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Phone: 775-900-9987
Fax: 775-900-9954

New Patient Information

Name (Last, First, MI):_______________ D.O.B.__________ Sex:______
Primary Language:_______________ Lives w/ Parent/Guardian:__________
**Ethnicity: Hispanic or Non-Hispanic *Race: White/Hawaiian-PacificIslander/Black/AmericanIndian-AlaskanNative/Asian*
Guarantor:_______________

Name (Last, First, MI):_______________ D.O.B.__________ Sex:______
Primary Language:_______________ Lives w/ Parent/Guardian:__________
**Ethnicity: Hispanic or Non-Hispanic *Race: White/Hawaiian-PacificIslander/Black/AmericanIndian-AlaskanNative/Asian*
Guarantor:_______________

Name (Last, First, MI):_______________ D.O.B.__________ Sex:______
Primary Language:_______________Lives w/ Parent/Guardian:__________
**Ethnicity: Hispanic or Non-Hispanic *Race: White/Hawaiian-PacificIslander/Black/AmericanIndian-AlaskanNative/Asian*
Guarantor:_______________

Name (Last, First, MI):_______________ D.O.B.__________ Sex:______
Primary Language:_______________Lives w/ Parent/Guardian:__________
**Ethnicity: Hispanic or Non-Hispanic *Race: White/Hawaiian-PacificIslander/Black/AmericanIndian-AlaskanNative/Asian*
Guarantor:_______________

***(*)** Indicates optional information requested under the Affordable Care Act, including **Ethnicity** (Hispanic or Non-Hispanic) and **Race** (Caucasian, Hawaiian, Pacific Islander, Black, American Indian, Alaskan, Asian)*
***Guarantor** is the contact with financial responsibility for medical care*

Primary Insurance:

Policy Holder's Name:_______________ Policy holder's D.O.B:__________Policy Holder's Sex:__________
Insurance Carrier:_______________ ID#_______________Group#_______________
Insurance Address:____

Secondary Insurance (Medicaid or Tricare only):

Policy Holder's Name:_______________Policy holder's D.O.B:__________Policy Holder's Sex:__________
Insurance Carrier:_______________ID#_______________Group#_______________
Insurance Address:____

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Contact Information (Complete all items for each biological parent or legal guardian):

*Parent Name (Last, First, MI):*_____
*Street Address:*_____ *Birthdate*_____
*City, State & Zip:*_____
*Home Phone:*_____ *Home Email:*_____
*Work Phone:*_____ *Work Email:*_____
*Cell Phone:*_____ *Employer:*_____
*Relationship to Pt(s):*_____ *Occupation:*_____
*Lives with Patient?*_____

*Parent Name (Last, First, MI):*_____
*Street Address:*_____ *Birthdate*_____
*City, State & Zip:*_____
*Home Phone:*_____ *Home Email:*_____
*Work Phone:*_____ *Work Email:*_____
*Cell Phone:*_____ *Employer:*_____
*Relationship to Pt(s):*_____ *Occupation:*_____
*Lives with Patient?*_____

***Preferred Method of Contact:** **Email** **Text** **Phone** ***Preferred Number:** **HM** **Cell** **WK**

***Please Note:** Ideally, we prefer to contact parents via email for appointment reminders and general information unless otherwise specified. If you wish to be contacted by other means, please indicate on the form.*

Responsible Party:

_____
Name (Please print) Signature Date

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

Who has primary legal custody? First Name: _____ *Last Name:* _____

Are there any legal restrictions that would prevent 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 explain and provide a copy of any legal paperwork that supports this restriction.

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EMERGENCY CONTACT (Excluding Parents / Guardians)

NAME_____ TELEPHONE NUMBER _____

RELATIONSHIP_____

NAME_____ TELEPHONE NUMBER_____

RELATIONSHIP_____

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Patient Authorization

Please read, initial, and sign below.

(Initial)_____**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the Ponderosa Pediatrics Financial Policy dated September 1, 2019, including the Financial Responsibility and Insurance Coverage polices found within.

(Initial)_____**Credit Card on File:** I understand that by providing my current credit card information to Ponderosa Pediatrics that I am authorizing it to be charged for any balance remaining after all insurances on file have been billed and processed.

(Initial)_____**Assignment of Benefits**: I hereby authorize payment directly to PONDEROSA PEDIATRICS, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to PONDEROSA PEDIATRICS, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third-party payor.

(Initial)_____**No Show/Walk-In Fee**: I acknowledge that I received, reviewed, and agree to comply with the Ponderosa Pediatrics "No Show Policy" and "Walk-In Policy" agree to pay any fees incurred from failure to comply.

