PATIENT INITIAL DEMOGRAPHICS

Patient Name: _____ ☐ Male ☐ Female Date of Birth: ____/____ /____

Mailing Address: _____

Physical Address: _____

Primary Phone #: _____ E-mail: _____

Preferred Pharmacy: _____

Race: (check all that apply)

☐ White ☐ Native Hawaiian/Pacific Islander

☐ Asian ☐ American Indian/Alaska Native

☐ Black/African America

Ethnicity:

☐ Hispanic/Latino

☐ Non Hispanic/Latino

☐ Declined to Report

Language: (Primary)

☐ English

☐ Spanish

MOTHER STEP-MOTHER LEGAL GUARDIAN (Please circle one) FATHER STEP-FATHER LEGAL GUARDIAN

Name: _____

Home #: _____

Cell #: _____

Work #: _____

Date of Birth: _____/_____ / _____

SS#: _____

Employer: _____

Name: _____

Home #: _____

Cell #: _____

Work #: _____

Date of Birth: _____/_____ / _____

SS#: _____

Employer: _____

If patient lives at two different addresses, please provide. This address is: ☐Mother's ☐ Father's

Address: _____ City: _____ State: _____ Zip: _____

Whom can we contact in case of emergency AND if necessary release protected health information?

Name: _____ Relationship to Child: _____ Phone#: _____

Primary Insurance Information: *(Insurance card required at time of appointment)*

Name of Insurance Company: _____

Policy # or AHCCCS #: _____ Group #: _____

Policy Holder: _____ Relationship to Child: _____

Secondary Insurance Information: *(Insurance card required at time of appointment)*

Name of Insurance Company: _____

Policy # or AHCCCS #: _____ Group #: _____

Policy Holder: _____ Relationship to Child: _____

Consent to Treat and Responsibility Statement – I, acting as guardian of the above patient, herby give consent for the patient to receive medical evaluation and treatment by providers at Yavapai Pediatrics. I have received a copy of the Privacy Rules from Yavapai Pediatrics and authorize the above named people to receive my child's Protected Health Information. I assign all benefits and payments from my insurance company to be paid directly to Yavapai Pediatrics. I understand that if for any reason my insurance does not make payments, I am responsible for all services. I accept responsibility for co-pays, deductibles, co-insurance, and any other balances not paid by the insurance. I authorize the release of all medical information necessary to process this claim and pertinent to my child's medical care and related benefits. This assignment will remain in effect until revoked by me in writing. A photocopy or facsimile of this assignment is considered to be as valid as the original. I also understand that by signing below, I authorize use of the above named patient's personal health information to be used for providing necessary treatment, payment, and other healthcare operations. Any other use of this information will require a separate release authorizing such use.
A signature is necessary for us to process insurance claims and to ensure payment for services rendered.

Signature: _____ Date: _____ Witness Initials _____

Attention Parents of Newborn Babies

It will be necessary for you to contact your employer or your insurance provider's member services department ***WITHIN 30 DAYS OF YOUR CHILD'S BIRTH.*** You will need to complete the appropriate forms to add your baby to your family policy. ***THIS IS NOT DONE AUTOMATICALLY.*** If the paperwork is not completed and received by your insurance provider within the 30-day grace period, there is a strong possibility that coverage will be denied until the next insurance open enrollment period through your employer. Therefore, to avoid any charges that you will be responsible for if your baby is not added as a covered dependent, please fill out the forms ***WITHIN 30 DAYS OF YOUR CHILD'S BIRTH.***

If your insurance provider requires that you choose a Primary Care Physician (PCP), make sure you select one of the three providers in this practice. There may be a separate form to complete specifically for this reason. If one of our physicians is not chosen when required by your insurance provider, your insurance provider will deny payment and any balance will become 100% your responsibility.

If you have any questions, please do not hesitate to call our office.

☐ **I plan to enroll my newborn child with our current insurance carrier.**

☐ **I DO NOT plan to enroll my newborn and understand I will be responsible for any payment required at time of service.**

Parent/Legal Representative Signature: _____ Date: _____

Employee's Initials _____

Thank you for your prompt attention to this matter.

