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New Patient Information

Name (Last, First, MI): ______________________________D.O.B.: __________________Sex: ______________
Primary Language: _______________Lives with Parent or Guardian (specify): ________________________
*Ethnicity: Hispanic or Non-Hispanic
*Race: White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: ___________________

Name (Last, First, MI): ______________________________D.O.B.: __________________Sex: ______________
Primary Language: _______________Lives with Parent or Guardian (specify): ________________________
*Ethnicity: Hispanic or Non-Hispanic
*Race: White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: ___________________

Name (Last, First, MI): ______________________________D.O.B.: __________________Sex: ______________
Primary Language: _______________Lives with Parent or Guardian (specify): ________________________
*Ethnicity: Hispanic or Non-Hispanic
*Race: White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: ___________________

Name (Last, First, MI): ______________________________D.O.B.: __________________Sex: ______________
Primary Language: _______________Lives with Parent or Guardian (specify): ________________________
*Ethnicity: Hispanic or Non-Hispanic
*Race: White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: ___________________

(*) Indicates optional information requested under the Affordable Care Act
(**) 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:

Policy Holder's Name:___________________Policy Holder's D.O.B.: ______Policy Holder's Sex: _________
Insurance Carrier: ______________________ID# ____________________Group #__________________
Insurance Address: ____

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Please complete all items for each **biological** parent or **legal** guardian.
****Stepparents are not included here unless they are legal guardians.****

Parent Name (Last, First, MI): _____
Street Address: _____ Birthdate: _____
City, State & Zip: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Employer: _____ Occupation: _____
Relationship to Patient: _____ Lives with patient: _____

Parent Name (Last, First, MI): _____
Street Address: _____ Birthdate: _____
City, State & Zip: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Employer: _____ Occupation: _____
Relationship to Patient: _____ Lives with patient: _____

Preferred Method of Contact: Phone E-mail Text

Preferred Phone Number: Home Cell Work

*Preferred phone number will be used for appointment reminders

_____

Name of Parent Completing Form (Please Print) **Signature** **Date**

If parents are divorced or separated, please complete this section:

Who has primary legal custody (First/Last): _____

Who is declared "financially responsible" for the child's insurance? _____

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 provide a copy of any legal paperwork that supports this restriction.

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Emergency Contacts (NOT Parents/Guardians) – Required

Patient Name: _____ **D.O.B.:** _____

Name: _____ Telephone Number: _____

Relationship to Patient: _____

Name: _____ Telephone Number: _____

Relationship to Patient: _____

*These contacts are for in the event our office cannot get in contact with either parent or legal guardian.
**If you would like to elect a person to bring your child to appointments, please complete the Authorization to Treat a Minor form.

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Authorization to Treat a Minor – Optional

Patient Name: _____ D.O.B.: _____

I authorize the person(s) listed below to accompany my child and authorize treatment for my child in accordance with the office policy of Ponderosa Pediatrics. This includes bringing the child to the office, providing an accurate medical history, disclosing protected health information, consenting to vaccinations and any procedures, and witnessing any physical examination by the provider. This adult has the responsibility to relay diagnoses and treatment plans to the parent or legal guardian. This adult also can make, change, or cancel appointments, manage health forms, and pick up prescriptions for the child. I agree to continue to comply with the financial policy.

Name: _____D.O.B.:_____
Phone: _____Relationship to patient: _____

Name: _____D.O.B.:_____
Phone: _____ Relationship to patient: _____

THIS CONSENT IS VALID FOR 2 YEARS FROM DATE SIGNED AND IS REVOCABLE BY EITHER PARENT AT ANY TIME.

Parent Name: _____ Phone Number: _____

Signature: _____Date: _____

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Patient Authorization

Please read, initial, and sign below. Please refer to the attached documents of this packet.

_____**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with Ponderosa Pediatrics' Financial Policy dated April 29, 2024, including the Financial Responsibility and Insurance Coverage policies found within.