(Initial)_____**Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the Ponderosa Pediatrics Privacy Policy.

(Initial)_____**Immunization Policy**: I acknowledge that I received, reviewed, and agree to comply with the Ponderosa Pediatrics Immunization Policy.

(Initial)_____**Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Ponderosa Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child if my child/children are a patient in this practice.

(Initial)_____**E-Prescribing:** I voluntarily authorize Ponderosa Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history so long as this child is a patient at this office.

(Initial)_____**Recording/Photo Policy:** Ponderosa Pediatrics does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recording or photos of any kind during the visit. I understand the policy and agree to comply.

(Initial)_____**Code of Conduct:** I acknowledge that I received, reviewed, and agree to comply with the Ponderosa Pediatrics Patient/Parent Code of Conduct.

Initial)_____I understand I can withdraw my consent at any time by contacting Ponderosa Pediatrics in writing at 6512 S McCarran Blvd. Suite D Reno, NV 89509. Withdrawal may result in dismissal from the practice.

Patient Name:_____DOB:_____ Pat #: _____

Patient Name:_____DOB:_____ Pat #: _____

Patient Name:_____DOB:_____ Pat #: _____

Patient Name:_____DOB:_____ Pat #: _____

Parent/Guardian name (Print): _____

Parent/Guardian Signature: _____

Today's Date: _____

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PONDEROSA PEDIATRICS FINANCIAL POLICY

(Effective September 1, 2019)

Thank you for choosing Ponderosa Pediatrics ("PONDEROSA") as your children's health care provider. We appreciate your trust in us and the opportunity to carry out our mission statement.

Our office and physicians are committed to providing you with the highest quality care at a fair and reasonable cost. To accomplish this goal, we are requesting your help in avoiding unnecessary billing issues that may happen because of incorrect insurance information.

The following is a copy of our payment policy. Acknowledgement and understanding of this Financial Policy must be signed. Patients cannot be seen unless the statement is signed.

PAYMENT IN FULL IS DUE AND EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered: This includes applicable coinsurance, copayments, and payments for services not covered or denied by the insurance company. If you participate in a High Deductible Insurance Plan or have deductible remaining on your current policy, we require a minimum of $50 payment at the time of service payable towards your bill. Our software securely encrypts and stores your credit card information displaying the last 4 digits of your credit card number only, and PCI compliance runs regularly on all PONDEROSA devices. For your convenience, a current credit card may be kept on file. Please provide your credit card to the front office staff to be linked to your account with the Patient Authorization Form. The credit card on file authorizes PONDEROSA to run your card for any balances due after all insurances have processed.

Missed Copays: We are required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and PONDEROSA in default of the insurance contract.

Any co-payments that are not paid at the time of the office visit will be subject to a "missed co-payment processing fee" of $5.

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Returned Check Fee: There is currently a $30 fee for any checks returned by the bank. Cash or credit card payments will be required for any account with more than one Returned Check Fee in a twelve-month period.

Missed Appointment Fee: Missed Appointments represent a cost to PONDEROSA, you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to any Well Child/Preventative Care appointment and 2 hours prior for any sick visits. A "No Show" fee of $35 will be assessed upon review of your account if appointment is not cancelled within the timeframe stated. Three no shows, per family, within a twelve-month period may result in dismissal from the practice.

Ponderosa Pediatrics accepts cash, personal checks, debit cards, Visa, Master Card, and Discover. We currently ***Do Not*** accept American Express.

BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

INSURANCE FILING AND ASSIGNMENT OF BENEFITS

Regarding Insurance: As a courtesy to our patients, PONDEROSA will file claims to any insurance carrier with whom we are participating providers. It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the insurance company has not processed and paid the claim within a timely manner or has denied the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for treatment.

Change of Insurance/Change of Address: Please notify the office as soon as possible of all insurance and address changes. If the guarantor does not notify the office within 15 days of any changes the guarantor is responsible for all charges not paid because of change in insurance coverage.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued. Payment is due within (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the guarantor's responsibility to pursue the insurance company on their child's behalf.

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Divorce: In the case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. 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.

Insurance Release: This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for service rendered if any of the following conditions apply:

- My child/children may have a pre-existing condition or other diagnosis that may not be covered by my plan.
- Provider not participating in my health plan.
- Unmet deductible under my health plan contract.
- Well child check-up, immunizations, as well as other routine services may not be covered by some insurance plans. Please check with your insurance carrier if you are not sure if routine services are covered. (e.g. Surveys and Assessments performed during well child exams)

Outstanding Balance: If you have a balance on your account, we will send you a monthly statement.

PONDEROSA understands that full payment may not be possible in certain circumstances. As a courtesy, PONDEROSA offers a payment plan. This payment plan is a binding contract referred to as a "Payment Plan Agreement". For services to be rendered, patients with a Payment Plan Agreement must be in full compliance with all conditions of the agreement. Failure to make scheduled payments on the payment plan or not paying off a balance in full may result in your account being turned over to a collection agency.

If we must refer your account to a collection attorney, you agree to pay all collection costs that are incurred. If there becomes a need to send the balance of an account to a collection agency due to non-payment of the account, the physicians of Ponderosa Pediatrics will no longer be able to provide care. In this case, the guarantor will receive written notification and given adequate time to find a new health care physician.

If your account is sent to collections and then paid in full, the parent/guardian may request the practice reinstate the patient's account. If the practice permits reinstatement, the practice may charge a $25 reinstatement fee which is not billable to insurance. The fee must be paid prior to scheduling any future appointments.

Waiver of Confidentiality: You understand if the account is submitted to a collection attorney or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transfer of Records: Should you wish to transfer care to another physician, you will need to complete the authorization to release records form, which can be obtained from any of our clinic locations. This form needs to be completed in its entirety for us to process the request. All balances should be paid before records are transferred.

Billing Inquiries: Questions about a bill should be directed to our Billing Department at 775-238-4169.

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PREVENTATIVE VISIT CONSENT FORM

Notice to All Parents/Guardians and Patients Receiving a Preventative Exam:

A normal, routine physical examination will only include Preventative care. For further explanation, please contact your insurance company directly. The Affordable Care Act initiated that insurance plans cover the Preventative visit at 100%. It is important to understand, that during your preventative visit the physician will be following all guidelines set forth by the American Academy of Pediatrics for the age of your child. The Affordable Care Act does not govern the components of the preventative visit, and depending upon your individual plan benefits, your insurance company may process one or more components to your deductible or out-of-pocket expense, (e.g., vision screening, health risk surveys).

If there are any abnormal symptoms, diagnoses, medication refills or other examination due to acute illness, the Physician is required to document these items in your child's medical chart with additional codes that may result in an Office Visit charge in addition to your Preventative exam today. In these cases, the insurance may require you to pay the contracted co-pay, deductible, co-insurance or additional funds based upon the specifics of your individual plan benefits.

Ponderosa Pediatrics is focused on providing the highest quality of care for you child(ren).

I understand that my signature below represents my acknowledgement to abide by these terms for one year following the date below. This form will be presented for review and acknowledgement at my child's next scheduled preventative visit following the expiration of the one (1) year date.

Parent/Patient Authorization

_____I have read, understand and agree to abide by the terms stipulated above.

_____I do not agree and do not wish to have my child seen for a Preventative/Physical at this time.

_____ _____

Parent's Name (Print) Parent's Signature

Patients Name: _____ Date: _____

Account #: _____

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Ponderosa Pediatrics Immunization Policy

At Ponderosa Pediatrics we are dedicated to providing the highest quality of evidence - based medical care to our patients. This includes our adherence to the vaccine schedule recommended by national organizations such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP).

These well-respected organizations and committees include panels of experts in pediatrics as well as infectious disease. The goal is to eliminate or minimize preventable serious disease, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyze reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect your child. Be aware that there are vaccines used in other countries that are not routinely used in the United States to protect those children from even more diseases.

At Ponderosa Pediatrics we strive to provide the highest quality care, while respecting the wishes of our parents. Should a family desire to alter the schedule or withhold all recommended vaccines, Ponderosa Pediatrics feels that this decision not only puts your child at risk of serious preventable disease, but also contributes to the health risk of others.

Please be advised that if you desire an “alternate” vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Ponderosa Pediatrics, the AAP, the AAFP and the ACIP. Because we believe that this decision puts your child at risk for vaccine preventable disease and increases health risks for others, Ponderosa Pediatrics respectfully declines to be your children’s pediatricians.

Thank you.

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Code of Conduct for Parents and Patients

In an effort to provide a safe and healthy environment for staff, visitors, patients, and their families, Ponderosa Pediatrics expects visitors, patients, and accompanying guests or family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are not permitted. This list is inclusive but not limited to:

- Physical assault or inflicting bodily harm
- Throwing objects
- Climbing on furniture or toys*
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing or inappropriate gestures
- Inappropriate language (i.e. cursing)
- Attempting to intimidate or harass other individuals (including staff)
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with but not limited to race, language, gender, or sexuality
- Recording or taking photos in the office without consent

If you are subjected to any of these behaviors or witness in appropriate behavior, please report to any staff member. Violators or subject to removal from the office and/or discharge from the practice.

