be treated by WVP. Payment is due at the time of service regardless of who is accompanying the child. If the child lives with someone other than the parent(s), we must have a copy of legal document(s) stating where the child resides.
4. _____I understand that failure to show up to my child's scheduled appointment constitutes as a NO SHOW. I know that WVP reserves the right to discharge me, as a patient, from the practice after the third NO SHOW. I understand that a $25 NO SHOW fee may be applied to my account for each occurrence. If I am unable to keep my child's scheduled appointment I will call the office at least 24 hours prior to my scheduled appointment to reschedule.
5. _____The provider's at WVP kindly request that cell phones not be answered during appointments. If cell phone use becomes disruptive, the provider may walk out of the room and your appointment would be rescheduled.
6. _____I understand that there is a charge of $10 for any forms that I request the doctor to complete on my behalf. The payment for completion of these forms will be collected at the time of request.
7. _____In the case of a returned check, I understand that a fee of $25 will be added to my account balance and it may prevent me from being able to pay with checks in the future.
8. _____I understand that any lab services performed and sent to an outside laboratory, such as LabCorp or Sonora Quest, will be billed separately by those labs. **Any questions or concerns regarding that bill should be directed to the lab, not WVP billing department.**
9. _____I understand that once my account is 120 days past due, it will be sent to our outside collection agency, J.R.,Bros. This will prevent me from scheduling appointments for my whole family, until the balance is paid in full.

I have read and I understand the above policies of West Valley Pediatrics.

Parent/Guardian Name Printed | Parent/Guardian Signature | Date | Rev 11/17

WVP Policy for Parents

Patient Name:_____ DOB:_____

The providers and staff of West Valley Pediatrics are here to take care of children. Our focus is on the medical, psychological and emotional health of your child(ren)- NOT legal issues involving divorce, separation, or custody agreements. That is why we ask that you read and agree to the following:

- Please make decisions regarding vaccinating your child(ren), circumcision, reproductive education, etc. prior to visiting our practice.
- Either parent or legal guardian is able to schedule an appointment for their child, be present for the visit, and/ or obtain a copy of the visit summary. ***Unless there is a court order in the child's record that restricts a parent's rights. Please do not ask us to limit the other parent's involvement in the child's care.***
- Payments are due and the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. ***We will collect payment due from the parent who brings the child to the visit.*** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- Both parents/ legal guardians can sign a "Consent to Treat" form. This means other persons (grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during that visit. ***We will NOT be involved in any disputes regarding named individuals on your child(ren)'s Consent to Treat form***. Both parents/ legal guardians can see who is named on each other's forms; however we will not comply with requests to eliminate names on other's form, unless instructed by the court. Please refer these requests to your attorney.
- Additionally, we will not:
    - Call the other parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
    - Restrict the involvement of either parent or legal guardian in your child(ren)'s care, unless authorized by law.
    - Tolerate appointment scheduling/cancelling patterns of behavior between parents.
- It is the responsibility of both parents to communicate with each other about the patient's care, office dates/visits and any other pertinent information relevant to the care of the child. Please do not ask our providers to call the non-attending parent following visits.
- Should the issues that come between parents become disruptive to our practice or impede the care of children, we reserve the right to discharge your family from further treatment.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Parent/Legal Guardian Signature Date

HIPAA Notice of Privacy Practices

West Valley Pediatrics
10750 W McDowell Rd, #G-700
Avondale, AZ 85 312
623-873-0321

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 describes how we 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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

HIPAA Notice of Privacy Practices

West Valley Pediatrics
10750 W McDowell Rd, G700
Avondale, AZ 85392
623-873-0321

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices;

Patient Name:_____DOB:_____

Parent/Guardian Signature:_____Date:_____