_____**Assignment of Benefits**: I hereby authorize payments paid 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 child's examination and/or treatment to my insurance company and/or other third-party payor.

_____**No Show/Walk-In Policy**: I acknowledge that I received, reviewed and agree to comply with the Ponderosa Pediatrics "No Show Policy" and "Walk-In Policy." Three no shows per family will result in the family being dismissed from the practice.

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

_____**Immunization Policy**: I acknowledge that I received, reviewed and agree to comply with the Ponderosa Pediatrics Immunization Policy. I understand that failure to comply may result in dismissal from the practice.

_____**Consent to Treat**: I have the legal right to consent to medical and surgical treatment for my child. 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 and other healthcare providers in this medical office to provide treatment to this child.

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

_____**Recording/Photo Policy**: Ponderosa Pediatrics does not permit recording devices in the exam room or common areas; this includes use of the camera function on cell phones. We do not allow recordings or photos of any kind during the visit.

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

_____ **Withdrawal Consent:** 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. Withdraw may result in a dismissal from the practice.

Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____

Parent/Guardian Name (Print): _____ Date: _____
Parent/Guardian Signature: _____

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Credit Card Authorization

I authorize Ponderosa Pediatrics to charge my unpaid co-payment, work-in charges, HSA account and/or 60-day balances due under $500.00 to the credit card listed below. Any balance over $500.00 we are required to contact you to discuss payment terms.

This authorization will remain in force on each of my children's accounts up to 6 months, in the event they are no longer patients of Ponderosa Pediatrics, or until a written request by the cardholder is given by me, instructing the practice to remove the authorization.

Please give your card to the Front Desk to be scanned into our secure system.

Please circle: VISA MASTERCARD DISCOVER

_____ _____
Name on the Card Last 4 digits of card number

_____ _____
Cardholder Signature Date of Authorization

_____
Cardholder Email Address for all payment receipts

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

_____ _____ _____/_____/_____
Patient's Last Name Patient's First Name Date of Birth

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Acknowledgment of Financial Policy

(Effective April 29, 2024)

Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____

_____ *(initial)*

Financial Policy: I acknowledge that I received, reviewed, and agree to comply with Ponderosa Pediatrics' Financial Policy dated April 29, 2024, including the Financial Responsibility and Insurance Coverage policies found within.

_____

Name of Parent Completing Form (Print) **Signature** **Date**

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Acknowledgement of Notice of Privacy Practices

I, _____ acknowledge that I have been given the opportunity to receive a copy of the Notice of Privacy Practices from Ponderosa Pediatrics on behalf of my child or children.

_____I have received the document on _____(date)

_____I have waived my right to receive the document on _____ (date) which does not deny me the right to receive my copy at some future date.

Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____

_____
Signature

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Preventative Visit Consent Form

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 physical 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 (for example, vision screening or development surveys).

If there are any abnormal symptoms, diagnoses, new medication prescriptions or refills, or other examination due to acute illness or problem, 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 the preventative exam. In these cases, the insurance may require you to pay the contracted copay, deducible, co-insurance or other additional funds based on the specifics of your individual plan benefits.

Ponderosa Pediatrics values your time and wants to be sure you get the most out of your child's appointment. However, if the additional service is not considered urgent and will interfere with other's patient's appointments, you may be asked to schedule another appointment to discuss the concerns outside of the preventative care visit.

I have read, understand and agree by the terms stipulated above.

_____	_____	_____
Parent's Name (Print)	Parent's Signature	Date

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

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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) 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 diseases, thereby promoting the health of all children. These national experts routinely analyze available information and research, monitor the prevalence of vaccine-preventable diseases, and analyzes reported serious adverse events following vaccine administration. This information is used to create the best vaccine schedule to protect children. 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, and the ACIP. We believe that this alternate decision puts your child and others at risk, Ponderosa Pediatrics respectfully declines to be your child's pediatrician.

I have read and understand the immunization policy.

