VIP KIDS CLINIC

SEEMA SHARMA M.D.

Patient Information:

First Name:_____Middle:_____Last:_____

Date of Birth:_____Gender:_____Email:_____

Complete Address:_____Zip Code_____

Mobile Phone:_____Home Phone: _____

Race/Ethnicity (Circle all that applies) American Indian / Alaska Native, Hispanic/Latino, Asian,

Black/African American, Native Hawaiian/Pacific Islander, Caucasian, Other: _____

Parent Information

1st Parent's name:_____D.O.B._____

2ns Parent's name:_____D.O.B._____

Language Spoken _____

Insurance Information: PRIMARY Plan Type: HMO, PPO, POS, EPO, Other

Insurance Name:_____ID:_____

Group:_____Subscriber's Name:_____DOB:_____

Employer:_____Work Phone:_____

SSN: _____

Insurance Information: SECONDARY Plan Type: HMO, PPO, POS, EPO, Other

Insurance Name:_____ID:_____

Group:_____Subscriber's Name:_____DOB:_____

Employer:_____Work Phone:_____

SSN:_____

Emergency Contact

_____

Home Phone:_____Mobile Phone:_____

Medications

Preferred Pharmacy:_____-Address:_____

Phone Number:_____Cross Streets:_____

Medication Name:_____Dose (mg)_____Times/day

_____

Medication Name:_____Dose (mg)_____Times/day

_____

Allergies

Does the child have any allergies to food?

_____

Does the child have any allergies to drugs?

_____

Does the child have any environmental allergies?

_____

Is the child allergic to latex?_____Has the child had allergy testing? _____

Birth History (Children 2 and under only)

Method of Delivery: (circle one) Vaginal/Cesarian Section Weeks Pregnant at Delivery: _____

Birth Weight:_____ Birth Hospital:_____Days in Hospital:

_____

Mother's age at Patient's Birth:_____ Father's age at Patient's Birth: _____

Mother's 1st, 2nd, 3rd Pregnancy:_____ Problems During Delivery?

_____

Did the child pass the hearing screening? _____

Any problems during the first month of life?

_____

Feeding History: (circle one) Breastmilk / Formula / Both Special Diet? _____

Development (Children under 5 only)

Please input the age when your child first:

Rolled_____Walked_____Sat_____Crawled_____First Word _____

Talked_____Toilet Trained_____Any known delays?

_____

School History

My Child is in: (circle one) Daycare / Preschool / Public School / Private School / Home School

School Name:_____Year_____School Problems? yes/no

Is your child in special classes?_____Discipline or behavior problems? _____

Has your child been seen by psychologist, speech therapist or special teachers? _____

Medical History

Past Medical History

Does your child have any chronic medical conditions or serious injuries? _____

Has your child ever been hospitalized (Including NICU at birth)? _____

Has your child ever had any surgeries?

_____

Family History

Diabetes yes/no Relationship to child _____

Convulsions yes/no Relationship to child

_____

Cancer yes/no Relationship to child

_____

Asthma yes/no Relationship to child

_____

Heart Disease yes/no Relationship to child

_____

Other yes/no Relationship to child

_____

Family Profile

Parent Name_____Age_____Health

_____

Parent Name_____Age_____Health

_____

Parent Name_____Age_____Health

_____

Parent Name_____Age_____Health

_____

Parent Name_____Age_____Health

_____

Child's parents are (Circle one): married / separated / divorced / other

Number of people living with you?_____Are your child's immunizations up to date? Yes/no

Any smokers in your house? Yes/no Outside? Yes/no Pets? Yes/no what kind of pet? _____

Within the last week has your child had any of the following symptoms: (please check mark if they apply)

General: Fever_____Night sweats/chills_____Decreased Appetite_____Increased crying _____

Respiratory: Cough_____Wheezing_____Difficulty breathing _____

Neurologic: Headaches_____Seizures_____Weakness _____

Cardiovascular: Shortness of breath_____Chest pain_____Exertion _____

Gastrointestinal: Abdominal Pain_____Vomiting_____Diarrhea_____Constipation _____

Eyes/Ears/Nose/Throat:Red eyes____Earache____Runny nose_____Nasal congestion____Sore throat____

VIP KIDS CLINIC **FINANCIAL/OFFICE POLICIES**

We would like to welcome you to our office. The following information is provided to avoid any misunderstanding concerning payments for services. Please take a moment to read this information sheet concerning our financial and office policies.

- All co-pays and deductibles are due at the time of check in. Payment for services for cash payments are due "IN FULL". For your convenience, we accept cash, debit, and credit.
- I fully understand VIP KIDS will bill my provided insurance as a courtesy. In the event of non-payment by my insurance carrier, I fully understand that I am financially responsible for payment of my treatment. If my account becomes delinquent, I fully understand that I am hereby responsible for all fees related to repaying the amounts owed to VIP KIDS.
- Fees for non-covered services are due at the time service is rendered.
- If your insurance company changes, you must notify us immediately so that we can obtain a copy of your new card and submit claims to the correct address.
- If your insurance is through Exchange you will be required to show proof of payment before services are rendered.
- We require at least 24 hours advance notice for all appointment cancellations. If you miss your appointment or fail to cancel our policy is to charge $50.00 for missed office appointments. If patient has three or more "no show, no call" appointments, then it may result in termination of physician and patient relationship.
- Returned checks will be subject to $30.00 fee.
- We reserve the right to refuse service (including prescriptions) to patients who repeatedly no show
- FMLA/Disability forms are subject to $30.00 fee. Comprehensive letters or forms are $150.00
- Letters for Insurance / Employer purposes are subject to a $30.00 fee
- Please allow 72 hours to process prescription refills. To expedite processing your request, ask your pharmacy to fax a refill request to the office

- Please allow 48 hours to process referral requests. If you are referred to a specialist or a diagnostic testing facility, It is your responsibility to schedule the appointment.

- WE PROVIDE STANDARD OF CARE. WE DO NOT KNOW WHAT YOUR INSURANCE COVERS PARTIALLY OR COVERS COMPLETELY; CO-INSRUANCE, DEDUCTIBLE, OUT OF POCKET IS ALL PARENT RESPONSIBILITY. WHICHEVER DOCUMENT OR SCREENING IS DONE IN OFFICE; PHQ-9, M- CHAT, URINE TESTS, HEMOGLOBIN OR ANY TESTS DOCTOR DEEMS NECESSARY FOR COMPLETE PATIENT CARE MAY BE PARENT RESPONSIBILITY.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. We do understand that temporary hardships may affect timely payment of balance. We encourage you to communicate with the billing office to assist you in the management of your account if any problems should arise.

I herein authorize payment of medical benefits to Thomas Parisi, MD of a Prof Corp when an assigned claim is filed. My signature authorizes VIP KIDS Clinic to release any medical information necessary to process insurance claims. My signature below indicates that I understand and accept policies.

Patient Name_____ **Date:**_____

Parent / Legal Guardian (Print Name) _____

Parent / Legal Guardian (Signature) _____

Privacy Notice

At VIP KIDS CLINIC, we are committed to treating and using protected health information about you responsibly. The notice of privacy Policies describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations. Each time you visit VIP KIDS CLINIC, a record of your visit is made. This information, often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care and will provide them with reports that should assist them in treating you if needed
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- We may disclose your information for payment for the health care services billed were actually provided
- Sources of data for medical records
- Source of Information for public health officials charged to improve the health and the state of the nation

Although your health record is physical property of Personal Medical Care, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and obtain a copy of your health record as provided by 45 CFR 164.524 (reasonable fees apply)
- Amend your health record as provided by 45 CFR 164.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.522(b)

Our Practice is required to:

- Maintain the privacy of your health information
- Abide by terms of this notice, provide you with our legal duties and privacy practices with respect to information we collect and maintain about you
- Accommodate reasonable requests you may have to communicate your health information, but will also notify you if we are unable to a requested restriction

We reserve the right to change our practices and to make the new provisions effect for all protected health information we maintain. For more information or to report a problem you may contact our privacy officer at 702-898-9191. If you believe your privacy rights have been violated, you can either file a complaint with Debra Livingston or with the office for Civil Rights. There will be no retaliation for filing a complaint.

Office for Civil Rights, US Department of Health and Human Rights, 50 United Nations Plaza-Room 322 SF, CA 94102

I request the following restriction concerning the use of my medical information

_____

_____

_____

I agree with the Privacy Notice Act and fully understand my rights regarding my personal medical information

Patient Name:_____**Date:**_____

Parent / Guardian Name:_____**Signature:**_____

Refusal of Recommended Immunizations

Child's Name _____ DOB _____

Parent's / Guardian's Name

_____

My child's pediatrician or other health care provider, _____, has advised me that my child (named above)

I have been given a Vaccine Information Statement from the Centers for Disease Control and Prevention that explains each immunization and the disease(s) it prevents. I have discussed the recommendation and my refusal with my child's pediatrician or other healthcare provider. They have answered all of my questions about the recommended immunizations. I know I can find more information at https://www.cdc.gov/vaccines/parents/FAQs.html.

I understand the following:

- Immunization(s) are recommended by my child's pediatrician or healthcare provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention.
- The benefits and risks of the recommended immunization(s)
- If my child does not receive the immunization(s) according to the standard, evidence-based schedule, the consequences may include:
  - Contracting the illness the immunization is designed to prevent, which could lead to serious complications as listed in the table.
  - Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.
- Some immunization-preventable diseases are common in other countries. My unvaccinated child could get one of these diseases while traveling or from someone who traveled to another country.

I agree to tell all health care professionals in all settings which immunization(s) my child has not received and if my child is under immunized, as my child may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been immunized.

If you change your mind at any time, speak with your child's pediatrician or other health care provider. You can always accept immunization(s) for your child in the future.

I acknowledge that I have read this document in its entirety and understand it.

Parent / Guardian Signature:

_____

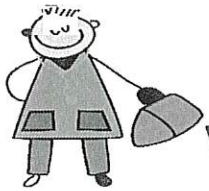
Date: _____

_____

Pediatrician / Other Health Care Provider:

_____

Date: _____



VIP KIDS CLINIC

3265 E. Warm Spring Rd.
Las Vegas, NV 89120
PH: (702)749-7979
Fax: (702)749-7985

RELEASE OF MEDICAL RECORDS

By signing this release of medical records, I authorize you to release confidential health information to the physician/facility or entity.

○ **REQUESTING** ○ **SENDING**

Name/Facility Name: _____

Phone Number: _____

Fax Number: _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

○ **All Records** ○ **Vaccine Records** ○ **Visit Notes** ○ **Labs/Imaging**

Parent/Guardian Name: _____

Parent/ Guardian Signature: _____

Relationship to child: _____

Witness Signature: _____ Date _____

PLEASE FAX ALL RECORDS TO (702) 749-7985. Thank You!