Siena Pediatrics
2441 W Horizon Ridge Parkway
Henderson, NV 89052
Phone: 702.248.7337
Fax: 702.478.5465

Child 1: Last Name:_____ First Name: _____
DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No
Ethnicity:☐Hispanic☐ Non-Hispanic☐Unknown Race:☐ Asian☐ Black☐ Hawaiian☐ White
Allergies to Medications:_____ ☐ None
Food/Seasonal Allergies:_____ ☐ None

Child 2: Last Name:_____ First Name: _____
DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No
Ethnicity:☐Hispanic☐ Non-Hispanic☐Unknown Race:☐ Asian☐ Black☐ Hawaiian☐ White
Allergies to Medications:_____ ☐ None
Food/Seasonal Allergies:_____ ☐ None

Child 3: Last Name:_____ First Name: _____
DOB: _____Sex:___Primary Language:_____Do you need an interpreter? ☐ Yes ☐ No
Ethnicity:☐Hispanic☐ Non-Hispanic☐Unknown Race:☐ Asian☐ Black☐ Hawaiian☐ White
Allergies to Medications:_____ ☐ None
Food/Seasonal Allergies:_____ ☐ None
******PLEASE ASK FRONT DESK FOR ANOTHER SHEET FOR ADDITIONAL CHILDREN******

Email Address: _____

Mother/Guardian Info: Name: _____
Relation to patient:_____ Lives with patient: ☐ Yes ☐ No
Date of birth: _____Social Security Number: _____
Street or PO Box:_____ Apt/Unit No.:_____
City _____State_____ Zip _____
Cell phone: (____)_____Work phone: (___)_____
Employer:_____Occupation:_____

Father/Guardian Info: Name: _____
Relation to patient:_____ Lives with patient: ☐ Yes ☐ No
Date of birth: _____Social Security Number: _____
Street or PO Box:_____ Apt/Unit No.:_____
City _____State_____ Zip _____
Cell phone: (____)_____Work phone: (___)_____
Employer:_____Occupation:_____

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How would you ideally prefer to be contacted regarding the following (check only one):

Medical Issues: ☐ Home phone ☐ Work Phone ☐ Cell Phone

May we leave voicemail ☐ with detail ☐ without detail

Insurance:

Primary policy:

Insurance Company: _____

Insurance Street or PO Box:_____City _____State___ Zip _____

Policy's holder's name:_____Policy holder's date of birth:_____

ID# _____Group#_____

Secondary policy:

Insurance Company: _____

Insurance Street or PO Box:_____City _____State___ Zip _____

Policy's holder's name:_____Policy holder's date of birth:_____

ID# _____Group#_____

Pharmacy:

Name of Pharmacy: _____ Telephone # _____

Address: _____

Additional Contact Questions:

Who should receive billing statements? _____

(If it should be a person other than the one completing this form, please provide legal documentation supporting this claim)

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ Yes ☐ No

If yes, please provide a copy of any legal paperwork that supports this restriction.

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FINANCIAL AND COLLECTION POLICY
PLEASE READ THE FOLLOWING CAREFULLY:

INTIAL	
	Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage.
	We bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time service is rendered.
	If you have Managed Care insurance, please make sure you have contacted them and named us as your primary care physicians or you will be responsible for payment of services.
	Photo ID and Insurance card must be provided for every visit.
	You agree to pay all insurance co-pays at the time of check in and prior to services being rendered.
	If Siena Pediatrics cannot verify your insurance at the visit or if you do not bring current proof of insurance to each visit, you agree to pay charges in full prior to your visit.
	If any charges incurred by you or your dependents are submitted to a collection agency, you agree to pay all fees including, but not limited to, both collection agency fee and the account balance. Once account has gone to collections, we cannot waive the collection agency's fees.
	If you need to cancel/reschedule your appointment, we require 24 hours' notice, so we can schedule another patient who needs medical care. If appointment isn't cancelled, you will be assessed a $35 penalty fee.
	If you incur 3 No Show appointments within a year time period, you may be discharged from our practice, however there will be a 30 days' grace period for sick visits only.
	You agree to pay $35 returned check fee, in addition to the amount of the check, on any of your personal checks which are returned to this office by our bank.
	While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at the exact time. Siena Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. You agree not to hold Siena Pediatrics responsible in any manner for time spent waiting to be seen.
	If your insurance has not paid within 90 days, you agree to pay all charges which have been incurred by you or your dependents at the time of visit, regardless of your insurance company's instructions.
	ALL medical record requests will take 5 business days, and photo ID must be provided during pick up. We will assess $25 charge for FMLA paperwork.
	Our office bills are for doctor services only. Fees for lab work or cultures are billed separately by the appropriate lab.
	Patient refunds will be released once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any copays, coinsurance, deductibles, or any other charges your insurance carrier may apply towards your responsibility. Time frame is usually 6 to 8 weeks. We do understand that temporary hardships may affect timely payment of your balance.
	If there is any change of insurance, it is the parent's responsibility to notify Siena Pediatrics of the changes.
	For all newborns, parents are responsible to add child within first 30 days post birth. If child is not added within this time period, your visits will be treated as cash pay and/or all balances due will be parent's/guardian's responsibility.
	As the child's parent, I understand that it is my responsibility to make and attend all follow up visits ordered by the doctor. I understand the doctor would not order a follow up visit if it wasn't important. I also understand that Siena Pediatrics cannot call me and remind that I need to make a follow up appointment. Therefore, it is my responsibility if I should fail to schedule or attend a follow up visit.
	I understand I am fully responsible to make and attend my appointments when referred to a specialist. I accept all responsibility if I fail to schedule or attend appointment with a specialist.
	You agree and understand any damages to Siena Pediatrics facility, equipment or property by you, your child, or associated party will be financial responsibility. Any damages or destruction incurred to Siena Pediatrics will result in recuperation of reparation costs and could be subject to termination from the practice.