_____	_____	_____
Parent's Name (Print)	Parent's Signature	Date

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

Patient Name: _____DOB: _____

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Policy for Divorced or Separated Parents – Required

At Ponderosa Pediatrics, our pediatrician and staff are dedicated to our patients and providing quality medical care to your child(ren). We are advocates of your child's medical, emotional, psychological, and physiological health. We are not involved in and are not party to any legal issues involving divorce, separation, or custody agreements. Please read the following and acknowledge your understanding of this policy.

1. Do not place the pediatrician, medical assistants, receptionists, billing staff or the manager in the middle of domestic issues or disagreements over the phone and in the office.
2. Please make decisions about your appointments, vaccinations, and or other medical procedures **PRIOR** to arriving at our office.
3. In situations where there is a confirmed, documented, current **court order** in place that specifies that one of the parents will have limited access to the minor child's health records or visits to our office, our office must have a copy of this court order on file.
4. In the event there is **not** a court order on file with our office, either parent or legal guardian can sign a "consent to treat" form that authorizes any named individuals (grandparents, extended family, nanny, etc.) to bring your child to the practice for treatment and to be present during the visit and consent to any treatment for such visit. *We will not be involved with any disputes regarding named individuals on the consent forms, unless instructed by the court. Either parent and or legal guardian can schedule an appointment for their child, be present for the visit and obtain a copy of the visit summary, subject to a medical records fee.*
5. Communication between one another regarding the patient(s) care, office visit dates, and any other information pertinent to the patient is the parent(s)' responsibility. The pediatrician is not responsible for communicating visit information to each custodial parent separately, how will they call or contact the non-attending parent following the visit(s).
6. Additionally, the staff will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by a court of law or tolerate appointment scheduling and or cancelling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance, or any additional fees charged by your insurance are due at the time of service regardless which parent is present at the service and regardless of which parent is responsible for medical expenses. This practice is **NOT** a party to your divorce agreement. Payments will be collected from the parents accompanying the child for the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, the *authorizing parent is responsible to collect from the other parent*. Any disputes about payment that end in the collection process will be due at the next service date or the patient will not be seen.
8. If any of the above points become an issue at any time at our office or compromise patient care, we have the right to discharge the family from the practice.

By signing this form, you agree to honor the above policy and you understand that failure to honor the above policy may result in the discharge of your family from the practice.

Parent/Legal Guardian (Print)	Signature	Date

Patient Name	D.O.B.

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Telehealth Informed Consent

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 Telehealth.

Patient's Name: _____ DOB:_____

Clinician's Name: Lari L. 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 my treatment, therefore is generally confidential. There are, by law, exceptions to confidentiality; including mandatory reporting of child abuse, and any threats of violence made towards a reasonably identified person. I also understand that if I am in such a 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.
- I understand that dissemination of any personally identified images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
- I understand that 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.
- Furthermore, I 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, could be interrupted, or accessed by unauthorized persons.
- I understand that Telehealth treatment is different from in-person treatment 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.

I have read and understand the information provided to me above. I have the right to discuss any of this information with my healthcare provider and have any questions I 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.

_____ _____
Parent/Legally Authorized Representative (Print) Date

_____ _____
Signature Relationship to Patient

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Authorization to Release or Disclose Protected Health Information

Patient's Name: _____ Date of Birth: _____ Date of Request: _____

Address: _____Phone: _____

Please check the box which best defines your need:

☐ Request Medical Records **FROM:** ☐ Send Medical Records **TO:**

Facility Name: _____Fax Number: _____

Address: _____ Phone Number: _____

Dates of Service: _____ Email Address: _____

Reason for Request: _____

The following information is to be disclosed <u>TO</u> Ponderosa Pediatrics <u>OR</u> _____.

Problem List Immunization Record Medication List Last Well Visit

Growth Charts Drug Allergy History **Entire Medical Record**

- 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 or drug abuse.
- 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.
- I understand that authorizing 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.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- 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 6 months from the 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 the release of these medical records.

