

## Step By Step Pediatrics Medical Treatment Agreement

Patient or the patient's legal representative agrees to the following terms of treatment.

1. **MEDICAL TREATMENT:** The patient consents to the treatment, services and procedures which may be performed in the clinic, which may include multiple visits, and which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatment or procedures, anesthesia, or clinic services rendered under the general or specific instructions of the responsible physician or other health care providers. The clinic may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.
2. **LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTH CARE PROVIDERS:** The patient will be treated by his/her attending doctor or health care providers and will be under his/her care and supervision. Some physicians and other health care providers furnishing services to the patient, including radiologist, pathologist, anesthesiologist, and the like, may not be Clinic employees and while the services they render are authorized by this consent, they are responsible for their own treatment activities. These providers may bill the patient separately for their services.
3. **CLINIC POLICY FOR DIVORCED OR SEPARATED PARENTS:** In general, we ask that parents NOT place our office in the middle of family disagreements. We rely on our parents to keep our practice atmosphere calm, professional, and caring. State law states that both parents, regardless of custodial status, have a right to the child's medical record. If there is a court order stating restrictions, we ask that you provide the documentation to our office. We ask that whoever brings the child to the office for the visit be prepared to pay any co-pays or balances on the account regardless of who is designated by divorce agreement to pay. We ask that you DO NOT ask our office to collect payments from a parent who is not at, or may be unaware of the appointment. Your child's health and wellbeing is our top priority and our providers will act in the best interest of the child. The patient is aware that should they require a detailed copy of this policy, one can be requested and provided to them.
4. **MONEY AND VALUABLES:** The clinic will not be responsible for loss or damage to items such as glasses, contact lenses, jewelry, or money.
5. **TEACHING PROGRAM:** The clinic participates in training programs for physicians and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of doctors or clinic employees. These persons may also observe care given to the patient by doctors and clinic employees.
6. **RELEASE OF INFORMATION:** The clinic or treating provider may disclose all or any part of the patient's medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION) to third parties (including insurance companies or their representatives, specialists, other health care professionals participating in the patient's care) and may be reviewed for teaching purposes.

**I have read and understand this Treatment Agreement and I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the parent's behalf to sign this agreement.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## FINANCIAL AGREEMENT

I agree that if I do have insurance, that my co-pay is due at the time of service per my insurance contract. I also understand that I may be asked to pay a balance that resulted from my office claims being adjudicated by my insurance, in which they applied money towards my deductible or co-insurance.

If I do not have insurance, or have insurance, but a service provided is not a covered benefit, all fees are to be paid at the time of visit. I am aware that the office offers a cash discount for cash paying patients who pay at the time of service. If I am utilizing the VFC program for immunizations, I am aware that those fees, if applicable, are also due at the time of the visit.

I am aware that should I not pay my co-pays at the time of service, as well as if I have continuous no-shows to scheduled appointments, there will be additional charges added to my balance.

**In the unfortunate event that an account becomes delinquent, the account will be transferred to an outside collections agency. There will be a 50% collections charge that will be added to your bill. In addition to the account being transferred out, the patients on the account are automatically discharged from the practice.**

If I have any questions regarding the office's billing policies or if I need to make payment arrangements, I can call the billing office at (602) 795-3655.

**I have read and understand the financial agreement.**

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

# Step By Step Pediatrics

Courtney Bishop, MD   Julie Peterson, MD   Tanya Horner, MD   Theresa Lindstrom PA-C   Beverly Ricketts, PNP

PATIENT INFORMATION		
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Patient Name:	Gender:	DOB:
	SSN:	
Address:	Home Phone:	
	Work Phone:	
City, State, Zip:	Cell Phone:	
E-Mail Address:	Additional Phone:	
INSURANCE INFORMATION		
<b>Primary Insurance:</b>	<b>Secondary Insurance:</b>	
Policy Subscriber Name:	Policy Subscriber Name:	
Subscriber DOB:	Subscriber DOB:	
Subscriber SSN:	Subscriber SSN:	
RESPONSIBLE PARTY		
Name:	DOB:	
Relationship to patient:	SSN:	
Address:	City, State, Zip:	
Home Phone:	Work Phone:	
PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN	
Parent/Legal Guardian Name:	Parent/Legal Guardian Name:	
Address: (If different than pt)	Address: (If different than pt)	
Home Phone:	Home Phone:	
Work Phone:	Work Phone:	
Cell Phone:	Cell Phone:	
EMERGENCY CONTACT		
In an emergency notify:		Relation:
Home Phone:	Work Phone:	Cell Phone:
MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION		
<p style="text-align: center;">ALL COPAYMENT, COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME SERVICE IS RENDERED.</p> <p>Under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I hereby authorize Step By Step Pediatrics to provide such medical services, either regular or emergency, as may be determined by my physician to be in the best interest (or the best interest of my dependent if I am signing as a parent or guardian). I also hereby authorize Step By Step Pediatrics to furnish information to insurance carriers concerning my medical condition and treatments. I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any and all amounts not covered by insurance. In the event of default, I promise to pay collection costs and reasonable attorney fees as may be required to effect collection of this account.</p> <p style="text-align: center;">I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED THE "HIPPA" NOTICE OF PRIVACY PRACTICES.</p>		
Signature of Patient or Parent: _____		Date: _____