We encourage you to communicate any problems so that we can assist you in the management of your account. We also offer payment arrangements. You may speak with our billing department for further assistance.

_____ _____

Parent/Guardian Signature **Date**

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IMPORTANT INFORMATION

Insurance

By contracting with insurance companies, Siena Pediatrics has agreed to file insurance claims for patients who participate in these plans. **In order to do so, we must see your child's insurance card** (current at the time of the appointment) **and parent/guardian photo ID at EVERY visit.** If you do not have the necessary information and we are unable to verify your coverage, we must ask for payment at the time of visit.

We collect all co-payments at the time services are rendered. A monthly statement will be sent to you detailing unpaid charges, if you have questions regarding items which have not been paid by your insurance, we ask that you call your insurance company, as benefit packages vary by insurance policy.

Methods of Payment

We accept MasterCard, Visa, American Express, Discover and debit card. It is the parent's responsibility to know details of their insurance plan, its benefits and the amount of the co-payment.

Effective Immediately!!!!

New Vaccination Policy!!!! Our practice strongly believes in administering childhood vaccination for diseases prevention. In support of our beliefs and for the health and well-being of our patient population, **we are not accepting new patients to the practice who do not comply with the minimum recommended vaccines.**

Important

Do not call from a phone that does not accept blocked calls, as physicians will be calling from a phone with a blocked number. Also, please do not call for routine calls after hours (such as a dose of medication), please respect our physicians' time with their families. These calls are subject to change. For any urgent care issues that occur after midnight, patients are encouraged to be seen by a health professional.

In Case of Emergency

If your child is experiencing a life-threatening emergency, please call 911 for immediate help. Urgent problems during regular office hours can be handled by contacting the office during our business hours. Notify the staff member who answers the phone that you have an urgent problem and your call will be handled immediately. The physicians can be reached for urgent problems after hours by calling our answering service at 702-248-7337 and the service will page the physician on call. The provider will then return your call at the number you provide.

PLEASE SIGN BELOW TO ACKNOWLEDGE AND UNDERSTAND OUR POLICIES.

_____ _____

Parent/Guardian Signature **Date**

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Authorization Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person brings your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Siena Pediatrics and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the Siena Pediatrics provider/staff.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) **Relationship**

_____ _____
Name of Person (allowed to bring child) **Relationship**

_____ _____
Parent/Guardian Signature **Date**

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my child's health care, **Siena Pediatrics** originates and maintains paper and/or electronic records describing my child's health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that **Siena Pediatrics** is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to **Siena Pediatrics** to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

I fully understand and accept the terms of this consent.

X_____ _____
Parent/Guardian Signature **Date**

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NON-CONTRACTED INSURANCES

Listed below are the insurances that our practice is not contracted with. By signing this form, you are acknowledging this list and are aware that if you have any one of these insurances and continue to proceed with care from our facility, you will be responsible for all charges for that date of service.

***Health Plan of Nevada HMO (Currently in the process of credentialing with our practice)**

***Sutter Select administered by UMR**

***Coventry Healthcare Partners HMO**

***BCBS/Amerigroup Medicaid**

***SilverSummit Healthplan Medicaid/Ambetter**

***PacifiCare HMO**

***All exchange plans except HPN Nevada Exchange**

***Blue Cross Pathway except for Tier 2 network**

***Cigna Local Plus plans**

***Standard Life**

***United Healthcare Compass Balanced Plan**

***Aetna Value Network**

_____ _____

Parent/Guardian Signature **Date**

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ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Siena Pediatrics Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

_____ _____

Parent/Guardian Signature **Date**

FRONT DESK_____