

CENTER FOR CHILDREN'S SURGERY
3121 S. MARYLAND PKWY., SUITE 400, LAS VEGAS, NV 89109
PH# (702) 650-2500 * FAX# (702) 650-2220

Patient's Name: _____

SS# _____ Birth Date: _____ Male: _____ Female: _____

Address: _____ Apt# _____ City, State, Zip: _____

Home Phone # (____) _____ Cell Phone# (____) _____

Reason for Referral: _____ Primary Care Physician: _____
Phone # _____

Who is the Legal Guardian of this patient? (Please Circle) Mother Father Both Other _____

Father or Legal Guardian

Name: _____

Birth Date: _____

Phone # _____

Address: _____ Apt# _____

City, State, Zip: _____

SS# _____

Employer: _____

Occupation: _____

Emergency contact: (Name) _____ Phone# _____

Mother or Legal Guardian

Name: _____

Birth Date: _____

Phone # _____

Address: _____ Apt# _____

City, State, Zip: _____

SS# _____

Employer: _____

Occupation: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

Address: _____ Phone # _____

Policy Holder's Name: _____ DOB: _____ SS# _____

Policy's ID# _____ Group# _____

SECONDARY INSURANCE COMPANY: _____

Address: _____ Phone # _____

Policy Holder's Name: _____ DOB: _____ SS# _____

Policy's ID# _____ Group# _____

INSURANCE/PATIENT RESPONSIBILITY

Center for Children’s Surgery is contracted with many insurance carriers and is required to submit claims for medical services for patients covered under these contracts. It is the responsibility of the patients/guarantor to be prepared to pay any office visit co-pays, co-insurance portions and yearly deductibles and any non-covered services. In the event of a denial of coverage from your insurance carrier, all charges will become the patient/guarantor responsibility.

As a courtesy for our patients we will submit claims to insurance carriers in which we are not network providers. If we are not a network provider for your insurance company, responsibility for payment of all services provided by the physicians, remain with the patient/guarantor.

If we are not a network provider for your insurance company and in the event we have not received payment after 90 days or we receive a denial of payment from your insurance carrier, charges will become the responsibility of the patient/guarantor.

I certify that all information given on the **Patient Registration Form** is complete and accurate to the best of my knowledge. In the event of default on payment of the charges, the responsible party agrees to pay collection fees including reasonable attorney fees.

INITIAL _____

ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my child’s physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim form. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize my insurance company to pay and hereby assign directly to **Center for Children’s Surgery** all benefits, if any, otherwise payable to me for services as described on the attached forms. I further acknowledge that any insurance benefits, when received by and paid to **Center for Children’s Surgery** will be credited to my account, in accordance with the above assignment.

INITIAL _____

RETURNED CHECK

If a check is returned because of insufficient funds, I understand I will be charged \$25.00 fee per check. The check must be replaced by cash, money order or certified check.

INITIAL _____

AUTHORIZATION

I hereby authorize treatment of the patient named and understand that I am financially responsible for all charges whether paid by my insurance company for all treatment rendered. I authorize Center for Children’s Surgery to release any medical information including diagnosis, x-ray, test results, reports and records pertaining to any treatment or examination rendered to the patient. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal and at times when the Doctor deems it necessary in order to ensure the best medical care on behalf of the child.

I have read the above and accept financial responsibility in full for this account/

SIGNED _____ **DATE** _____
PARENT/LEGAL GUARDIAN

CENTER FOR CHILDREN'S SURGERY

PATIENTS NAME

DATE OF BIRTH

MOTHER'S NAME

(LEGAL GUARDIANS)

FATHER'S NAME

YOUR CHILDS MEDICAL HISTORY

ANY ALLERGIES TO MEDICATIONS? ___ NO ___ YES IF SO, PLEASE LIST _____

LATEX ALLERGY? ___ NO ___ YES

WAS YOUR BABY BORN FULL TERM? ___ NO ___ YES

PREMATURE? ___ NO ___ YES IF YES, AT HOW MANY WEEKS _____

COMPLICATIONS OF DELIVERY? _____

BIRTH WEIGHT _____ BIRTH HEIGHT _____

DID YOUR BABY HAVE JAUNDICE? ___ NO ___ YES

HOW LONG WAS YOUR CHILD'S HOSPITAL STAY? _____

HAS YOUR CHILD HAD OR HAVE ANY OF THE FOLLOWING:

