Step By Step Pediatrics

Courtney Bishop, MD, Aseema Maher, MD, Abigail Alviar, DO
Sarah Nguyen, MD, Theresa Lindstrom, PA-C, Beth Jaco, 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	
Primary Insurance:	**Secondary Insurance:**
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

ALL COPAYMENT, COINSURANCE AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME SERVICE IS RENDERED.

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.

I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED THE "HIPPA" NOTICE OF PRIVACY PRACTICES.

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_____
- ☐ Cognitive Impairment/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***_____

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**

Courtney Bishop, MD, FAAP
Aseema Pani Maher, MD, FAAP
Abigail Alviar, DO, FAAP

STEP BY STEP
PEDIATRICS

Sarah Nguyen, MD
Theresa Lindstrom, PA-C
Beth Jaco, PNP

VISIT BILLING

Our goal at Step By Step Pediatrics is to provide the best medical care for your child. We endeavor to make the process of medical billing as clear as possible. We will try to help you to navigate the confusion of insurance billing limitations, regulations and laws.

We are required to bill according to the services we provide. We will usually bill a Well Check/Preventative Visit or Sick Visit. On occasion, if we address an illness or chronic medical condition at a well check, we may bill for both on one day. Examples of issues that could be billed separately include the need for prescriptions, referrals, labs, or x-rays to be ordered; a complaint that would have needed a separate visit to the office to be treated; or an issue, chronic or new, that takes up a significant amount of additional time.

Please keep in mind that while the appointment may have been scheduled just for a Well Check or Sick visit, if both kinds of services are provided during a visit, then both services may be billed. You may then be responsible for paying a co-payment for each service, meeting your deductible, or co-insurance, depending on your insurance coverage.
Initials here _____. Examples include: headaches, stomach pain, constipation, obesity, autism, ADHD, symptoms of illness, fatigue, feeding issues and mental health.

In general, we try to focus on preventive care in Well Checks because reviewing and discussing the growth and development of children deserves and requires adequate time. However, we realize that important issues may occasionally need to be covered the same day. We apologize for any billing inconveniences, but hope that by sometimes covering sick complaints during Well Checks, we have saved you the time and inconvenience of another trip to our office for a Sick Visit.

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of **$25.00** for all missed appointments ("No Shows"). We require 24 hour advance notice if you need to cancel an appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

_____ _____
Patient Name Date of Birth

_____ _____
Parent/Guardian Name Date

_____
Parent/Guardian Signature

5680 W. Chandler Blvd., Suite 3 • Chandler, Arizona 85226 • Phone: 480-776-0440 • Fax: 480-776-0444
www.stepbysteppediatrics.com

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

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STEP BY STEP PEDIATRICS

Sarah Nguyen, MD
Theresa Lindstrom, PA-C
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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., Ste 3 Chandler, AZ 85226, (480) 776-0440 FAX (480) 776-0444

Courtney Bishop, M.D., FAAP
Aseema Maher, M.D., FAAP
Abigail Alviar, D.O., FAAP
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Theresa Lindstrom, PA-C
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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.**
The patient or the patient representative has the right to revoke this authorization by contacting the office at (480) 776-0440 and speaking to an office representative and explain why they are revoking the authorization so that the office can document the change.

PATIENT NAME_____**DOB**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

IF PATIENT IS A NEWBORN, PLEASE INCLUDE
MOTHER'S NAME_____
MOTHER'S DOB_____

PCP or PARENTAL SIGNATURE_____
RELATIONSHIP TO CHILD_____

REASON FOR RECORDS TRANSFER_____

TODAY'S DATE_____/_____/_____
This authorization will be valid for one (1) year from the date of signature or if desired can be designated an expiration date. If you would like to designate an expiration date for this authorization, please enter date _____/_____/_____

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STEP BY STEP
PEDIATRICS

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Notice of Privacy Practices

Our Commitment To Your Privacy

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices.

We may use and disclosure your individually identifiable health (PHI) in the following ways:

1. **Treatment:** Our practice may use your PHI to treat you. This includes ordering tests which will help us to reach a diagnosis. We may disclose your PHI to other health care providers for the purposes related to your treatment.
2. **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services you may receive from us. We may have to share PHI with your insurance company requiring details in regards to your treatment.
3. **Health Care Operations:** Our practice may use and disclose your PHI to operate our business. Our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment
5. **Treatment Options:** Our practice may use and disclose your PHI to inform you of potential treat options or alternatives

Use and Disclosure of your PHI in certain special circumstances

The following categories describe unique scenarios in which we may use of disclose your identifiable health information.

1. **Public Health Risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals of drug recalls
2. **Health Oversight Activities** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, investigations, audits, surveys or other activities for the government to monitor government programs.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request.
4. **Law Enforcement.** We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, subpoena or summons.
5. **Serious Threat to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

_____ _____

Patient Name **Date**

_____

Parent/Guardian Signature