Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name: ______________________ Sex: M_____ F_____ DOB: __________

Patient's Name: ______________________ Sex: M_____ F_____ DOB: __________

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Patient's Name: ______________________ Sex: M_____ F_____ DOB: __________

Patient's Name: ______________________ Sex: M_____ F_____ DOB: __________

Patient's Home Address: ______________________ Home Phone: (____) _____-______
Street City ST Zip Code

Marital Status of Child's Parents (please check one):

PARENT'S INFORMATION

Married _______ Single_______ Separated_______ Divorced_______

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Mother's Name: ______________________ Date of Birth: __________

Same as above ☐ Home Address: ______________________
Street City ST Zip Code

Cell: ______________ Email: ______________

Employer: ______________ SSN# ______________

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Father's Name: ______________________ Date of Birth: __________

Same as above ☐ Home Address: ______________________
Street City ST Zip Code

Cell: ______________ Email: ______________

Employer: ______________ SSN# ______________

INSURANCE INFORMATION

Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number
Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number

Emergency Contact (Not living with you): Name: ______________________ Phone: (____) _____-______

How did you hear about our practice? ______________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physicians of Great Destinations Pediatrics for Medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney fees, and all other costs.
I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child.

FINANCIAL/OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy and agree to abide by the terms of this office policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, Including Omnibus Rule.

______________________ _____/_____/_____
Responsible Party Printed Name Date

______________________ ______________________
Responsible Party Signature *Relationship to Patient(s)*

Great Destinations Pediatrics, P.C.

Patient Name: ______________________________ DOB: ____________

Patient Name: ______________________________ DOB: ____________

Patient Name: ______________________________ DOB: ____________

Parent/Legal Guardian Name: ______________________________

CONSENT FORM FOR MEDICAL CARE

The following persons have my permission to authorize medical treatment if I am not available to give my consent. I understand that it is the parent(s) responsibility to notify Great Destinations Pediatrics of any changes with the list of authorized caregivers in writing.

1. Name ______________________________

   Phone ____________________ Relationship ____________________

2. Name ______________________________

   Phone ____________________ Relationship ____________________

3. Name ______________________________

   Phone ____________________ Relationship ____________________

THIS CONSENT WILL BE VALID FROM _____/_____/_____ TO _____/_____/_____

(Today's Date) (Future Date)

AUTHORIZATION FOR TEST RESULTS

Parent/Legal Guardian Contact Information (please choose preferred method):

By checking the Abnormal/Normal boxes below you are giving permission to leave a voicemail or secure email for your child's test results if you cannot be reached at the time of the call.

Abnormal	Normal	
☐	☐	Primary Phone Number on File
☐	☐	Secondary Phone Number on File
☐	☐	Email: ____________________
☐	☐	Other Contact Name: ____________________

Relationship to patient: ____________________

Telephone: ____________________

I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE THE ORDERED TESTS DONE AND HAVE BEEN EXPLAINED THE IMPORTANCE AND REASONING FOR THE TESTING. I UNDERSTAND GDP CONTACTS ALL PATIENTS WITH NORMAL AND ABNORMAL TEST RESULTS AND IT IS MY RESPONSIBILITY TO CONTACT GDP IF I HAVE NOT RECEIVED THE RESULTS. THIS AGREEMENT WILL REMAIN IN EFFECT INDEFINITELY.

BY SIGNING THESE AGREEMENTS I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO INFORM GREAT DESTINATIONS PEDIATRICS OF ANY CHANGE OF INFORMATION.

____

Parent Signature Date

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PATIENT HISTORY

CHILD'S NAME________________________ DOB______________

Form completed by: ________________________ Relationship to child: ______________

Child's Birth History

Birth Weight__________ Was the baby born at term? ________weeks Place of Birth______________

Was the delivery ☐ Vaginal ☐ Cesarean If Cesarean, why?______________

Any complications during pregnancy or delivery? ☐ Y ☐ N Explain: ______________

How long did the baby stay in the hospital after birth? __________ Did baby pass the hearing test? ☐ Y ☐ N

Did baby receive the Hepatitis B vaccine? ☐ Y ☐ N Did the baby receive the Vitamin K vaccine? ☐ Y ☐ N

Did baby have any problems? (i.e. Jaundice, respiratory distress, infection) ______________

During pregnancy, did mother: Use tobacco ☐ Y ☐ N Drink Alcohol ☐ Y ☐ N Use drugs or medications ☐ Y ☐ N ☐ Used prenatal vitamins

What______________ When______________

Past Medical History

Has your child ever had any problems with the following? **If YES, please explain:**

☐ Y ☐ N ADHD ______________
☐ Y ☐ N Asthma/RAD ______________
☐ Y ☐ N Allergies (food/environmental) ______________
☐ Y ☐ N Anemia/Blood Disorders ______________
☐ Y ☐ N Bones/Joints ______________
☐ Y ☐ N Chickenpox ______________
☐ Y ☐ N Diabetes ______________
☐ Y ☐ N Ears (multiple infections)/Hearing ______________
☐ Y ☐ N Eyes/Vision ______________
☐ Y ☐ N Gastro ______________
(GE Reflux/Constipation/Diarrhea)
☐ Y ☐ N Heart ______________
☐ Y ☐ N Repeated infections ______________
☐ Y ☐ N Seizures/Headaches ______________
☐ Y ☐ N Skin (Eczema) ______________
☐ Y ☐ N Urine/Kidneys ______________
Other______________

Hospitalizations______________

Surgeries ______________

Current Social History

Please list all those living in the child's home.