HEART PROBLEMS? ___ NO ___ YES EXPLAIN _____

LUNG PROBLEMS? ___ NO ___ YES EXPLAIN _____

SEIZURES OR NEUROLOGICAL PROBLEMS? ___ NO ___ YES EXPLAIN _____

INTESTINAL PROBLEMS? ___ NO ___ YES EXPLAIN _____

KIDNEY OR URINARY PROBLEMS? ___ NO ___ YES EXPLAIN _____

FREQUENT EAR INFECTIONS? ___ NO ___ YES EXPLAIN _____

ASTHMA? ___ NO ___ YES EXPLAIN _____

IS YOUR CHILD GROWING/DEVELOPING ON SCHEDULE? ___ YES ___ NO EXPLAIN _____

IMMUNIZATIONS UP TO DATE? ___ NO ___ YES

ENVIRONMENTAL ALLERGIES? ___ NO ___ YES EXPLAIN _____

BLOOD TRANSFUSIONS? ___ NO ___ YES BLOOD DISORDERS? ___ NO ___ YES EXPLAIN _____

DATE REVIEWED _____ REVIEWED BY _____

CENTER FOR CHILDREN'S SURGERY

HOSPITALIZATIONS?

REASON	DATE	HOSPITAL

OPERATIONS?

SURGERY	DATE	HOSPITAL	SURGEON

MEDICATIONS?

DRUG	DOSAGE	HOW OFTEN

FEMALE PATIENTS ONLY: HAS YOUR CHILD'S PERIODS STARTED? ___ YES ___ NO

IF YES, WHEN DID THEY BEGIN? _____ LAST MENSTRUAL PERIOD? MONTH ___ YEAR ___

NAME OF DOCTORS WHO TAKE CARE OF YOUR CHILD:

PEDIATRICIAN _____ PHONE _____

OTHER SPECIALISTS: _____ PHONE _____

HOME HEALTH CARE AGENCY: _____ PHONE _____

FAX: _____

FAMILY HISTORY

DIABETES? ___ YES ___ NO

ANESTHESIA PROBLEMS? ___ YES ___ NO

EASY BLEEDING OR BRUISING? ___ YES ___ NO

SICKLE CELL ___ YES ___ NO

LIST ANY DISEASES THAT RUN IN THE CHILD'S FAMILY

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

DATE: _____

TO: _____

ADDRESS: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL AND/OR CLINICAL RECORDS OF MY CHILD, AND THOSE RECORDS ARE TO BE SENT TO :

CENTER FOR CHILDREN'S SURGERY
3121 S. MARYLAND PKWY., SUITE 400, LAS VEGAS, NV 89109
PH# (702) 650-2500 * FAX# (702) 650-2220

PLEASE PRINT PATIENTS FULL NAME

DATE OF BIRTH

OTHER NAMES PATIENT IS KNOWN BY: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN

RELATIONSHIP TO PATIENT

WITNESS

DATE

SPECIAL INFORMATION REQUESTED: _____

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Center for Children's Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law –enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorizations. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fund Raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box:

[] Please do not use my information for fund raising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include"

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Center for Children's Surgery Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Front Desk Receptionist or Office Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Center for Children's Surgery
3121 S. Maryland Pkwy, Ste. #400
Las Vegas, NV 89109

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(RECIBO DE RECONOCIMIENTO DE NOTICIA DE DERECHOS PRACTICOS DE PRIVACIDAD)**

Center for Children's Surgery reserves the right to modify the privacy practices outlined in the notice.
(El Centro De Sirugia De Ninos reserve el derecho de modificar la privacidad de practicos que resumen en la noticia)

Signature/Firma

I have received a copy of the Notice of Privacy Practices for Center for Children's Surgery.
(Yo he recibido una copia de la Noticia de Derechos Practicos de Privacidad para El Centro De Sirugia de Ninos)

Name of Patient/Print (Nombre del Paciente/Letra de Molde)

Signature of Patient/Firma del Paciente

Date/Fecha

Signature of Patient Representative/Firma del Representative del Paciente

(Required if the patient is a minor or and adult unable to sign this form/Requerida si el paciente es menor (o) adulto no puede firmar)

Relationship to Patient/Relacion del Paciente