Step By Step Pediatrics, P.C.
5680 W Chandler Blvd Suite 3 Chandler AZ 85226

PATIENT INFORMATION		
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Patient Name:	Gender:	DOB:
Address: City, State, Zip:	Home Phone: Cell Phone:	

INSURANCE INFORMATION **Please give ID and all insurance cards to the front office**	
Primary Insurance:	**Secondary Insurance**:
Policy Subscriber Name:	Policy Subscriber Name:

PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN
Parent/Legal Guardian Name:	Parent/Legal Guardian Name:
Address: (If different than pt)	Address: (If different than pt)
DOB:	DOB:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email address:	Email address:
Employer/Profession:	Employer/Profession:

EMERGENCY CONTACT OTHER THAN PARENTS/GUARDIANS		
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 ("HIPAA"), I hereby authorize Step By Step Pediatrics to provide such medical services, either regular or emergency, as may be determined by the 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.

Signature of Patient/Parent/Guardian: _____ Date: _____

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5680 W Chandler Blvd, Suite 3 Chandler AZ 85226
Ph: 480-776-0440 Fax: 480-776-0444
Frontoffice@stepbysteppediatrics.com

Patient Financial Responsibility and HIPAA notification

For this notice, "patient" means the patient, patient's parent, or legal guardian

I. Financial Policy

Please bring your current ID and insurance card to every visit. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible, co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you will be responsible to pay the full balance. For those patients without insurance, a self pay discount will be applied. All fees are due at the time of service.

Claims not paid within 90 days will be made patient due; the patient will then need to contact the insurance company for further claims payment actions. Late fees/penalties may apply. Failure to pay outstanding balances may result in collections action and/or termination from the practice. If an account is turned over to collections, a 50% collections charge will be added to the total and the patient will be discharged from the practice.

II. No Show/Cancellation Policy

Step by Step Pediatrics requires a minimum of 24-hour notice prior to the appointment time when canceling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window will result in a $30 FEE per infraction (payable upon receipt of billing). If you have 3 no-shows in a 12 month period, you may be subject to discharge from the practice.

Telephonic, text, and email reminders are made by our staff and/or automated system when time permits. However, it is ultimately the patient's responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone 480-776-0440, but it must be at least 24 hours in advance of the appointment. Please assist us in maintaining good service through efficiency.

III. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. This includes releasing information to your attorney, insurance, other medical providers, and/or facilities. If you would like a more detailed description of such uses and disclosures, please refer to the Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices before signing this consent form. The terms of the Notice of Privacy Practices may change from time to time. You can get a copy of the latest Notice of Privacy Practices from the front office. We also post a copy of the Notice of Privacy Practices in our office.

You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

IV. My Acknowledgement

I have read and understand the financial and no show/cancellation policy described above.

Patient Name _____ DOB _____

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship to patient

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Visit Billing and Medical Treatment Agreement and Policies

For this notice, "patient" means the patient, patient's parent, or legal guardian

I. Visit Billing _____ Initials

Our goal at Step by Step Pediatrics is to provide the best medical care for your child. We strive to make the process of medical billing as clear as possible and help you navigate insurance billing limitations, regulations, and laws.
We are required to bill according to the services we provide. The two most billed services are Well Child Check/Preventive Visit or Sick Visit. If we address an acute illness, chronic medical condition, etc that is not directly related to the parameters of a well child visit, then a sick visit may also be billed. Examples include but are not limited to: headaches, stomach pain, constipation, obesity, ADHD, autism, fatigue, feeding issues, behavior issues, mental health

Please keep in mind that while the original appointment may have been scheduled for a Well Child Check or Sick Visit, if both kinds of services are provided during a visit, then both services may be billed. In such case, you may then have a copay, deductible, or co-insurance that may apply.
In general, we try to focus on preventive care in Well Child Checks as reviewing and discussing the growth and development of children deserves and requires adequate time to cover all the necessary elements. However, we realize that important issues may occasionally need to be covered on the same day. Not only will this save you a trip on a different day, but it also helps to address the problem in the most efficient manner.

II. Medical Treatment Agreement _____ Initials

We prefer that a parent/guardian be present at each visit. However, we understand that occasionally extended family or other persons may need to be in attendance on the parent/guardian's behalf.
By signing this agreement, you give consent to have your child examined and treated as medically necessary. Treatment may include routine vaccinations, in-office labs, minor procedures with local anesthesia, administration of inhaled medications such as albuterol, etc.

II. Other Office Policies

- We ask that parents NOT place our staff in the middle of family disagreements. We rely on our parents to keep our atmosphere calm and professional. State law allows both parents, regardless of custodial status, to have rights to the child's medical record (unless court documented paperwork states otherwise and has been provided to us.) The parent attending the visit will be responsible for any copays or other fees due—regardless of who carries the insurance. We ask that parents work together on how fees will be paid. Our office will not call the other parent for payment nor will we balance bill. _____ **Initials**
- Our clinic participates in training programs for physicians, nurses, medical assistants, etc. Some patient services may be observed and/or performed by training personnel, but will always be supervised by a healthcare provider or clinic staff. _____ **Initials**
- We will share vaccination records with schools and daycares at your request and without written consent. You must provide us with school contact and/or fax number. _____ **Initials**
- The clinic assumes no responsibility for purses, wallets, diaper bags, water bottles, etc. Please secure your items during the visit. Any items left will be placed in lost and found and will be discarded if not claimed in 30 days. _____ **Initials**
- We participate in Arizona's Health Information Exchange with partner Contexture. This is a statewide database that allows hospitals, labs, health plans, emergency personnel, etc to have access to your records. If you choose to opt out, please get the form from the front desk. _____ **Initials Opting Out?** _____