_____ _____

Signature of patient or legal representative Date

_____

If signed by a legal representative, relationship to patient

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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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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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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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Ponderosa Pediatrics Financial Policy

(Effective April 29, 2024)

Thank you for choosing Ponderosa Pediatrics as your children's healthcare provider. We appreciate your trust in us and the opportunity to carry out our mission statement.

Our office is 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 due to 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.

INSURANCE CARD IS REQUIRED AT EVERY VISIT

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 acquire knowledge and understanding of what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested that 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 30-45 days 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.

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

- My child 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 and/or out of pocket cost under my insurance plan contract.
- Well child check-ups, 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 (for example, development surveys/assessments performed during well child exams).

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

Payment is required at the time services are rendered: This includes applicable coinsurance, copayments, patient balances, and payments for services not covered or denied by the insurance company. If you participate in a high deductible insurance plan or have a 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 Pediatrics devices.

Payment Methods Accepted: Ponderosa Pediatrics accepts cash, personal checks, debit cards, Visa, Mastercard and Discover. We do not currently accept American Express.

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Phone: 775-900-9987
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Missed Copays: We are required by our insurance contracts to collect all copays at the time of service. Failure to collect copays puts the responsible party and Ponderosa Pediatrics in default with the insurance contract.

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 amount totaling more than one Returned Check Fee in a twelve month period.

Missed Appointment Fee: Missed appointments represent a cost to Ponderosa Pediatrics, you, and to other patients who could have been seen in the time set aside for your child. Cancellations are required 24 hours prior to any well child/preventative care appointment and 2 hours prior to any sick or problem visits. A "No Show" fee of $50 will be assessed upon review of your account if appointment is not cancelled within the timeframe stated. ***Three no shows per family will result in the family being dismissed from the practice.***

Payments: Unless other arrangements are approved by our organization in writing, the balance of your statement is due and payable when the statement is issued. Payment is due within 60 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.

Divorce: In the case of divorce or separation, the parent authorizing treatment for the child on that day 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 parents' responsibility to collect from the other parent to cover the cost of the patient's visit. (Refer to the Divorce Policy.)

Outstanding Balance: If you have a patient balance on your account, we will send you a statement. Ponderosa Pediatrics understands that full payment paid by the due date may not be possible in certain circumstances. As a courtesy, Ponderosa Pediatrics may offer 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 have incurred. If there becomes a need to send the balance of an account to a collection agency due to non-payment of account, Ponderosa Pediatrics will no longer be able to provide care to your child. In this case, the guarantor will receive written notification and given adequate time to find a new health care provider. If your account is sent to collections, you will be unable to reinstate your child's account with us.

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 matter of public record.

Transfer of Records: Should you wish to transfer care to another medical provider, you will need to complete the authorization to release records form, which can be obtained from our office or on our website. This form needs to be completed in its entirety for use to process the request. All balances should be paid before records are transferred.

Billing Inquiries: Preferred method is to visit www.ponderosapeds.com and select "Patient Billing Inquiry." If prefer to phone, please call (833) 206-3686.

PONDEROSA PEDIATRICS

6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

Code of Conduct for Parents and Patients

To provide a safe and healthy environment for staff, visitors, patients, and their families, Ponderosa Pediatrics expects everyone to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

Adults are expected to supervise children at all times.

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
- Drawing on furniture
- Making verbal threats to harm another individual or destroy proper
- Intentionally damaging equipment or property
- Making menacing or inappropriate gestures
- Inappropriate language (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, fax, email or other forms of written or 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 inappropriate behavior, please report it to any staff member.

Violators are subject to removal from the office and/or discharged from the practice.

Medical Records Fees

Medical Records (for Patient)	$0.35 per page after 5 pages
Medical Records (for Third Party)	$50 for over 500 pages; $25 for first 20 pages, then $0.50 for every other page thereafter plus postage/shipping.

PONDEROSA PEDIATRICS

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health h information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your healthinformation. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are_ treating you.	***Example:*** ***A*** *doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Una copia de esta notificacion esta disponible en español a su solicitud.