Cultivating Healthy Lives!
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YavapaiPediatrics.com

HIPAA FORM

Notice of Privacy Practices

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, or from another payment source for our services rendered to you for reimbursement. This information may also be used for related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. You also have the right to restrict disclosure of encounter information to an insurer if it is paid fully out of pocket. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. You may also request electronic copies of information held electronically.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. Any breaches will be reported. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

Patient/Legal Guardian Signature:_____ Relationship: _____

Printed Name _____ Date _____

All questions concerning this Notice or requests made pursuant to it should be addressed to:

YAVAPAI PEDIATRICS
3001 N. MAIN ST., SUITE 1C
PRESCOTT VALLEY, AZ 86314
(928) 458-5470

Health History Form

Name: _____ **DOB:** _____ ☐ Male ☐ Female

Previous Last Name (if different than above): _____

Please list all additional people in your household:

Name	Age	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list additional people on the back

Birth History

Hospital/Place of Birth: _____ Birth Weight: _____

Were there any problems during pregnancy or delivery? ☐ Yes ☐ No

If Yes, please explain: _____

How many weeks pregnant were you when your baby was born? _____

How many days was the baby in the hospital/complications? _____

Did your baby pass their hearing screen? ☐ Yes ☐ No

If No, please explain: _____

Did your baby receive the Hepatitis B vaccine? ☐ Yes ☐ No

Past Medical History

Please list any chronic medical conditions, acute or serious illnesses/injuries: _____

_____

_____

Has child had any surgical procedures? ☐ Yes ☐ No

If Yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If Yes, please explain: _____

Does child have any allergies? ☐ Yes ☐ No

If Yes, please list: _____

Has child been diagnosed with any behavioral problems? ☐ Yes ☐ No

If Yes, please explain: _____

Does child have any problems with Vision/Hearing/Speech? ☐ Yes ☐ No

If Yes, please explain: _____

Does child currently take any medications? ☐ Yes ☐ No

If Yes, please list names and doses: _____

_____

Family History (Please mark all that apply)

Conditions of biological family members ****PLEASE EXPLAIN AND INDICATE WHOM****

☐ Allergies _____

☐ Asthma _____

☐ Lung disease _____

☐ Heart disease _____

☐ High blood pressure _____

☐ High cholesterol _____

☐ Birth defect _____

☐ Cancer _____

☐ Thyroid disease _____

☐ Kidney disease _____

☐ Diabetes _____

☐ Gastrointestinal disease _____

☐ Growth problems _____

☐ Obesity _____

☐ Seizures/Epilepsy _____

☐ Stroke _____

☐ Developmental delay _____

☐ Behavior problems _____

☐ Alcohol and/or drug abuse _____

☐ Depression _____

☐ Mental Illness _____

Have any of the child's siblings died? ☐ Yes ☐ No

If Yes, please explain: _____

Has any family member under the age of 50 died suddenly? ☐ Yes ☐ No

If Yes, please explain: _____

Social History

Relationship of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Not married but living together ☐ Not married, not living together ☐ Widowed ☐ Other

Whom does the child reside with? _____

Do you attend a church and/or have a religious preference? ☐ Yes ☐ No If yes, what _____

Does your child attend daycare/school? ☐ Yes ☐ No ☐ Home schooled

Are there pets in the home? ☐ Yes ☐ No If yes, what_____

Is your home supplied by well water? ☐ Yes ☐ No

Does anyone smoke? ☐ Yes ☐ No Does the patient smoke? ☐ Yes ☐ No

If under the age of 8, does your child use a car seat or booster? ☐ Yes ☐ No

Does your child use a bicycle helmet? ☐ Yes ☐ No ☐ N/A

Are there firearms/weapons in your home? ☐ Yes ☐ No

If Yes, are the lock/stored away from the children? ☐ Yes ☐ No

Office Policies

Office Hours

The office is open from 8:00a to 5:00p, Monday thru Thursday, and 8:00a to 4:30p, Friday. Last appointment of the day is at 4:00p/4:30pm. Office visits are by appointment only. We will try our best to work additional sick/well visits as time allotments allow. If you have questions of an urgent nature after hours, please call our office and follow the directions given on our afterhours message. If you have a life-threatening emergency, call 911 or go directly to the nearest ER/Hospital.

Appointments

Appointments are made for all new patients, well checkups, rechecks, and sick visits. The number of available well appointments is determined by the time of the year. In the winter time there are fewer well appointment times than in the summer. Please make your well appointment as far in advance as possible. Cancellations should be made at least 24 hours in advance in order to allow us to offer your appointment time to other patients needing care.
A parent or legal guardian must accompany all children/teens under the age of 18. The parent/guardian may complete an authorization form for another designated person to seek medical care for their child/children (see Permission to Treat form).

Well Child Visits

Please note that well visits are entailed to cover "well issues" (growth, development, routine screening, etc.). Your insurance company dictates these guidelines. If your child is being seen for a well visit and you have additional concerns, you may need to schedule another appointment. If you choose to have a well and sick appointment at the same visit, or a procedure that requires follow up care, you will be responsible for any additional charges your insurance company dictates, including but not limited to a second co-pay/deductible/or co-ins.