*Adults are expected to supervise children in their care.

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Ponderosa Pediatrics Form Fees (Effective September 1, 2019)

Medical Records (for Patient)	$0.35 per page after 5 pages
Medical Records (for Third Party)	$50 for over 500 pages $25.00 for paper; first 20 pages then $.50 for every page thereafter plus postage/shipping

PONDEROSA PEDIATRICS

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Initial History Questionnaire

Name of Patient:_____Birth date:_____Age: _____

Form Completed by:_____Date:_____Relationship:_____

HOUSEHOLD			
Please list all those living in the child's home			
Name	Relationship To child	DOB	O Lives with both parents
			O Parents divorced/separated – joint custody
			O Parents divorced/separated – sole custody
			O Lives with adoptive parents
			O Lives with foster parents
			If one or both parents are not living in the home, how often does the child see the parent(s) not in the home
BIRTH HISTORY (for children under age 3 only)		◯ **Do not know birth history**	

Birth Wt._____Was baby born term? **Yes No** How many weeks at time of delivery _____
Were there any prenatal or neonatal complications? **Yes No** If yes, explain: _____
Was NICU stay required? **Yes No** If yes, explain:_____
Was the delivery **Vaginal Cesarean** If Cesarean, why?_____
During pregnancy, was child exposed to: **Tobacco: Yes No Alcohol: Yes No Drugs or Medications: Yes No**
If yes to any above, please explain: _____
Did mother take prenatal vitamins: **Yes No** Did baby go home with mother from hospital? **Yes No**
If no, explain:_____
_____How long was baby breastfed:_____Is baby: **Breastfed Formula-fed**

GENERAL

Does your child have any chronic medical conditions? **Yes No Explain**:_____
_____
Has your child had any surgeries? **Yes No Explain**:_____
_____
Has your child been hospitalized? **Yes No Please list dates/ages**:_____
_____
Is your child taking medications? **Yes No Please list medications/dosages**:_____
_____
Is your child allergic to medications or food? **Yes No**
Please list medication or food and reaction type **(hives, rash, etc.)**_____
Do you feel your family has enough to eat? **Yes No Explain**: _____

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BIOLOGICAL FAMILY HISTORY (Include parents, siblings, and grandparents				
Have family members had the following:				☐ **Family History Unknown**
Nasal Allergies or other allergies	Yes	No	Who	Comment
Asthma or another lung disease	Yes	No	Who	Comment
Heart condition (before age 55)	Yes	No	Who	Comment
High blood pressure	Yes	No	Who	Comment
High cholesterol	Yes	No	Who	Comment
Diabetes/endocrine disorders	Yes	No	Who	Comment
Cancer (before age 55)	Yes	No	Who	Comment
Anemia or Blood Disorder	Yes	No	Who	Comment
Sudden Death (before age 55)	Yes	No	Who	Comment
Epilepsy or seizures	Yes	No	Who	Comment
Mental /developmental disorder	Yes	No	Who	Comment
ADD/ADHD	Yes	No	Who	Comment
Genetic Disorder	Yes	No	Who	Comment
Liver Disease	Yes	No	Who	Comment
Gastrointestinal disorder	Yes	No	Who	Comment
Kidney Disease	Yes	No	Who	Comment
Bed Wetting (>10 Yrs.)	Yes	No	Who	Comment
Hearing impairment	Yes	No	Who	Comment
Vision impairment/eye disorder	Yes	No	Who	Comment
Immune Problems (HIV/AIDS)	Yes	No	Who	Comment
Alcohol/Drug Abuse	Yes	No	Who	Comment
Mental Illness (Depression/Anxiety)	Yes	No	Who	Comment
Additional family history				

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PAST MEDICAL HISTORY **Does your child have or has your child ever had:**			
Chickenpox	Yes	No	When
Frequent Sinus infections	Yes	No	Explain
Frequent Ear infections	Yes	No	Explain
Frequent Strep Throat/Tonsillitis	Yes	No	Explain
Infectious illnesses (Aids/HIV/Hepatitis)	Yes	No	Explain
Environmental Allergies or Food Allergies	Yes	No	Explain
Asthma/lung problems	Yes	No	Explain
Heart problems (murmur, septal defect)	Yes	No	Explain
High Blood Pressure	Yes	No	Explain
Gastrointestinal problems (GERD)	Yes	No	Explain
Genetic Disorder	Yes	No	Explain
Urinary tract infections/kidney reflux	Yes	No	Explain
Vision problems	Yes	No	Explain
Hearing problems	Yes	No	Explain
Skin conditions (eczema/psoriasis)	Yes	No	Explain
Anemia or bleeding problem	Yes	No	Explain
Blood transfusion	Yes	No	Explain
Neurologic problems	Yes	No	Explain
Epilepsy or seizures	Yes	No	Explain
Frequent headaches (daily/weekly)	Yes	No	Explain
Cancer	Yes	No	Explain
ADHD/ADD	Yes	No	Explain
Mental health concerns	Yes	No	Explain
Orthopedic problems (scoliosis, DDH)	Yes	No	Explain
Diabetes (Type I or Type II)	Yes	No	Explain
Thyroid or other hormone problems	Yes	No	Explain
If female, any problems w/ periods?	Yes	No	Explain
Obesity/overweight	Yes	No	Explain
Sleep problems/snoring	Yes	No	Explain
History of fractures/concussions	Yes	No	Explain
Alcohol/drug/tobacco use	Yes	No	Explain
History of family violence/abuse	Yes	No	Explain

Girls only: Has had her first period? Yes No Age of first period if applicable:_____

Any other significant problems:

_____

_____

_____

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Patient Centered Medical Home

We strive to be the "Medical Home" for your children and provide equally for all our patients a safe environment where you can expect to receive a comprehensive assessment and a personalized treatment strategy based on the most current evidence-based guidelines. We will conduct surveys from time to time and ask that you answer thoughtfully as we will use your feedback to guide us toward quality improvement that is important to you.

Please think of us as the first place to come for advice and care regarding all your child's health care needs. This includes physical, developmental, and emotional health, as well as a place to help you find the appropriate specialist or access community resources. We also want to coordinate your care. Let us know if you have been treated by a specialist, an emergency department, or any outside healthcare professional. Informing us of medications, test results, and procedures are keys to having a complete understanding of your child's health. Every time you are seen for care outside of our office, please request that a copy of the visit or test result is sent/faxed to us so that we can best serve you.

In addition, let us know if you are using any over-the-counter medications or have undertaken any self-care regimens. Review your patient information on the patient portal and tell us if the information we have on file is incomplete or inaccurate. Good care requires a partnership between your family and our office. We appreciated your help and look forward to working with you.

Why PCMH?

Benefits for Patients

Stay healthy. Patients who are treated in PCMHs tend to receive preventive services and screenings at a higher rate than patients who are not in PCMHs, helping them stay healthy.

Better communication. Communication with patients and their families/caregivers is a core concept of the PCMH model, which also emphasizes enhanced patient access to clinical advice and medical records.

Better management of chronic conditions. According to research, PCMHs are especially helpful for patients with complex chronic conditions.

Have a better experience. When medical home attributes are described to people, they say it is the type of care they want to receive.

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Authorization to Release or Disclose Protected Health Information

Patient's Name:_____Date of Birth:___/_____/_____Date of Request: _____

Address:_____Day Time Ph: (___)_____
(Street, city, state, zip code)

Please list where PONDEROSA Pediatrics is to request medical records FROM:

Facility Name: _____ Fax Number: _____

Address: _____ Phone Number: _____

City, State: _____

Dates of Service:_____**Reason for request**: _____

The following information is to be disclosed to PONDEROSA Pediatrics: (Please send ONLY the information listed below.)

List of records to be sent:

Problem List	Immunization Record	Medication List	Last Well Visit
Growth Chart	Drug Allergy History	ADHD History (if applicable)	
Entire Medical Record			

Please send ONLY THE REQUESTED INFORMATION via fax to Ponderosa Pediatrics: (775) 900-9954

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.
Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I do not specify an expiration date, event or condition, this authorization will expire in six months from date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Ponderosa Pediatrics of any and all accountabilities concerning these medical records.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient

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INFORMED CONSENT TO TELEHEALTH

Telehealth allows Ponderosa Pediatrics to consult, treat and educate using interactive audio, video or data communication regarding my child's treatment. I hereby consent to participating in medical care via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Patient's Name: _____ Clinician: Lari Frazee, D.O. with Ponderosa Pediatrics

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person health concerns. Any information disclosed by me during the course of my treatment, therefore, is generally confidential.
There are, by law, exceptions to confidentiality, including mandatory reporting of child, adult abuse, and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my healthcare provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our session or other communication by my healthcare provider to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person healthcare services and that if my healthcare provider believes I would be better served by another form of healthcare service, such as in-person treatment, I will be referred to seek an in-person appointment in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my healthcare provider and to have any questions I may have regarding my treatment answered to my satisfaction.
I understand that I can withdraw my consent to Telehealth communications by providing written notification to Ponderosa Pediatrics. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Patient Name Date

_____

_____

Guardian Signature

_____

If signed by legal representative, relationship to patient