Name	Relationship to child	Birth date

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
____

☐ Y ☐ N If child is under 4'9", do you have them in a booster or car seat?
☐ Y ☐ N If child is less than 2 years old, are they in a rear facing car seat?
☐ Y ☐ N Do you and your child wear your seatbelt?
☐ Y ☐ N Do you have guns in the home?
☐ Y ☐ N If yes to above, do you keep them locked?
☐ Y ☐ N If your child is older than 6 months, do they use sunscreen?
☐ Y ☐ N Do you have pets in the home? ______________
☐ Y ☐ N If you have a pool, do you have a gate surrounding it?
☐ Y ☐ N Are all of your medications and cleaners out of reach or locked?
☐ Y ☐ N Does your child wear a bicycle helmet when biking, skating, or horseback Riding?
☐ Y ☐ N Does anyone smoke in or outside of the house, including close relatives and caregivers?
☐ Y ☐ N Is anyone verbally or physically abusing you or your child?
Allergies to medications, food, or insects: ______________
____

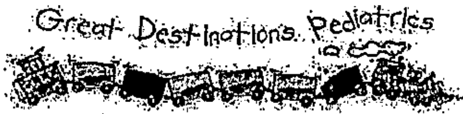
Family History

Relationship	Age, if Living	Age at Death & Cause of Death
Pt's Mother		
Pt's Father		

Patients Siblings
How Many Sisters? __________ How Many Brothers? __________

Family Medical Problems: (*Immediate Family, No greats or extended family*)
Please identify any medical problems blood relatives have or ever have had.

Condition		Family Member(s) Please indicate Maternal/Paternal
Allergies	☐ Y ☐ N	
Anemia/Blood Disorders	☐ Y ☐ N	
Asthma	☐ Y ☐ N	
Birth Defects	☐ Y ☐ N	
Bone/Joint Disorders	☐ Y ☐ N	
Cancer	☐ Y ☐ N	
Diabetes	☐ Y ☐ N	
Eye or Ear Disorders	☐ Y ☐ N	
Genetic Defects	☐ Y ☐ N	
Heart Disease/Problems	☐ Y ☐ N	
Hepatitis B or C	☐ Y ☐ N	
High Blood Pressure	☐ Y ☐ N	
HIV/Aids	☐ Y ☐ N	
Kidney Disease/Problems	☐ Y ☐ N	
Lung Disease	☐ Y ☐ N	
Mental Disease/Disorder	☐ Y ☐ N	
Mental Retardation	☐ Y ☐ N	
Muscle Disorders	☐ Y ☐ N	
Neurological Disorders	☐ Y ☐ N	
Rheumatoid Arthritis	☐ Y ☐ N	
Rheumatic Fever	☐ Y ☐ N	
Seizures/Convulsions	☐ Y ☐ N	
Skin Disease	☐ Y ☐ N	
Thyroid Disease	☐ Y ☐ N	
Tuberculosis	☐ Y ☐ N	
Other		



Authorization to Release Medical Information

Patient Information:

Patient's Name: ______________________ DOB: __________

Patient's Name: ______________________ DOB: __________

Patient's Name: ______________________ DOB: __________

Patient's Name: ______________________ DOB: __________

Address: ______________________ Phone: __________

I hereby authorize Great Destinations Pediatrics, PC to **SEND** ☐ **RECEIVE** ☐ photocopies of medical records concerning the above-named patient(s) **TO/FROM:**

Practice/Company or person(s) authorized to release/receive records:

Name/Practice/Company: ______________________

Address: ______________________

____

Phone: __________ Fax: __________

Email: ______________________

For the purposes of: ______________________

SEND RECORDS TO:

Great Destinations Pediatrics, P.C.
7757 W. Deer Valley Rd, Ste 275 Peoria, AZ 85382
Phone: (623) 878-2800 · **Fax:** (623) 878-9150
Email: Frontdesk@gdpeds.com

Records to be included *(check all that apply)*:

_____ All Medical Records _____ Immunization Records

_____ Consult Reports (*Specialist Name(s)/type of specialty*) ______________________

_____ Labs, X-rays *(Date(s) of service)* ______________________

_____ Hospital/Urgent Care Notes *Date(s) of service:* ______________________

_____ The following information should NOT be released (*Please specify*): ______________________

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.
This request will remain in effect for 1year from the date of this request. I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken. PLEASE ALLOW A MINNIMUM OF 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS.

