Rocky Mountain Pediatric Surgery

Patient Registration

Health ONE Clinic Services

Patient's Information:

Patient's Name (Last) _____ (First) _____ (M.I) _____

DOB: _____ Age: _____ Male ☐ Female ☐ SS #: _____

Address: _____

City:_____ State:_____ Zip Code:_____

Race: _____ Ethnicity: _____ Preferred Language: _____

Parent/Guardian 1: **Relationship to patient:**_____

Name (Last) _____ (First) _____ (M.I) _____

DOB: _____ Email Address: _____ Permission to contact via Email: Yes ☐ No ☐

Address: Same as above ☐ _____ Permission to leave detailed information on a voicemail (including lab results, etc.)

Phone: _____ Mobile: _____ ☐ Phone ☐ Mobile ☐ Neither

Parent/Guardian 2: **Relationship to patient:**_____

Name (Last) _____ (First) _____ (M.I) _____

DOB: _____ Email Address: _____ Permission to contact via Email: Yes ☐ No ☐

Address: Same as above ☐ _____ Permission to leave detailed information on a voicemail (including lab results, etc.)

Phone: _____ Mobile: _____ ☐ Phone ☐ Mobile ☐ Neither

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: _____

Primary Care/Pediatrician's Information:

Physician's Name: _____ Practice Name: _____

Address: _____

(Street) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Referring Physician's Information: Same as above ☐

Physician's Name: _____ Practice Name: _____

Address: _____

(Street) (City) (State) (Zip)

Phone Number : _____ Fax Number:_____

Primary Insurance Information: See card attached ☐

Insurance Name: _____ Policy Holder Name:_____

Policy Holder's DOB: _____ Employer: _____

ID#: _____ Group #:_____

Secondary Insurance Information (if applicable): See card attached ☐

Insurance Name: _____Policy Holder Name:_____

Policy Holder's DOB: _____ Employer: _____

ID #: _____ Group #: _____

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address : _____

How did you hear about our office?

☐ Primary Care Doctor ☐ Website ☐ Friend/Word of Mouth ☐ Other: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ Date: _____

Rocky Mountain Pediatric Surgery Patient History

General Information:

Patient Name: _____ DOB: _____

Reason for Visit: _____

Primary Care Physician/Pediatrician: _____

Is there a legal agreement in place regarding the medical treatment/information of the child? Ye☐ N☐

Birth History:

How much did your child weigh at birth? _____ pounds _____ ounces

If your child was born early (premature), at how many weeks? _____ weeks

How old was the child at discharge from the hospital? _____ (Age)

Medical History:

Please list hospitalizations ☐ None

Age _____ Reason for hospitalization: _____

Age _____ Reason for hospitalization: _____

Age _____ Reason for hospitalization: _____

Surgical History:

☐ None

Please list any operations (and approximate age). Please let us know if there were any anesthetic problems.

Age _____ Operation: _____

Age _____ Operation: _____

Age _____ Operation: _____

Anesthetic Problems? _____

_____

Has anyone in your family had an abnormal reaction to anesthesia? ☐ Yes ☐ No

Reaction: _____ Relation: _____

Allergies:

☐ None

Please list all known allergies

Medication _____ Reaction: _____

Medication _____ Reaction: _____

Medication _____ Reaction: _____

Food _____ Reaction: _____

Other _____ Reaction: _____

Latex ☐ Yes ☐ No

Current Medications:

☐ None

Please list all medications your child currently takes

Medication _____ Dose _____ Frequency:_____ Route:_____

Medication _____ Dose_____ Frequency: _____ Route:_____

Medication _____ Dose_____ Frequency: _____ Route: _____

Health Problems

☐ None

Please check any of the following that apply to your child

☐ Pneumonia	☐ Asthma	☐ Croup	☐ Bronchitis
☐ Ear Infections	☐ Strep Throat	☐ Diabetes	☐ Thyroid Problems
☐ Sinus Infections	☐ Skin Problems	☐ Hearing loss	☐ Vision Problems
☐ Anemia	☐ Broken Bones	☐ Kidney Disease	☐ RSV/Bronchiolitis
☐ Urinary Infections	☐ Seizures	☐ Heart Murmur	☐ Chronic Headaches
☐ Hepatitis	☐ Frequent Diarrhea		
☐ Reflux Disease	☐ Frequent Constipation		

Any Depression Concerns?

☐ Yes ☐ No ☐ N/A if under 12 years old

Immunizations

Are all immunizations up to date? ☐ Yes ☐ No

Has your child had a flu shot? ☐ Yes ☐ No

If yes, where?_____ When? (Approximately)_____

Smoking Status

Does your child smoke? Yes ☐ No ☐

Is your child exposed to second hand smoke? ☐ Yes ☐ No

Bleeding Problems

☐ None

Does your child have hemophilia or Von Willebrand's Disease? ☐ Yes ☐ No

Does your child bruise easily? ☐ Yes ☐ No

Does your child have chronic nose bleeds or bleeding gums? ☐ Yes ☐ No

Is there any family history of bleeding disorders? Yes ☐ No ☐

If yes, who? _____ Relation to child _____

Family History

Please list ages of parents and siblings and describe medication allergies, problems with anesthesia and chronic illnesses (such as asthma, diabetes, etc)

Mother Name: _____ Age: _____ Health Information: _____

Father Name: _____ Age: _____ Health Information: _____

Sibling Name: _____ Age: _____ Health Information: _____

Sibling Name: _____ Age: _____ Health Information: _____

Sibling Name: _____ Age: _____ Health Information: _____

Is there anything else you want us to know about your child?

Please describe any other concerns you want us to address or things you think we should know to protect your child during their office visit, operation or hospitalization.

_____

_____

_____

_____

Signature of patient (or Responsible Party): _____ Date: _____

Updated: December 20, 2016 replacing April 22, 2016, October 28, 2015, June 12, 2015 & November 21, 2013 version

A photocopy of this consent shall be considered as valid as the original.

FINANCIAL POLICY

We would like to thank you for choosing Rocky Mountain Pediatric Surgery for your child's care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE:
Your child is here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures. Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, radiology, anesthesiology, surgical assistant)

PAYMENT:
For patients with a co-pay plan, payment is expected at the time of service. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered, deductibles and coinsurance are your responsibility and will be billed to you by our office. Payment is due with-in 30 days. If surgery is recommended, we collect deductibles and co-insurance prior to surgery. Payment must be received 48-hours prior to surgery.

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff.

INSURANCE:
All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility as the parent/guardian to provide accurate and timely insurance information.

INSURANCE REFERRALS:
It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

CONSENT TO TREAT

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medially accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that HealthONE Clinic Services may include consent at satellite offices under common ownership

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Guardian/Responsible Party Signature: _____ Date: _____

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Rocky Mountain Pediatric Surgery

Patient Name_____ Date of Birth_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____(Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, Rocky Mountain Pediatric Surgery may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)

Third Party Collection. I acknowledge that Rocky Mountain Pediatric Surgery may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____(Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to Rocky Mountain Pediatric Surgery any insurance or other third-party benefits available for health care services provided to me. I understand Rocky Mountain Pediatric Surgery has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Rocky Mountain Pediatric Surgery, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Rocky Mountain Pediatric Surgery by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for Rocky Mountain Pediatric Surgery, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Rocky Mountain Pediatric Surgery or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Rocky Mountain Pediatric Surgery or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____