PATIENT REGISTRATION

Patient's Legal Name: _____

Patient's Preferred First Name (*If different from legal name*)**:** _____

Date of Birth: _____ **Legal Sex:** ☐ Male ☐ Female

Address: _____

Language: ☐ English ☐ Spanish ☐ Other: _____ ☐ Prefer not to answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

---

Father's Name: _____ **Date of Birth:** _____ **Please Circle:** Natural Step Adoptive

Email address: _____ **Phone #:** _____

Address (*if different from patient's*)**:** _____

Mother's Name: _____ **Date of Birth:** _____ **Please Circle:** Natural Step Adoptive

Email address: _____ **Phone #:** _____

Address (*if different from patient's*)**:** _____

Primary Insurance: _____ **Subscriber's Name:** _____

Secondary Insurance: _____ **Subscriber's Name:** _____

Emergency Contact: (*This should be an individual that we may contact in an emergency situation that is **NOT** a parent or guardian*)

Name: _____ **Phone #:** _____ **Relationship to patient:** _____

I acknowledge the above is true to the best of my knowledge and hereby authorize Arizona Kids Pediatrics, LTD to examine and treat my child when necessary. I also authorize the release of my child's protected health information (PHI), acquired in the course of examination to carry out treatment, payment, and health care operations of my child. I hereby authorize my insurance benefits be paid directly to Arizona Kids Pediatrics, LTD. I acknowledge that copies of the Notice of Privacy Practices, including the Omnibus rule are available to me per the HIPAA guidelines, upon my request.

_____ _____ _____

Signature **Print Name** **Date**

PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Current Medications

Please list any current medications your child is on at this time (including over the counter medications):

Name	Strength	Frequency Given
1.		
2.		
3.		
4.		
5.		
6.		

Medical History

Please list any medical conditions your child has. Acute and/or chronic (ex: asthma, allergies, reflux)

1._____ 2._____

3._____ 4._____

Allergies/Intolerance

Please list all allergies/intolerances to medications and foods, and their reactions.

Allergy/Intolerance	Reaction
1.	
2.	
3.	
4.	

Continued on back side

PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Surgical History

Please list any surgeries your child has had and the date

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Male patient's only: ☐ Circumcised ☐ Uncircumcised

Patient's Family History

Name	Gender	Year of Birth
Patient's Father:		
Patient's Mother:		
Patient's Sibling:		
Patient's Sibling:		
Patient's Sibling:		
Patient's Sibling:		
Patient's Sibling:		
Patient's Sibling:		

Social History

Any smokers at home: ☐No ☐Yes ☐Inside ☐Outside ☐Mother ☐Father ☐Other_____

Smoke detectors installed and checked regularly: ☐ Yes ☐ No

Pets at home: ☐No ☐Yes Type_____

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name :_____
   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:_____
   Last Name First Name MI

4. Primary Provider's Name:_____
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-E is marked, the child is eligible for the VFC program. If column F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine					Not eligible for VFC Vaccine	
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in Kids Care	***Other underinsured	**Has health insurance that covers vaccines**

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are eligible for VFC vaccines but will need to be billed to AHCCCS as KidsCare.*

****Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

Please be advised:
If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines for Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.
Thank You.

Please sign below indicating that you understand and agree with the above statement.
Signature: _____Date:_____

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. 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
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

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, care coordination, care or case management, transition of care planning and population health services.

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

The Health Current Board of Directors can expand the reasons why healthcare providers and others 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.

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 federally-assisted 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 the 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. Contact your healthcare provider and you can get a copy within 30 days.

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. Contact your healthcare provider and you can get a copy within 30 days. 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 Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
   Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. 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 INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

healthcurrent

ARIZONA KIDS PEDIATRICS

Health Information Practices Acknowledgement

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 complete and return an Opt Out Form to my healthcare provider.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Name(s) of patient(s) in practice:

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

HIPAA Notice of Privacy Practices

Effective date of this notice: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include,

but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.
For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your relationship to the patient. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.
Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be

involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us – We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint.

We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER: Sarah/Practice Manager
Phone: (623) 225-7030
Email: sarah@arizonakidspediatrics.com

Arizona Department of Health Services
150 North 18th Avenue
Phoenix, Arizona 85007
Phone: (602) 542-1025
Fax: (602) 542-0883

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Original Effective Date: April 14, 2003
Revised: September 23, 2013
Reviewed by BH – 01/03/2017

PRIVACY PRACTICES ACKNOWLEDGEMENT

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

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Name(s) of patient(s) in practice:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Address: _____

Phone: Preferred) _____ **Phone: Secondary)** _____

Above listed patient/parent authorizes the following healthcare facility to make record disclosure:

Facility Name: _____

Facility Address: _____

Facility Phone:_____ **Facility Fax:** _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

This information may be disclosed and used by the following individual or organization:

Release To: ARIZONA KIDS PEDIATRICS

Address: 14823 W BELL RD. SUITE 208 SURPRISE, AZ 85374

Phone: (623) 225-7030 **Fax:** (623) 225-7497

Medical Records (check one) ☐ **ALL medical records** ☐ **The following described records *only* (specify types and/or dates):**

_____

☐ **Please mail records** ☐ **Please fax records** ☐ **Will pick-up records**

I may revoke this authorization at any time providing I notify Arizona Kids Pediatrics, LTD in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative — Date

_____ _____

Printed name of Authorized Representative — Relationship to Patient

_____

Telephone number of Authorized Representative

OFFICE USE ONLY

Prepared and transmitted by:
Date: