708 S Coeur D' Alene Lane
Payson, AZ 85541
Ph: (928) 468-8603
Fax: (928) 468-8625

Behavioral Health
Ph: (928) 363-1469
Fax: (928) 363-4023

PEDIATRIC (NEWBORN) RECORD

Dear parents: Welcome to Ponderosa! Please bring this completed form to the first visit as it helps us learn more about your child and how to best care for them and support you.

Child's Name: _____ Birth date: _____

SECTION A: CURRENT INFORMATION

1. List any questions or issues you would like to talk about: _____
   _____
2. FEEDING: Breast (Yes/No) Formula (Yes/No) If so, which formula? _____
   a. Is your child taking any vitamins? (Yes/No) If yes, what type? _____
   b. Is your child taking an iron supplement? (Yes/No)

SECTION B: PAST HISTORY

1. Were there any unusual illnesses or complications during pregnancy, including abnormal prenatal labs or testing? (Yes/No) If yes, please explain: _____
   _____
2. Where was your baby born? Hospital _____ Clinic _____ Home _____ Other _____
3. Name of doctor or midwife who delivered your baby: _____
4. What was your baby's birth weight? _____ lbs _____ oz.
5. Did your baby have any problems during the newborn period or need to stay in the NICU? (Yes/No) If yes, please explain: _____
   _____

SECTION C: FAMILY HISTORY

1. Is this child's mother living? (Yes/No) Age? _____ In good health? (Yes/No)
2. Is this child's father living? (Yes/No) Age? _____ In good health? (Yes/No)
3. Number of other children in family: ____ Ages of the other children? _____
   a. If applicable, are your other children in good health? (Yes/No)

4. Please explain any “no” answers for the above questions 1-3 in the Family History:
   _____
5. Was mom taking any medications during pregnancy? If yes, please list: _____
   _____
6. Do any family members have a history of diabetes, seizures, tuberculosis, asthma, allergies, migraines, developmental delays, deafness, or blood disorders? (Yes/No) If yes, please circle those that apply.
7. Please list any additional medical conditions in your family not listed above and list who has them: _____
   _____
8. Last grade in school completed by mother: _____ by father: _____

SECTION D: SOCIAL HISTORY

1. Who lives at home with your child? _____
2. Who cares for your child during the day? _____
3. Anyone in the home who smokes either inside or outside of the home? (Yes/No)
4. Any animals in the home? (Yes/No) If yes, what kind? _____
5. Are there any problems with income, housing, sleeping arrangements or food for your child or your family? (Yes/No)
   a. If yes, please explain: _____
6. Do the adults in the family usually agree on raising and discipline of the child? (Yes/No)

Medical Treatment Agreement

Patient Name_____DOB_____

Patient or the patient's legal representative agrees to the follow terms of clinic encounters:

1. **MEDICAL TREATMENT**
   The patient consents to the treatment, services, and procedures which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments, procedures, or anesthesia.
2. **TELEMEDICINE**
   The patient consents to medical visits via electronic platforms including but not limited to video and/or verbal communication using smart phones, tablets, laptops, computers, Teams, Google Meets, and all/any other types of electronic formats to communicate the patient's healthcare services.
3. **LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTHCARE PROVIDERS**
   The patient will be treated by his/her attending physician or health care provider and be under their supervision. Physicians and other healthcare providers providing services to the patient may include but are not limited to radiologists and pathologists who are generally not employees of the clinic. These providers may bill separately for their services. Questions about whether a healthcare provider is an agent or employee of the clinic should be directed to administration during normal business hours.
4. **TEACHING PROGRAM**
   The clinic participates in training programs for physicians and healthcare personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or clinic employees.
5. **RELEASE OF INFORMATION**
   The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED HEALTH INFORMATION) may be released to the following:
   a. Healthcare providers or their agents who are providing or have provided healthcare to the patient, any individual accrediting the facility or conducting utilization review quality assurance, or peer review and to the clinics and providers legal representatives and professional liability carriers.
   b. Individuals and organizations engaged in medical education and research, provided that information may only be released for the use in medical studies and research without patient identifying information.
   c. Individuals and entities as specified by federal and state laws and/or in the clinic's notice of privacy practices.
   d. Patient records of services provided at any time may be exchanged among these facilities where necessary to provide appropriate patient care. This release shall continue for so long as the medical and/or financial records are needed for any of the above stated purposes.
   e. This is an assignment of benefits and rights under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.
   f. Individual visit summary available upon request.
   g. Staff will return patient phone calls within 24 hours, Mon-Fri 8am-5pm. After hours and weekends contact the on-call provider.
   h. Refill requests take 3 business days. Please contact your pharmacy to request refills.

6. **CONTRABAND**
   Drugs, alcohol, weapons and other articles specified as contraband by the Clinic may not be brought onto clinic premises. Any illegal substances will be confiscated and turned over to Law Enforcement authorities.
7. **COMMUNICATION**
   _____OK to call my home and leave a message
   _____ call my home phone but DO NOT leave a message
   _____ DO NOT CALL MY PHONE, call only this number: _____
   _____ DO NOT speak to a family member
   _____ OK to send me my health information by encrypted email.
   I authorize the following individuals to inquire and receive verbal information regarding my care:

   1. _____Relationship_____Phone_____
   2. _____Relationship_____Phone_____
   3. _____Relationship_____Phone_____

I have received the notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign the agreement.

Signature of Patient/Representative/Parent of a minor child **Date**

NOTICE OF HEALTH INFORMATION PRACTICES

You are receiving this notice because your yealthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current, a Contexture company. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

Hospital records	Radiology reports
Medical history	Clinic and doctor visit information
Medications	Health plan enrollment and eligibility
Allergies	Other information helpful for your treatment
Lab test results	

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and other participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and other may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the

rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statues title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers-even in an emergency
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

ACKNOWLEDGEMENT RECEIPT: HIPPA NOTICE OF PRIVACY PRACTICES

By reviewing and signing this form, you acknowledge that Ponderosa Family Care has given you the right to review and obtain a copy of the HIPPA privacy policies, which explain how your health information will be handled in various situations, if you would like to review the detailed form or obtain a copy, please see the receptionist.

"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 choose to Opt Out."

Signature of Patient/Representative/Parent of a minor child **Date**

Printed name

Every Patient is automatically opted into the HIE program.

I opt out of PFC sharing my information with AZ HIE. Only initial if you **do NOT want** to participate in the Health Information Exchange Program, _____. The front desk will give you the **opt out form** to fill out and give back to them.

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. Please take your time to read our office policies and procedures. If you would like a copy one will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments: All co-payments must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments from patients could potentially force insurance companies to terminate our contract with them. Ponderosa Family care has permission to deduct payments owed from my banking account of my choosing via debit, credit, or check.

3. Non-Covered services: Please be aware that some - and perhaps all- of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurance companies. Take the time to review what your insurance policy will cover before making an appointment. You will be asked to sign a medical waiver before each procedure is done, regardless of your insurance coverage. Ponderosa Family Care has permission to deduct payment owed from my bank account of my choosing via debit, credit.

4. Proof of insurance: All patients must complete their patient information form before seeing the doctor; this must be filled out completely. We must obtain a copy of your current insurance card. Our new system will verify your insurance benefits, but it is your responsibility to verify that your insurance has eligible benefits to see your physician. If you fail to provide us with the correct insurance information, you will be responsible for the balance on your claim.

5. Claims. Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment: If patient remainder balance is over 90 days past due, it will go to our collection agency, and you will be discharged as a patient from the practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis only.

8. Missed appointments: Our policy is to charge for missed appointments not cancelled within a 24-hour period before your scheduled appointment time. These charges will be your responsibility and billed directly to you. This office is very busy and has a high patient volume; when you miss your appointment without letting us know, it prevents us from giving your appointment time to another patient that needs a physician. Please help us to serve you better by keeping your regularly scheduled appointment. From time to time our office is forced to reschedule patient appointments, due to emergencies. We ask our patients to show compassion and understanding, when these situations arise.

9. Patient Portal: If you have an e-mail address, please provide this information to our front desk receptionist. She will set up a temporary password for you to join our patient portal. The patient portal will give you the opportunity to fill in your demographics, insurance information, and provide the doctor with your complete medical history, along with providing you the opportunity to view your labs, x-ray results, and visit summary, and see your latest statements and make payments. The patient portal is a vital tool, as it will provide you with a complete medical history. The information that you provide is imported into your medical chart, so your doctor can understand your medical problems. This also helps expedite the time you spend in the waiting room. You can update your demographics, insurance information and medical history at any time should any information change. When doing this you are providing your doctor with useful information regarding your medical health. Contact the front desk to have your patient portal enabled.

10. Prescriptions: We require a 72-hour window to fill all prescriptions. Make sure that when calling in to refill a prescription, you leave one clear and slowly spoken message with your name, the medication name, the pharmacy you prefer and your phone number. Be sure that you have at least one week of your medication left when you call in for refills. To expedite this process, please call your pharmacy and request the refill through them; if you do not receive your refill within 72 hours, then please call our office.

11. ACH processing. Patient Payment Authorization (Credit Card / ACH)
    I authorize Ponderosa Family Care to charge my credit card or debit my bank account (ACH) for services rendered, including any applicable copayments, deductibles, balances due, missed appointment fees, or agreed-upon treatment packages. I understand that: Charges will be processed using the payment method I have provided. This authorization will remain in effect until revoked by me in writing. I may revoke this authorization at any time by providing written notice; however, revocation will not apply to charges already processed.
    If a payment is declined, I may be responsible for any associated fees and for providing an alternative form of payment. I am responsible for keeping my payment information current.
    I certify that I am the authorized account holder and that I authorize these transactions.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

Printed Name:_____

Signature of Patient/Representative/Parent of a minor child _____ **Date:**_____