______________________ ______________________
Patient or legally authorized individual signature Date

______________________ ______________________
Printed name if signed on behalf of the patient Relationship to patient.

STAFF ONLY:

_______ Verified Email _______ Verified DL _______ Employee #1 _______ Employee #2

Fax #1 _______ *Fax #2* _______ *Fax #3* _______

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Great Destinations Office Policies

By signing this form, you understand and agree to the policies of Great Destinations Pediatrics. Our mission is the care of our patient is priority one, and that all patients be treated with respect and with the highest quality of care.

Financial Policy

Payments and Insurance Submissions

Great Destinations will submit claims and process payments with the insurance company on your behalf. Payment in full for accounts 60 days or older, not paid by the insurance company will be your responsibility. Non-insured, high deductible amounts not yet met, and if coverage cannot be verified by the insurance company at time of service will need to pay for charges at the time of service. It is your responsibility to know what is covered versus not covered by your insurance plan.

________ Initial

Returned Checks:

Great Destinations policy on **returned checks is a fee of $30.00** added to the account. The service charge must be paid in full in 3 business days by either cash or credit card. The patient's account will then be required to pay all services by cash or credit card moving forward.

_________Initial

Appointments:

We require a 24-hour notice of cancellation prior to your scheduled appointment. Appointment time is scheduled for one patient, should you have more than one child needing to be seen a second appointment must be scheduled, we do not allow "add ons". If an appointment is missed and not canceled within the 24-hour timeframe a **fee of $25.00** will be charged to the account. Same day appointments must be canceled 2 hours prior to your scheduled appointment time to avoid the No Show Fee.

_________Initial

Medical Records/Requested forms:

All medical releases need to be submitted in writing using the Medical Release FROM/TO on the GDP website or obtained from the front desk and must be submitted by a parent or legal guardian. Medical records released to new PCP are free of charge. Vaccine records are provided free of charge. PHI (Personal Health Information - medical records) requested by a parent or legal guidance must be submitted in writing using the Medical Release FROM GDP form and received via mail, email, fax or drop off. PHI are required to be in either paper or electronic form, per parent or legal guardian's request. GDP will provide the electronic form for the PHI, no outside device will be used due to risk of security. Parent or legal guardian may request the PHI to be mail, emailed or faxed and understand the risk in transmitting private information through those various means and GDP is not liable for any security risks during transit. GDP has 5 business days to comply with this request that is submitted via email, fax, or mail. Walk in requests may take up to 10 days to process this request. A prepayment **fee of $25.00** is

required, as allowed through the HIPPA Privacy rule. Arizona state law states that a physician may charge a reasonable fee for medical records, per AZ statute 12-2295.

________Initial

FMLA Forms:

If you are requesting the completion of FMLA forms you must email, fax, or drop off the form with your portion completed. Once the office has completed the form, it can be faxed or mailed to you, or any other party designated by you at time of request. A prepayment **fee of $25.00** is required. You may pay at time of drop off or by calling the billing department at 623-878-2800 ext. 103.

________Initial

Divorced/Separated Parents:

Great Destinations Pediatrics' providers and staff are dedicated to our patients and providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, psychological, and physiological health. We are not party to or to be involved in any legal issues involving divorce, separation, or custody agreements. Please read and agree to the following so that we may provide care to your child(ren).

1. The physicians, medical assistants, office, and billing staff will not be put in the middle of domestic issues or disagreements over the phone or in the office.
2. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice.
3. Only in situations where there is a confirmed, documented COURT ORDER will one of the parent's be denied access to the minor child's health records or visits at the office. Great Destinations Pediatrics must have a copy of the COURT ORDER on file along with a letter from the authorized parent's attorney stating what role Great Destinations Pediatrics is required to adhere to per the COURT ORDER.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Consent to Treat" form that authorizes any named individuals (like grandparents, nannies, etc.) to bring your child to our practice, be present during the visit and consent to any treatment during the visit. We will not be involved in any disputes regarding named individuals on the consent form unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. This is subject to medical records fees.
5. It is both parents' responsibility to communicate with each other about the patient's care, office visits dates and any other pertinent information relevant to the patient. It is not the responsibility of the physicians to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law nor tolerate appointment scheduling/cancelling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, co-insurance or any additional fees charged by your insurance are due **at the time of service** regardless of which parent is responsible for medical expenses. We are not a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from

the other parent. Any disputes about payments that end up in the collections process, will be due at the next time of service or the patient will not be seen.

8. If we feel any if the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice.

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

_________Initial

Patient Name & Date of Birth	Patient Name & Date of Birth
Patient Name & Date of Birth	Patient Name & Date of Birth
Patient Name & Date of Birth	Patient Name & Date of Birth

Guardian Signature or Patient (18 yrs. or older) **Today's Date**

Guardian Name Print **Relationship to Patient**