Child's Name _____ DOB _____

Pediatric Health History Form

Child's Name_____

Date of Birth_____ Age_____ Male Female

Race/Ethnicity _____

Tribal Affiliation _____

Your Name_____

Relationship to Child_____

Pregnancy/Neonatal Period

Where was your child born? __Hospital __Birthing Center __Home
Is child by __birth __adoption __ stepchild __Other
Complications during pregnancy _____
During pregnancy, any exposure to:
__Smoking __Alcohol __Drugs __Medications
Delivered by ___Vaginal ___C-section
Reason for C Section _____
Delivery Complications _____
Was the child premature? _No __Yes, born at _____ weeks
Birth Weight _____ Length _____
Other problems in first months of life _____
_____
Is child deaf or has hearing impairments? __No __ Yes
Is child blind or has visual impairments? __ No __ Yes

- □ 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 disabilities/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

Any unusual feeding or dietary issues? _____
Any concern about your child's development
Speech Motor Social Behavior
Explain:_____

Social History

Who lives in primary residence with patient? (Do not include patient)

Name _____ DOB_____Relation? _____
Name _____ DOB_____Relation? _____
Name _____ DOB_____Relation? _____
Name _____ DOB_____Relation? _____
Name _____ DOB_____Relation? _____

Child's parents are: __Married __Unmarried __ Divorced __Other
Are there any custody issues? NO YES, please explain
_____
Childcare: __Parents __Relatives __Daycare __Babysitter/Nanny
Do any household members smoke? YES NO
Any concerns about school performance? NO YES, please explain
_____
Any concerns about peer or teacher relationships? NO YES, please explain
_____
Any recent changes/stresses in child's life? NO YES, please explain
_____

Family History Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma				
Anemia/Blood disorder				
Genetic condition				
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 yes/checked boxes:
_____
_____
_____

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
__ Gender identity concerns

Reviewed by_____ ***Date***_____

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Authorization for Confidential Information Release/Request

Patient Name_____ DOB _____

Address _____ City_____ State_____ Zip_____

If patient is a newborn, mother's name _____ DOB _____

Parent/Guardian _____ Phone Number_____

I authorize Step by Step Pediatrics, P.C. to

____ Release my information **TO** ____ Request my information **FROM**

The following physicians, clinics, hospitals, and/or facilities:

Name, Phone, Fax #_____

Name, Phone, Fax #_____

Reason for request: _____

Information Needed: □ ALL From date _____ to _____

- □ Office Visit Notes
- □ Newborn Screening Info
- □ Immunization/Vaccine Record
- □ Recent Labs (within the past 6 months unless otherwise indicated _____)
- □ Imaging (CT, MRI, Xray, etc) _____
- □ Mental Health/Behavioral Health, Psychiatric, and/or Psychotherapy notes
- □ Other _____

Medical records requests may contain confidential information on HIV status (A.R.S. Section 36-661), communicable diseases (A.R.S. Section 36-881), alcohol or drug abuse (42 CFR Section 2.1 ET SEQ), and/or mental health diagnosis, status, and/or treatment information. **Specifically *EXCLUDE*** ____HIV/AIDS ____ STD ____ Psychiatric disclosure

I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken in reliance on it. This consent will expire 365 days from today's date, unless Step by Step Pediatrics is otherwise notified.

_____ _____
Patient/Parent/Guardian Signature Date

Relationship to Patient: ____ Self ____ Parent ____ Power of Attorney/Legal Guardian

Authorization for Confidential Information via EMAIL

Step by Step Pediatrics
5680 W Chandler Blvd, Suite 3 Chandler AZ 85226

Patient Name_____ DOB _____

Patient Name_____ DOB _____

Patient Name_____ DOB _____

Parent/Guardian Name_____ Phone # _____

Parent/Guardian Name_____ Phone # _____

I authorize *Step by Step Pediatrics* to release my child's information to myself via EMAIL.
I understand that email cannot be guaranteed 100% secure by either party and accept the risks involved with sending personal health information and financial records via email.

I understand that I must send an email FROM THE EMAIL that I need my records sent to and state that I am requesting the records sent to this email. This is to ensure that the correct email has been stated and that no typographical errors have been made.

The email(s) that I will be sending the request from is:

_____

_____

I understand that by giving permission to allow my personal health information to be disclosed without restriction and may include sensitive information about my child's medical condition and health history.

I understand that I may withdraw this consent at any time in writing except to the extent that action has been taken in reliance on it. This consent will last while my child is being treated by Step by Step Pediatrics unless I withdraw my consent during treatment. This consent will expire 365 days after my last visit date, or 365 days after today's date if my child is no longer a patient, unless Step by Step Pediatrics is otherwise notified by me.

_____ _____
Patient/Parent/Guardian Signature Date

Relationship to Patient: ____ Self ____ Parent ____ Power of Attorney/Legal Guardian

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Permission for Minor Child to be Attended by Non-Parent/Guardian

The follow persons may present my child for diagnosis, treatment, and immunizations

Name: _____ DOB _____

__Mother __ Father __Legal Guardian

Name: _____ DOB _____

__Mother __ Father __Legal Guardian

For (child) _____ DOB _____

For (child) _____ DOB _____

For (child) _____ DOB _____

I hereby voluntarily consent to the rendering by the below named person (s) of such care as bringing my child to office visits, accept orders/prescriptions, and/or consenting to injections, immunizations, etc. I understand that services will be performed by authorized members of the staff or their designees as may be necessary in their medical opinion. I understand that this authorization gives permission for this person (s) to be made aware of personal and confidential health information. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

We/I hereby give consent to _____ for the mentioned permissions listed above and who will be attending visits for the above mentioned child/children.

Relationship to child _____ Phone number _____

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered by this practice.

Signature of Parent/Guardian _____

Date _____

This consent is valid until revoked in writing.