**Pediatric Health History Form- Initial Visit**

Child's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Your Name \_\_\_\_\_  
 Relationship to Child \_\_\_\_\_

**Child's Past Medical History**  
**Social History**

**Pregnancy/Neonatal Period**  
 Where was your child born? \_\_\_\_\_  
 Is the child yours by  birth  adoption  stepchild  other  
 Complications during pregnancy \_\_\_\_\_

**During pregnancy, any exposure to the following:**  
 Smoking  Alcohol  Drugs  Medications

Delivery by  Vaginal  C-Section  
 Reason for C-section \_\_\_\_\_  
 Delivery Complications \_\_\_\_\_

Was your child premature  No  Yes, born at \_\_\_\_\_ weeks  
 Birth Weight \_\_\_\_\_ Length \_\_\_\_\_  
 Other problems in the newborn period \_\_\_\_\_

**Infancy/Childhood/ Adolescence**

Has your child ever been treated for or diagnosed with: (explain)

- Asthma \_\_\_\_\_
- Wheezing or bronchiolitis \_\_\_\_\_
- Seasonal allergies or eczema \_\_\_\_\_
- Food allergy \_\_\_\_\_
- Recurrent ear infections \_\_\_\_\_
- Heart murmur/abnormality \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Urinary tract infections/abnormality \_\_\_\_\_
- Genetic syndrome \_\_\_\_\_
- Seizures \_\_\_\_\_
- Anemia \_\_\_\_\_
- Broken bone/joint problem \_\_\_\_\_
- ADHD \_\_\_\_\_
- Mental retardation or learning disability/autism \_\_\_\_\_
- Depression/anxiety \_\_\_\_\_

Other chronic medical conditions \_\_\_\_\_

Has your child ever been hospitalized?  No  Yes (explain)

Previous surgeries and dates \_\_\_\_\_

Please list any specialist your child has seen and reason: \_\_\_\_\_

**Medications**

**ALLERGIES** to medicine/vaccines (list and describe reaction)

Current medications and dose: \_\_\_\_\_

Vitamins \_\_\_\_\_

Herbal Supplements \_\_\_\_\_

Over-the counter meds \_\_\_\_\_

**Development/ Nutrition**

Has your child had any unusual feeding/dietary problems? Explain.

Any concern about your child's development  
 Speech  Motor  Social  Behavior

Explain: \_\_\_\_\_

**Social History**

Who lives in primary residence with patient?

Name	Relationship	Date of Birth	Occupation/Education

Child's parents are  Married  Unmarried  Divorced  Other  
**ARE THERE ANY CUSTODY ISSUES THAT WE SHOULD BE AWARE OF?**

NO  YES  
**EXPLAIN** \_\_\_\_\_

Childcare :  Parents  Relatives  Daycare  Babysitter/nanny

Do any household members smoke?  Yes  No

Any concerns about school performance?  No  Yes, explain

Any concerns about peer or teacher relationships?  No  Yes, explain

Any recent changes/stresses in your child's life?  No  Yes, explain

**Family History**

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma				
Anemia				
Blood disorder				
Cancer				
Heart attack/disease				
High Cholesterol				
High blood pressure				
Stroke				
Diabetes				
Thyroid disease				
Kidney disease				
Seizures				
Migraines				
Depression/anxiety				
Alcoholism				
ADD/ADHD				
Autoimmune disease				

