PATIENT INFORMATION SHEET
PLEASE COMPLETE ALL INFORMATION

If you need help completing this form please ask the receptionist for assistance
(Si usted nececita alluda en completer forma favor de decirle a la receptionist)

Name: ____
(Nombre) **Last** (Apellido) **First** (Primer Nombre) **Middle** (2do Nombre)

Male (Masculino): _____ **Female** (Femenino):_____ **Age** (Edad): _________

Birthdate (Fecha de Nacimiento): ___________________

Address: ____
(Direccion) **City** (Ciudad) **State** (Estado) **Zip** (Codigo Postal)

Telephone: _________________ (Main contact number) **Cell Phone or Landline (Please circle one)**
(Telefono) **Can you receive text messages on this number?** **Y / N**

Ethnicity: (Please check one)
(Origen)
- Non-Hispanic/Latino
- Hispanic/Latino
- Decline
- Other: ____________

email:

Race: (Please check one)
(Raza)
- American Indian/Alaska Native
- Asian
- Black/African American
- Hawaiian/Pacific Islander
- White/Caucasian
- Decline
- Other: __________________

Parent Information (Informacion de los Padres)

Mother's Name: (Nombre de la Madre)		**Father's Name:** (Nombre del Padre)	
Birth Date: (Fecha de Nacimiento)		**Birth Date:** (Fecha de Nacimiento)	
Social Security # (Seguro Social)		**Social Security #** (Seguro Social)	
Home/Cell phone # (Telefono de la Casa)		**Home/Cell phone #** (Telefono de la Casa)	
Place of Employment/Phone Number (Empleo y Telefono)		**Place of Employment/Phone Number** (Empleo y Telefono)	
Address *(If different than patient)* (Otra Direccion)		**Address** *(If different than patient)* (Otra Direccion)	
List names and birthday of siblings: (Los nombres y fechas de nacimiento de los hermanos)			

Emergency Contact Information: *(Other than parent/guardian)*
(Persona de contacto en caso de emergencia)

Name: ___________________________ **Relationship:** ___________________________
(Nombre) (Parentesco)
Telephone (Telefono): ___________________________ **Cell Phone or Landline (Please circle one)**

****<u>**All Charges are due at the time of visit, unless other special arrangements have been made with the office in advance.**</u>****
(El pago por servicios recibidos hacerse al momento de la visits no ser que otro arreglos especiales se hayan hecho con anterioridad.)

<u>Primary Insurance Information</u> (Informacion del Sequro Primario)

Name:__________________________ **Policy/ID#:**_______________________
(Nombre) (Numero de Contracto/Poliza)

Billing Address:____
(Direccion)

Group/Private:_____________________ **GroupNumber:**__________________
(Grupo/Privado) (Numero de Grupo)

Subscriber Name:_____________________ **Mother**____ **Father**____ **Other**______
(Nombre del Asegurado) (Madre) (Padre) (Otro)

<u>Secondary Insurance Information</u> (Informacion del Sequro Secundario)

Name:__________________________ **Policy/ID#:**_______________________
(Nombre) (Numero de Contracto/Poliza)

Billing Address:____
(Direccion)

Group/Private:_____________________ **GroupNumber:**__________________
(Grupo/Privado) (Numero de Grupo)

Subscriber Name:_____________________ **Mother**____ **Father**____ **Other**______
(Nombre del Asegurado) (Madre) (Padre) (Otro)

Please be aware that you are responsible to notify the office with any insurance changes or switches. If office is not notified within 30 days YOU WILL be responsible for any balance accrued during that time.

<u>Assignment of Benefits</u> (Asignacion de Beneficios)

I hereby authorize payment directly to Dinosaur Junction Pediatrics, of physician benefits otherwise payable to me and payment of surgical or medical benefits including major medical insurance benefits, but not to exceed regular charges for these services. I understand that I am financially responsible to Dinosaur Junction Pediatrics for charges not covered by this assignment.

Insured's Signature:____
(Firma del Asequrado)

Relationship: **Mother:**________ **Father:**________ **Other** (Specify)______________
(Parentesco) (Madre) (Padre) (Otro-Especifique)

Patient History Form

Patient Name ____________________

Date ____________

	Patient History	Family History	Who/ When/ Details
ADHD	☐	☐	
Alcohol	☐	☐	
Allergic Rhinitis	☐	☐	
Anemia	☐	☐	
Apnea	☐	☐	
Appendicitis	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bedwetting (Enuresis)	☐	☐	
Bronchitis	☐	☐	
Cancer	☐	☐	
Celiac Disease	☐	☐	
Cholesterol	☐	☐	
Concussion	☐	☐	
Congenital Heart Disease	☐	☐	
Constipation	☐	☐	
Convulsions	☐	☐	
Depression	☐	☐	
Diabetes Mellitus	☐	☐	
Diarrhea	☐	☐	
Eczema	☐	☐	
Fracture	☐	☐	
Gastroenteritis	☐	☐	
Gastroesophageal Reflux	☐	☐	
Impetigo	☐	☐	
Jaundice	☐	☐	
Lactose Intolerance	☐	☐	
Leukemia	☐	☐	
Migraine	☐	☐	
Neurologic Disorder	☐	☐	
Otitis Media (ear infection)	☐	☐	
Prematurity	☐	☐	
Scoliosis	☐	☐	
Sinusitis	☐	☐	
Strep Pharangitis	☐	☐	
Thyroid Disorder	☐	☐	
Tonsilitis	☐	☐	
Trauma	☐	☐	
Ulcer	☐	☐	
Urinary Tract Infection	☐	☐	

Other ____________

Current on Immunizations Y/N ?

Past Surgical History/Date

Hospitalization/Date

Current Medications

Medication/Food Allergies

Preferred Pharmacy

Location

Social History

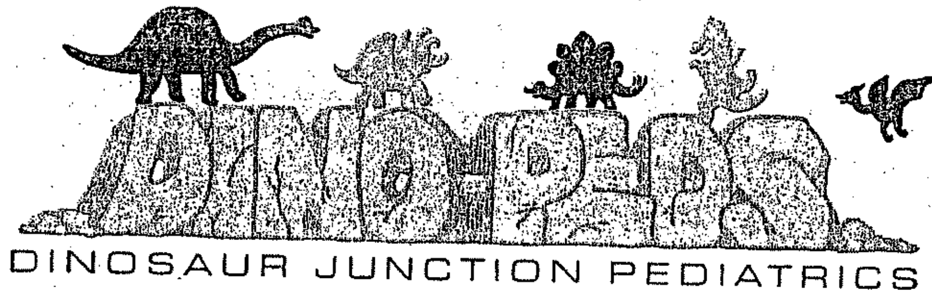
People Living in Household

School/Daycare

Parent Employment

Pets Yes ☐ No ☐

Smoke Exposure Yes ☐ No ☐



PRIVACY PRACTICE ACKNOWLEDGEMENT

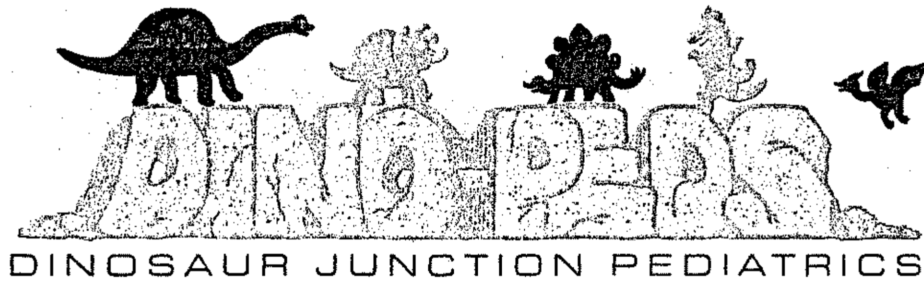
ACKNOWLEDGEMENT FORM:

I have received the Notice of Privacy and I have been provided and opportunity to review it.

CHILDS NAME:________________________________ **BIRTHDATE**____________________

PARENT SIGNATURE:____

DATE:____



Authorization for Release of Medical Attention

Date:____________

I, ______________________________, parent/guardian hereby authorize

Dinosaur Junction Pediatrics' medical staff permission to use their medical

judgment in treating our child, ________________________________

Sex: Male:_____ **Female:**_____ in the event of an emergency.

I hereby release ***Dinosaur Junction Pediatrics*** from all legal responsibility or liability that may arise from the act I have authorized in the above statement.

Signature:______________________________ **Date:**____________
(Parent/Guardian/self)

Witness:______________________________ **Date:**____________

DINO PEDS

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

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.

OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

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

2. 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.

3. Our providers reserve the right to refuse/terminate care to any patient for any reason they see appropriate.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new one available to you.

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 at the address provided at the end of this notice.

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, 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 fundraising 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 medical 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 a*

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 if an inmate 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 of 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 reasonable 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 help law enforcement officials capture a person who has admitted to being 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 crimes 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.*

YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. 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 get the forma to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you no more than $30.00 for the entire chart to release them to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. 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.
3. 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).
4. 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 the contact person listed at the end of this notice.
5. 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 o for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept you 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.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Questions or Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Dino Peds
1190 Bookcliff Ave #104
Grand Junction, CO 81501

DINO PEDS
FINANCIAL POLICY

Thank you for choosing Dino Peds as your child's health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. Please understand that payment of you bill is considered part of your care.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. **Copays are due at the time of service**. If you are unable to make your copay your appointment will be rescheduled.
In the case you cannot provide insurance information, do not have insurance, or have a deductible, payment for the visit will be due in full. Your health insurance policy is a contract between you and your insurance company. Even though you may have health insurance, you as the guarantor are responsible for payment of all services provided by Dino Peds. Therefore, it is also your responsibility to immediately notify our office of any insurance change to ensure that the correct insurance carrier is billed. If there is any change in your insurance company please ensure that we are listed as your Primary Care Physician (PCP).

Newborns
It is important that you add your newborn to your insurance policy within the first 30 days of life to prevent any lapse in coverage. It is your responsibility to provide our office with any new ID numbers.

Interest, Late fees, and Collection fees
We reserve the right to charge interest in the amount of 1.5% monthly (18% annually), on all past due account balances. All outstanding balances are due within 30 days of the statement date. As a courtesy, we will send out your first statement free of charge, a statement fee of $20.00 will then be applied to each monthly statement thereafter for any balance that is left unpaid.

Delinquent Accounts
If a large bill is anticipated and financial arrangements need to be made, a payment plan may be arranged with our billing office prior to your visit. Failure to resolve any past due accounts will result in referral to a collection agency. Any account that is forwarded to a collection

agency will be immediately dismissed from our practice. If you are on an HMO plan that requires you to be assigned to a PCP, a copy of the dismissal letter will be sent to the insurance company so that they will know to reassign you to another PCP.

Missed Appointments

Missed appointments are very disruptive to our office. They also deprive others from an appointment to see the doctor. If you have missed 2 scheduled appointments you may be asked to seek medical care elsewhere.

Transferring of Medical Records

If you are in need of transferring medical records, we will transfer a child's record to the new office one time free of charge. For more than one copy or to release the record to the parent there will be a $30 administration fee charged for each child's records to be transferred.