Cancelled and No-Show Appointments –All Cancellations Require 24 Hour Notice****

There may be a penalty/charge for missed appointments not cancelled 24 hours in advance. Repeated abuse of this may result in your child(ren) being discharged from this practice.

Phone Calls

Office Hours: All patients are encouraged to call the office at 928-458-5470 with any questions. Phone calls are a major part of any Pediatric Practice. Our office staff can answer many routine non-clinical questions. However, for medical related questions or problems, the non-medical office staff is not able to give any medical advice. Therefore, the Pediatricians, Nurse Practitioners, or Medical Assistants return all medical related questions.

After Hours: Calls should be limited to problems of an acute nature, which require attention before the office reopens. If your child or teenager becomes acutely ill after office hours and you cannot wait until the next morning, please call the office number 928-458-5470 and follow the prompts.

Prescriptions

If you need medication/prescription refills **please call your pharmacy** and the pharmacy will fax your refill request to our office. **For ADHD medications please call our office and leave a message for the nurse**. Please allow 72 hours for all medication refill requests to be processed. To avoid running out of your medication call the pharmacy at least 5 days before your prescription runs out. It is the policy in the office that no NEW medication is prescribed without the patient being seen in the office.

Cultivating Healthy Lives!
Clarisa I. Smith, MD
Christen M. Glennan, CPNP
Meagan Coomer, DNP
3001 Main St. Suite 1C | Prescott Valley, AZ 86314
p. 928.458.5470 | f. 928.458.5979
YavapaiPediatrics.com

If your child has not been seen in over a year, medication refill will also require an in person visit. Furthermore, it is the providers' general policy not to phone in antibiotic prescriptions. If your child is sick enough to require an antibiotic, we highly encourage he/she be seen.

Late Policy
We request that parents arrive 10 minutes prior to their child's scheduled appointment to complete any necessary paperwork. If you are more than 10 minutes late to your appointment it is very likely that you will be asked to reschedule the appointment. We strive to provide efficient and quality care and are unable to do so if you are unable to make your appointments on time.

Referrals and Prior Authorizations
The referral process can take up to 7-10 business days. This also includes authorizations for medications and procedures. Our office will contact you with additional information once the prior authorization or referral has been obtained.

Test Results
Our office with contact you with results once we have received them. If it has been longer than 7 days please contact our office.

Professional Fees
Our fees are reviewed and updated on a yearly basis. Office visit charges are based on severity of illness; records/labs ordered and/or reviewed, examination, time spent both with patient and reviewing records, and counseling time with parent and/or child.

I have read and understand the office policies of Yavapai Pediatrics and I agree to its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____	_____	_____
Parent/Legal Representative Signature	Relationship to Patient	Date

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Financial Policy

Yavapai Pediatrics will submit claims to your insurance as a courtesy. It is your responsibility to pay co-pays, deductibles, co-insurances, and any other balances not paid by your insurance. Insurance companies require that we submit all claims within a specific time limit. We do our best to follow all guidelines set forth by your insurance company. However, if your insurance changes and you don't inform us, we may be unable to bill the appropriate company within these time limits. It is critical that you keep our information up to date and let us know if you have more than one insurance carrier. Failing to do so may result in any balance becoming your responsibility.

Payment is expected as services are rendered unless prior financial arrangements have been made. We accept cash, checks, Visa, and Mastercard (a charge of $50.00 will be made for personal checks drawn on insufficient funds).

Please be prepared to pay your co-pay, coinsurance and/or deductible at the time of service; or if you do not have insurance, to pay for your visit in full. For patients with HMO plans, co-payment is required at the time of service. The amount of co-payment varies with different plans. You are responsible for knowing the co-payment amount and primary care physician listed on each child's card.

For patients with PPO plans, payment is required at the time of service until the new year's deductible has been met. After that, we require co-payments or your liability to be paid at the time of service.

The adult accompanying a minor to a visit and/or legal parents/guardians are responsible for full payment (regardless of insurance coverage) and will be set up as the person who receives the bill (guarantor) and must provide complete demographic information including both parents dates of birth and social security numbers, current address and telephone numbers.

Yavapai Pediatrics will not be involved in negotiating between parents/guardians in legal disputes. In order to change a guarantor, the person who will receive the bills must complete and sign an Updated Demographic Form. You are responsible for all balances not paid by your insurance carrier. Please pay your bill in full when you receive your statement or make payment arrangements with our Patient Account Services department. When checks are returned to us because of non-sufficient funds, a $25.00 charge be added to your account and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared. Physicals, well-visits exams, attention-deficit/hyperactivity disorder checks, and the like may be rescheduled if there are outstanding balances or if a co-payment is not made at time of service.