**Please explain all positives:**

**Review of Systems** (Check all that apply for patient)

**Constitutional**  
 \_\_\_ Fever, Chills \_\_\_ Fatigue  
 \_\_\_ Unexplained weight loss/gain  
 \_\_\_ Excessive thirst

**Ear, Nose and Throat**  
 \_\_\_ Loud Voice, hearing problem  
 \_\_\_ Mouth-breathing, snoring  
 \_\_\_ Ear pain  
 \_\_\_ Frequent runny nose

**Respiratory**  
 \_\_\_ Cough, short of breath  
 \_\_\_ Chest tightness, wheeze

**Musculoskeletal**  
 \_\_\_ Muscle pain, weakness  
 \_\_\_ Joint pain, swelling  
 \_\_\_ Bone pain

**Other (eye, skin, blood)**  
 \_\_\_ Blurry vision \_\_\_ Squinting  
 \_\_\_ Crossed eyes \_\_\_ Itchy eyes  
 \_\_\_ Rashes \_\_\_ Abnormal moles  
 \_\_\_ Abnormal bruising, bleeding

**Gastrointestinal**  
 \_\_\_ Nausea, vomiting, diarrhea  
 \_\_\_ Constipation, blood in stool  
 \_\_\_ Abdominal pain

**Cardiovascular**  
 \_\_\_ Chest pain, palpitations  
 \_\_\_ Tires easily with exertion  
 \_\_\_ Fainting

**Genitourinary**  
 \_\_\_ Frequent or painful urination  
 \_\_\_ Bedwetting, frequent accidents  
 \_\_\_ Vaginal or penile discharge

**Neurologic**  
 \_\_\_ Headaches \_\_\_ Seizures  
 \_\_\_ Clumsiness \_\_\_ Milestone delay

**Psychiatric/emotional**  
 \_\_\_ Anxiety/stress \_\_\_ Depression  
 \_\_\_ Sleep problem \_\_\_ Anger concern  
 \_\_\_ Concerns with attention, impulsivity

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**VACCINES FOR CHILDREN ELIGIBILITY WORKSHEET**

Vaccines for Children (VFC) is a federally funded vaccine program that enables Step By Step Pediatrics to administer vaccines at a discounted rate to patients who are insured through state funded insurance (AHCCCS), have private insurance but either have a high deductible plan or a low yearly wellness benefit, or are currently uninsured. **If the VFC fee applies, the amount is due at the time of service per the program requirements.**

**If you can check any of the situations below, your child(ren) are eligible for this program:**

\_\_\_\_\_ Enrolled in an AHCCCS insurance plan (FEE N/A)

\_\_\_\_\_ Underinsured\* (FEE APPLIES)

\_\_\_\_\_ Not insured (FEE APPLIES)

\*Plans are considered to be underinsured if there is a high deductible or a low yearly wellness maximum benefit.

**If you cannot check any of the above , please mark below:**

\_\_\_\_\_ Private commercial insurance plan that covers immunizations

\_\_\_\_\_  
**Child's Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Parent's Signature**

\_\_\_\_\_  
**Today's Date**

RECORDS TO BE **SENT TO** STEP BY STEP PEDIATRICS

FROM: \_\_\_\_\_  
**DOCTOR/ PRACTICE NAME OR HOSPITAL NAME**

\_\_\_\_\_  
**ADDRESS, CITY, STATE, ZIP**

\_\_\_\_\_  
**PHONE NUMBER/ FAX NUMBER**

I hereby authorize and request YOU to release any and all medical records to: **STEP BY STEP PEDIATRICS** at **5680 W CHANDLER BLVD., SUITE 3 CHANDLER, AZ 85226, (480) 776-0440/ FAX (480) 776-0444**

**Julie Peterson, M.D., F.A.A.P**  
**Courtney Bishop, M.D., F.A.A.P**  
**Tanya Horner, M.D., F.A.A.P.**  
**Theresa Lindstrom, PA-C**  
**Beverly Ricketts, PNP**

I request the release of photocopies of the above medical records in your possession or control. **FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE INFORMATION (AS DEFINED IN A.R.S. SECTION 36-881), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH, DIAGNOSIS AND/OR TREATMENT INFORMATION.**

**PATIENT NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**IF PATIENT IS A NEWBORN, PLEASE INCLUDE:**

**MOTHER'S NAME:** \_\_\_\_\_

**MOTHER'S DOB:** \_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_  
**RELATIONSHIP TO CHILD** \_\_\_\_\_

**TODAY'S DATE** \_\_\_\_\_