If you are experiencing financial difficulty, please discuss your situation directly with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent a child from receiving the care they need at the time they need it.

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However, if you ignore or fail to respond to your financial obligation, we reserve the right to discharge you from our practice. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at Yavapai Pediatrics. Your account may be sent to collections and all legal fees and collection expenses will be added to your balance.

UNPAID BALANCES

Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department. Balances not paid in full within 10 days of the date of the final (third) request letter will be forwarded to a collection agency. The patient/responsible party will then be responsible for the amount due plus all costs of the collection, including but not limited to all collection expenses charged by the collection agency, Court costs, Attorney's fees. Any discounts previously applied to the account may be reversed. If your account is forwarded to a collection agency, we will continue to see your child on emergency basis only for 30 days following a receipt of a discharge letter, giving you time to find a new source of medical care.

I have read and understand this financial policy and I agree to its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Patient's Name Printed Name of Parent/legal representative

_____ _____ _____

Parent/Legal Representative Signature Relationship to Patient Date

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YOUR INSURANCE COMPANY DECIDES IF YOU OWE US A CO-PAY

There is no such thing as a FREE WELL VISIT, despite what your insurance company advertises to you. There may be components of your well child check that your insurance company will not pay. It is your responsibility to know what is and is not covered and to pay for those uncovered services.

- The Affordable Care Act (ACA) legislated that insurance companies cannot charge a co-pay for preventative services.
- Your visit is charged and submitted to you or your insurance company exactly as it was before the ACA was passed. The difference now is that your insurance company has to pay for the preventative services and cannot pass a co-pay on to you.
- Insurance companies are allowed to charge for services that they determine are not preventative.
- Examples of services that may be provided on the day of your well visit that are NOT preventative services and where additional copay, coinsurance or deductible apply are:
    - Evaluation and treatment of an acute illness (like an ear infection, fever, flu, sore throat, injuries, etc…).
    - Evaluation and treatment of a chronic problem (like eczema, asthma, allergies, headaches, ADHD, joint pain, etc…).
    - Procedures that are not part of the routine recommended preventative/well child visit (like circumcision, breathing treatments or removing ear wax).
    - Any services that the insurance company says are not preventative. Services that are recommended during the well child visit that insurances **may** deem not preventative are: vision or hearing testing, blood and urine testing.
- If non-preventative services are provided to a patient, we are legally REQUIRED to report those services to your insurance company.
- YOUR INSURANCE COMPANY DETERMINES WHETHER OR NOT YOU OWE A CO-PAY, DEDUCTIBLE, OR CO-INSURANCE once they review the services provided.
- If your insurance determines that you owe a co-pay, we are required to collect it.
- If you receive a bill from us for a co-pay for the same date as your well visit, then a non-preventative service was provided to you on that date and YOUR INSURANCE COMPANY has determined what you owe us.

Yavapai Pediatrics is dedicated to the health and well-being of your child. We are more than happy to address ongoing issues during well visits at long as you understand that a co-pay may be billed at a later time. Don't get caught by surprise when you receive a bill for services. This is your contract with your insurance company and we are required to follow the contracts dictated by the insurance company. Please be understanding of this situation.

I have read and understand the above. I understand that if non-preventative services are provided at the time of a well child visit, I may be responsible for co-pays, co-insurance or deductible as dictated by the insurance company and their terms.

_____	_____	_____
Parent/Legal Representative Signature	Relationship to Patient	Date

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Vaccine Policy

Every day we encounter questions concerning the safety of the currently recommended vaccines and the immunization schedule. In response to the increasing concerns expressed by parents, we have developed a policy statement which we hope will carefully and thoroughly address your concerns.

Yavapai Pediatrics is implementing a new immunization policy effective immediately. Based on the currently available scientific data and facts, here is our policy regarding childhood immunizations. Please review this policy and contact us with any questions, concerns or if you need further clarification.

Yavapai Pediatrics has always endorsed the childhood immunization policy recommended by the American Academy of Pediatrics (AAP), the nation's premier institute dedicated to the health of ALL children. These guidelines, based on scrupulous worldwide scientific research, reflect no link between childhood vaccines and the risk of autism and/or other adverse neurological outcomes.

In recent years, the media and internet have bombarded families about the "risks" of vaccines. On the contrary, current evidence repeatedly validates the safety and efficacy of vaccines. There are false reports that some dangerous childhood illnesses, preventable by vaccination, are now nonexistent. When the majority of the population is immunized, "herd immunity" eradicates childhood diseases such as polio, whooping cough, measles, mumps, etc. In proportion to the declining rates of childhood immunization, this "herd immunity" in the general population has also declined. Potentially fatal and handicapping childhood diseases are therefore making a comeback in the US.

We realize that families may be apprehensive about making the decision to immunize their child(ren). For some families, it is a deeply personal choice because of a child or family member with special health care needs.

Yavapai Pediatrics has a duty to protect EACH child in the practice. It is a serious public health risk to expose patients to sick children in the waiting room who are NOT immunized. The most vulnerable patients, who will be most severely affected, are infants too young to be immunized.

Trust is the cornerstone of the parent/healthcare provider relationship. Therefore, we respectfully state that refusing one or all childhood vaccines is not conducive to a trusting partnership.

Effective immediately, Yavapai Pediatrics will no longer accept new patients whose parents have decided--with no valid medical reason--to not immunize their child in accordance with the AAP

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guidelines. We do this to protect our most vulnerable patients--newborns who are too young to receive vaccines and patients with weakened immune systems (such as children with cancer or transplanted organs) who have a valid medical reason they cannot receive vaccines.

The following vaccines, though highly recommended, if refused will not result in dismissal from our practice: HPV, Hepatitis B and Influenza.

Established families in our practice whose children are currently on "alternate schedules" or completely unimmunized will need to start bringing their child up to date on recommended vaccines. If you are a parent of such a family and you cannot agree to vaccinate your child according to the AAP schedule, we will ask that you find another medical practice aligned to your personal philosophy on vaccines. Please contact us if you wish your child's medical records be transferred to a different provider.

As inferred above, our new policy does NOT apply to children in whom vaccines cannot be administered for specific medical reasons.

We hope to allay your fears about vaccines and have a mutually satisfactory relationship in the years to come.

We thank you for understanding the changes we are making in hopes to provide your child with the highest standard of care.

_____ _____

Patient's Name Printed Name of Patient/ Legal Representative

_____ _____ _____

Parent/Legal Representative Signature Relationship to Patient Date

Cultivating Healthy Lives!
Clarisa I. Smith, MD
Christen M. Glennan, CPNP
Meagan Coomer, DPN
3001 Main St. Suite 1C | Prescott Valley, AZ 86314
p. 928.458.5470 | f. 928.458.5979
YavapaiPediatrics.com

Non-Parent Permission to Treat

I, the undersigned parent: _____,
hereby give the following designee the power to consent in my absence to medical care (any medical treatment, office procedures, injections of vaccines or medications, and physical assessments of health or illness) for my child:

Name of designee (only one per form): _____

Relationship to Patient: _____

Patient's name and date of birth:

_____ _____/_____/_____

This Permission to Treat expires one year from date signed and can only be revoked with my signature. I understand that this agreement will need to be renewed annually.

Parent/Legal Representative Signature: _____ Date: _____

Employee's Signature: _____ Date: _____

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What is your preferred method of contact for reminders, responses and health information?

☐ Telephone Preferred number: _____
Text messages for appointment reminders: ☐ Yes ☐ No
(will be utilized when available)

☐ E-mail E-mail address: _____

☐ Mail Mailing address: _____

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Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

1. I authorize the release of my child's health information from previous doctor's office/ hospital:

Practice/Hospital Name: _____ Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

2. The type and amount of information to be disclosed is as follows: *(include dates where appropriate)*

☐ Complete health records ☐ Lab results/ X-ray reports

☐ Physical exam ☐ Consultation reports

☐ Immunization records ☐ Other (specify): _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

4. This information may be disclosed to: Name: **Yavapai Pediatrics**

Address: **3001 Main Street, Suite 1C**

Prescott Valley, AZ 86314

Fax#: **(928) 458-5979**

If records are more than 25 pages, please mail.

For the purpose of: Medical Care (I understand that the above named provider is covered by the federal privacy regulations (HIPAA) and is bound by law to only use the information received for only purposes listed).

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 12 months from date of signature.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____ _____

Parent/Legal Representative Signature Relationship to Patient Date

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom is pertains or as permitted by state law (ORC- 3701.243 and federal law 42 CFR, part II.

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NOTICE OF PRIVACY PRACTICES

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

a. Keep your medical information private.

b. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

c. Follow the terms of the current notice.

We Have the Right to:

a. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

b. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

a. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the med-

-ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an intimate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes or reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to stop law enforcement official s capture a person who has admitted to being a part of a crime or has escaped from legal custody.

Workers Compensation:

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.

Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.

Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice