



6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

New Patient Demographics

Name (Last, First, MI): _____ D.O.B.: _____ Sex: _____
Primary Language: _____
*Ethnicity: Hispanic or Non-Hispanic
*Race: White/Hawaiian-Pacific Islander/Black/American Indian/Alaskan Native/Asian
**Guarantor: _____ Relationship to the patient: _____
Lives with: ___ both parents ___ split between parents ___ other: _____

(*) Indicates optional information requested under the Affordable Care Act

(**) Guarantor is the contact with financial responsibility for medical care

Please complete all items for each **biological** parent or **legal** guardian.

Stepparents are not included here unless they are legal guardians.

Parent Name (Last, First, MI): _____
Street Address: _____ Birthdate: _____
City, State & Zip: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Employer: _____ Occupation: _____
Relationship to Patient: _____ Lives with patient: _____

Parent Name (Last, First, MI): _____
Street Address: _____ Birthdate: _____
City, State & Zip: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Relationship to Patient: _____ Lives with patient: _____

Preferred Primary Phone Number (used for appointment reminders): _____

If parents are divorced or separated, please complete this section:

Who has primary legal custody (First/Last): _____

Who is declared "financially responsible" for the child's insurance? _____

Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes/No**. (If yes, please provide a copy of any legal paperwork that supports this restriction.)



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Initial History Questionnaire

Name of Patient: _____ Birth date: _____ Age: _____

Form Completed by: _____ Date: _____ Relationship: _____

HOUSEHOLD			
Please list all those living in the child's home			
Name	Relationship To child	DOB	<input type="radio"/> Lives with both parents
			<input type="radio"/> Parents divorced/separated – joint custody
			<input type="radio"/> Parents divorced/separated – sole custody
			<input type="radio"/> Lives with adoptive parents
			<input type="radio"/> Lives with foster parents
			If one or both parents are not living in the home, how often does the child see the parent(s) not in the home
BIRTH HISTORY (for children under age 3 only) <input type="radio"/> Do not know birth history			

Birth Wt. _____ Was baby born term? **Yes No** How many weeks at time of delivery _____

Were there any prenatal or neonatal complications? **Yes No** If yes, explain: _____

Was NICU stay required? **Yes No** If yes, explain: _____

Was the delivery **Vaginal Cesarean** If Cesarean, why? _____

During pregnancy, was child exposed to: **Tobacco: Yes No Alcohol: Yes No Drugs or Medications: Yes No**

If yes to any above, please explain: _____

Did mother take prenatal vitamins: **Yes No** Did baby go home with mother from hospital? **Yes No**

If no, explain: _____

_____ How long was baby breastfed: _____ Is baby: **Breastfed Formula-fed**

GENERAL

Does your child have any chronic medical conditions? **Yes No Explain:** _____

Has your child had any surgeries? **Yes No Explain:** _____

Has your child been hospitalized? **Yes No Please list dates/ages:** _____

Is your child taking medications? **Yes No Please list medications/dosages:** _____

Is your child allergic to medications or food? **Yes No**

Please list medication or food and reaction type (**hives, rash, etc.**) _____

Do you feel your family has enough to eat? **Yes No Explain:** _____



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PAST MEDICAL HISTORY

Does your child have or has your child ever had:

	Yes	No	When
Chickenpox			
Frequent Sinus infections			Explain
Frequent Ear infections			Explain
Frequent Strep Throat/Tonsillitis			Explain
Infectious illnesses (Aids/HIV/Hepatitis)			Explain
Environmental Allergies or Food Allergies			Explain
Asthma/lung problems			Explain
Heart problems (murmur, septal defect)			Explain
High Blood Pressure			Explain
Gastrointestinal problems (GERD)			Explain
Genetic Disorder			Explain
Urinary tract infections/kidney reflux			Explain
Vision problems			Explain
Hearing problems			Explain
Skin conditions (eczema/psoriasis)			Explain
Anemia or bleeding problem			Explain
Blood transfusion			Explain
Neurologic problems			Explain
Epilepsy or seizures			Explain
Frequent headaches (daily/weekly)			Explain
Cancer			Explain
ADHD/ADD			Explain
Mental health concerns			Explain
Orthopedic problems (scoliosis, DDH)			Explain
Diabetes (Type I or Type II)			Explain
Thyroid or other hormone problems			Explain
If female, any problems w/ periods?			Explain
Obesity/overweight			Explain
Sleep problems/snoring			Explain
History of fractures/concussions			Explain
Alcohol/drug/tobacco use			Explain
History of family violence/abuse			Explain

Girls only: Has had her first period? Yes No Age of first period if applicable: _____

Any other significant problems:



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BIOLOGICAL FAMILY HISTORY (Include parents, siblings, and grandparents)				
Have family members had the following:	<input type="checkbox"/> Family History Unknown			
	Yes	No	Who	Comment
Nasal Allergies or other allergies	Yes	No	Who	Comment
Asthma or another lung disease	Yes	No	Who	Comment
Heart condition (before age 55)	Yes	No	Who	Comment
High blood pressure	Yes	No	Who	Comment
High cholesterol	Yes	No	Who	Comment
Diabetes/endocrine disorders	Yes	No	Who	Comment
Cancer (before age 55)	Yes	No	Who	Comment
Anemia or Blood Disorder	Yes	No	Who	Comment
Sudden Death (before age 55)	Yes	No	Who	Comment
Epilepsy or seizures	Yes	No	Who	Comment
Mental /developmental disorder	Yes	No	Who	Comment
ADD/ADHD	Yes	No	Who	Comment
Genetic Disorder	Yes	No	Who	Comment
Liver Disease	Yes	No	Who	Comment
Gastrointestinal disorder	Yes	No	Who	Comment
Kidney Disease	Yes	No	Who	Comment
Bed Wetting (>10 Yrs.)	Yes	No	Who	Comment
Hearing impairment	Yes	No	Who	Comment
Vision impairment/eye disorder	Yes	No	Who	Comment
Immune Problems (HIV/AIDS)	Yes	No	Who	Comment
Alcohol/Drug Abuse	Yes	No	Who	Comment
Mental Illness (Depression/Anxiety)	Yes	No	Who	Comment
Additional family history				



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Authorization to Release or Disclose Protected Health Information

Patient's Name: _____ Date of Birth: _____ Date of Request: _____

Address: _____ Phone: _____

Please check the box which best defines your need:

Request Medical Records **FROM:**

Send Medical Records **TO:**

Facility Name: _____ Fax Number: _____

Address: _____ Phone Number: _____

Dates of Service: _____ Email Address: _____

Reason for Request: _____

The following information is to be disclosed **TO** Ponderosa Pediatrics **OR** _____.

Problem List	Immunization Record	Medication List	Growth Charts
Last Well Visit	Last 2 Years Visits	Entire Medical Record	

- I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.
- I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.
- I understand that authorizing disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire in 6 months from the date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Ponderosa Pediatrics of any and all accountabilities concerning the release of these medical records.

Signature of patient or legal representative

Date

If signed by a legal representative, relationship to patient



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Separate Household and Custody Policy – Required

Ponderosa Pediatrics is committed to providing the best possible care for your child. When parents or guardians live in separate households, clear communication and expectations are important to ensure consistent medical care.

This policy applies to families in which parents or guardians live in separate households, including situations involving divorce, separation, shared custody, or guardianship arrangements.

Communication and Medical Information

Unless restricted by a **court order**, both biological parents or legal guardians generally have access to their child's medical information. If a court order limits a parent's access to medical records or participation in medical visits, **a copy of the current court order must be provided to our office** and kept on file.

Ponderosa Pediatrics will not mediate disagreements between parents or guardians regarding medical care, appointments, or treatment decisions. Parents or guardians are responsible for **communicating with each other regarding appointments, treatment plans, and medical information** related to their child. No separate phone calls will be performed by the physician. It is best that both parents are present at the appointment.

Appointments and Visits

Unless restricted by a court order, either parent or legal guardian may: schedule appointments, bring the child to appointments, be present during the visit, receive visit summaries and medical information. Parents may authorize other individuals (such as grandparents, relatives, or caregivers) to bring the child to appointments by completing a **Consent to Treat** authorization form.

Financial Responsibility

Payment for services, including **copays, deductibles, coinsurance, and any patient responsibility balances**, is due at the time of service. The parent or guardian who brings the child to the appointment is responsible for payment at that time. Ponderosa Pediatrics is **not a party to custody agreements or divorce decrees** and will not determine financial responsibility between parents. Any reimbursement arrangements between parents are the responsibility of the parents.

Practice Expectations

Our staff and physicians cannot participate in custody disputes or disagreements between parents. If disagreements between parents interfere with patient care or office operations, Ponderosa Pediatrics reserves the right to **dismiss the family from the practice**.

Acknowledgment

By signing below, you acknowledge that you have read and understand the Ponderosa Pediatrics Separate Household & Custody Policy.

Patient Name: _____

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____



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Emergency Contacts (NOT Parents/Guardians) – Required

To help us care for your child safely, please complete the sections below.

Emergency contacts are individuals we may contact if we are unable to reach a parent or legal guardian. These individuals do not automatically have permission to bring your child to appointments or authorize treatment.

Patient Name: _____ D.O.B.: _____

Name: _____ Telephone Number: _____

Relationship to Patient: _____

Name: _____ Telephone Number: _____

Relationship to Patient: _____

Authorization to Treat a Minor – Optional

I authorize the person(s) listed below to accompany my child and authorize treatment for my child in accordance with the office policy of Ponderosa Pediatrics. This includes bringing the child to the office, providing an accurate medical history, disclosing protected health information, consenting to vaccinations and any procedures, and witnessing any physical examination by the provider. This adult has the responsibility to relay diagnoses and treatment plans to the parent or legal guardian. This adult also can make, change, or cancel appointments, manage health forms, and pick up prescriptions for the child. I agree to continue to comply with the financial policy.

_____ No other adults are authorized to bring my child to appointments.

Name: _____ D.O.B.: _____

Phone: _____ Relationship to patient: _____

Name: _____ D.O.B.: _____

Phone: _____ Relationship to patient: _____

THIS CONSENT IS MAY BE REVOKED AT ANY TIME BY EITHER PARENT OR LEGAL GUARDIAN.

Parent Name: _____ Phone Number: _____

Signature: _____ Date: _____



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Code of Conduct for Parents and Patients

Ponderosa Pediatrics is committed to maintaining a **safe, respectful, and supportive environment** for our patients, families, visitors, and staff. To ensure a positive experience for everyone, we expect all individuals in our office to behave in a respectful and appropriate manner. Parents and guardians are responsible for **supervising their children at all times** while in the office.

The following behaviors are not permitted. This list includes but is not limited to:

Threatening or Violent Behavior

- Physical assault or inflicting bodily harm
- Threats of violence toward patients, families, or staff
- Throwing objects or aggressive physical actions

Harassment or Intimidation

- Verbal threats or intimidating behavior
- Harassing, offensive, or threatening language
- Racial, cultural, or discriminatory slurs or remarks
- Harassment through phone calls, emails, letters, voicemail, social media, or other electronic communication

Disruptive Behavior

- Inappropriate language or profanity
- Menacing gestures or attempts to intimidate others
- Behavior that disrupts patient care or office operations

Damage to Property

- Intentionally damaging medical equipment, furniture, or office property
- Climbing on furniture or drawing on furniture or walls

Privacy Violations

- Recording audio, video, or taking photographs in the office without permission

If you experience or witness inappropriate behavior, please report it to a staff member immediately. Individuals who violate this Code of Conduct may be asked to leave the office and may be **dismissed from the practice**. In serious situations, **law enforcement may be contacted**.

Thank you for helping us maintain a safe and respectful environment for all patients and families.

Parent/Guardian Name (Print): _____ Patient Name: _____

Parent/Guardian Signature: _____ Date: _____



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Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Ponderosa Pediatrics' Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name

Date

Parent/Legal Guardian Name

Signature



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Ponderosa Pediatrics Financial Policy

(Effective April 1, 2026)

Thank you for choosing **Ponderosa Pediatrics** as your child's healthcare provider. We are committed to providing high-quality medical care while maintaining clear and fair financial policies. To help avoid misunderstandings and billing issues, we ask that all families review and sign this financial policy.

Guarantor Responsibility

The **guarantor** is the individual who accepts financial responsibility for the patient account. The guarantor is responsible for all charges incurred on the account regardless of insurance coverage, custody arrangements, or who accompanies the child to the visit.

The parent or legal guardian bringing the child to the appointment is responsible for payment of copayments and any patient balances due at the time of service unless prior arrangements have been made with our office.

Insurance

As a courtesy to our patients, Ponderosa Pediatrics will submit claims to insurance companies with whom we are participating providers.

Please remember:

- **Insurance cards must be presented at every visit.**
- It is the guarantor's responsibility to understand their insurance benefits, including deductibles, copayments, coinsurance, and covered services.
- Insurance coverage varies widely and is determined by your insurance company, not by our office.
- Any portion of services not covered by insurance is the responsibility of the guarantor.

If your insurance has not processed a claim within **60 days**, the balance may be transferred to the guarantor until the claim is resolved.

Change of Insurance or Address

Please notify our office as soon as possible of any changes to insurance coverage, address, or contact information. If we are not informed within **15 days** of a change, the guarantor may be responsible for charges not paid by insurance.

Payment at Time of Service

Payment is required at the time services are rendered. This includes:

- Copayments
- Coinsurance
- Deductible amounts
- Outstanding balances, including services not covered by insurance



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For patients with high deductible plans, a **minimum payment of \$50** may be required at the time of service and will be applied toward the patient balance.

Credit Card/ACH on File

Credit Cards/ACH numbers are stored securely in our **PCI-compliant payment system**. A signed Credit Card/ACH on File Authorization Form is **required for all patient accounts**. This authorization allows Ponderosa Pediatrics to securely store a credit or debit card or ACH for payment of patient responsibility balances after insurance processing. Balances remaining after insurance processing may be charged to the card/ACH on file. Whenever possible, families will be notified prior to processing larger charges.

Payment Methods

We accept the following forms of payment: Cash, Personal Checks, Debit Cards, Visa, Mastercard, Discover and American Express.

Returned Check Fee

A **\$30 fee** will be charged for any checks returned by the bank. After more than one returned check within a 12-month period, future payments may be required in cash or by credit/debit card.

Missed Appointment Policy

Missed appointments prevent other patients from receiving care and create scheduling challenges for our providers.

- **Well visits require 24 hours notice** to cancel or reschedule.
- **Sick or problem visits require 2 hours notice.**

Appointments cancelled outside these timeframes may be considered a **missed appointment** and may incur a **\$50 missed appointment fee**.

Appointment reminders may be sent by text, email, or phone as a courtesy. **Failure to receive a reminder does not waive the missed appointment policy.**

Families with three missed appointments may be subject to dismissal from the practice.

Administrative Forms

Completion of forms such as school forms, camp forms, sports physical forms, and similar documents will require physician review.

- Standard processing time is **3–5 business days**.
- Requests requiring completion within **24 hours** may incur a **\$25 expedited processing fee**.

Billing and Statements

Statements are generated approximately **every 30 days**. Balances are due upon receipt. Accounts that remain unpaid after **90 days** may be referred to an outside collection agency.

Patients may pay balances through the patient portal, using text to pay, by phone, by mail, or in person. Payment plans may be offered in certain situations at the discretion of the practice.



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Collections

If an account becomes seriously past due and is referred to a collection agency, additional collection costs may apply. Ponderosa Pediatrics reserves the right to terminate the provider-patient relationship for nonpayment following written notice and reasonable time for the family to secure another healthcare provider.

Divorce or Custody Arrangements

Ponderosa Pediatrics does not become involved in custody or divorce financial arrangements.

The guarantor listed on the account is responsible for all charges regardless of court orders or agreements between parents.

Medical Records Requests

Patients requesting copies of medical records must complete an **Authorization for Release of Information** form.

Copy fees are based on Nevada state guidelines:

- No charge for the first **5 pages**
- **\$0.35 per page** for pages 6–500
- **\$50 flat fee** for records exceeding 500 pages
- Postage fees may apply if records are mailed

Medical records will not be withheld due to unpaid balances.

Transfer of Care

If you choose to transfer your child's care to another provider, a signed medical records release form must be completed before records can be sent.

Billing Questions

For billing questions, please use Billing Questions Inquiry on the website or may phone the billing department at 775-900-9981.

Acknowledgment

I acknowledge that I have read and understand the Ponderosa Pediatrics Financial Policy and agree to comply with its terms.

Patient Name: _____

Guarantor Name: _____

Signature: _____

Date: _____



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Credit Card/ACH On File Policy - Required

To simplify the billing process and reduce the need for mailed statements, Ponderosa Pediatrics requires a credit or debit card or ACH to be securely kept on file for patient accounts.

All credit card and ACH information is securely stored in our **PCI-compliant payment system**. Our office does not have access to full card numbers or checking account numbers once they are stored.

Authorization

By signing this form, I authorize Ponderosa Pediatrics to securely keep my credit or debit card on file and to charge the card for amounts that are my financial responsibility.

Charges may include, but are not limited to:

- Copayments
- Deductibles
- Coinsurance
- Balances remaining after insurance processing
- Missed appointment fees
- Patient balances due on the account

Whenever possible, Ponderosa Pediatrics will notify families before processing charges **greater than \$100** to the card on file.

This authorization applies to **all current and future patients listed under my guarantor account**. This authorization will remain in effect until the patient account is closed, or written notification is received requesting removal of the card on file.

Patient Name: _____

Parent Name: _____

Name on Card/Account: _____

Last 4 digits of the number: _____

Payment receipts should be sent to the following email address: _____

Signature: _____

Date: _____



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Ponderosa Pediatrics Immunization Policy

At **Ponderosa Pediatrics**, we are committed to providing high-quality, evidence-based medical care for children. Preventive care is a central focus of pediatrics and a core value of our practice.

A key component of preventive care is **routine childhood immunization**. Vaccines protect children from serious and potentially life-threatening diseases and are an essential part of maintaining the health and well-being of our patients.

Our practice follows the immunization schedule recommended by the **American Academy of Pediatrics (AAP)**. These recommendations are based on extensive scientific research and are designed to provide the safest and most effective protection for children.

Vaccinations not only protect individual children but also help protect our community. Many infants and medically vulnerable individuals rely on high vaccination rates to reduce the spread of preventable infectious diseases.

Maintaining high immunization rates helps ensure a safe environment for all patients in our practice and also prevents office closure due to a visit from a patient with a vaccine preventable illness.

Because preventive care is fundamental to pediatric medicine and to the values of our practice, **Ponderosa Pediatrics requires patients to follow the recommended immunization schedule.**

Our practice **does not follow alternate vaccine schedules**, and we do not continue care for families who choose to delay or decline recommended vaccinations.

Families who choose not to vaccinate their children according to the recommended schedule will be asked to seek care with another pediatrician.

We understand that parents may have questions about vaccines and we are always happy to discuss concerns. Our practice is committed to helping families make informed decisions based on the best available medical evidence.

Acknowledgment

By signing below, I acknowledge that I have read and understand the **Ponderosa Pediatrics Immunization Policy**.

Patient Name: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Date: _____



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Preventative Visit Policy

Preventive (well-child) visits are designed to focus on **routine health maintenance**, including growth and development, age-appropriate screenings, immunizations, and anticipatory guidance based on recommendations from the **American Academy of Pediatrics**.

Many insurance plans cover preventive visits at **100% under the Affordable Care Act**. However, coverage may vary depending on your specific insurance plan.

Some services performed during preventive visits, such as **vision screening, developmental screenings, or other recommended tests**, may be applied toward your deductible or out-of-pocket costs depending on your insurance plan.

Additional Concerns During Preventive Visits

If additional medical concerns are addressed during your child's preventative visit, the physician will bill a separate office visit in addition to the preventative exam.

The physician may be required to bill an **additional office visit** in addition to the preventive exam if additional medical concerns are addressed during your child's preventive visit — such as:

- illness or new symptoms
- new medical concerns or diagnoses
- **chronic or ongoing medical conditions** (such as asthma, ADHD, eczema, or other conditions requiring management)
- medication management or prescription refills
- additional evaluation or treatment

When this occurs, your insurance company may apply **copays, deductibles, coinsurance, or other patient responsibility amounts** according to your plan benefits. These billing determinations are based on **insurance billing guidelines**, not the discretion of the practice.

Scheduling Considerations

Ponderosa Pediatrics strives to address concerns during your child's visit whenever possible. However, if additional concerns are extensive or require additional time, you may be asked to schedule a **separate appointment** so that adequate time can be devoted to your child's care. Parents are encouraged to schedule a **separate appointment for new or ongoing medical concerns whenever possible**.

Acknowledgment

I understand that addressing additional medical concerns during a preventive visit may result in **additional charges** based on my insurance plan.

Patient Name: _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Date: _____



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Patient Portal Communication Policy

Ponderosa Pediatrics offers a patient portal to provide convenient communication between families and our office. The portal allows secure messaging and access to certain health information. The patient portal is intended for **non-urgent communication only**.

Examples of appropriate portal use include:

- Rescheduling non urgent appointments
- Prescription refill requests
- Follow-up questions related to a recent visit
- Requests for forms
- Administrative questions

The patient portal **should not be used for urgent medical concerns or new medical problems**. If your child has a new medical concern, please call the office or self schedule using the patient portal to schedule an appointment.

Messages sent through the portal may not be reviewed immediately. Please allow 72 hours for a response.

If your child is experiencing a **medical emergency**, call **911** or go to the nearest emergency department.

Use of the patient portal constitutes agreement with this communication policy.

Patient Name: _____

Parent Name: _____

Signature: _____

Date: _____



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Telehealth Informed Consent

Telehealth allows Ponderosa Pediatrics to provide medical care using interactive audio, video, or electronic communication when appropriate.

Understanding Telehealth

I understand the following regarding telehealth services:

- Telehealth visits may include evaluation, consultation, treatment recommendations, and education.
- The pediatrician will determine **whether a telehealth visit is appropriate** for my child's medical concern. Some conditions require an **in-person examination**, and I may be asked to schedule an in-office visit if needed.
- Telehealth visits may **not be appropriate for new or worsening symptoms that require a physical examination**.
- Telehealth services use secure communication technology designed to protect the privacy of my child's medical information.
- While efforts are made to maintain confidentiality, there are potential risks with electronic communication, including technical failures, interruptions, or unauthorized access.
- Telehealth services may not always be appropriate for every medical concern, and there is **no guarantee of diagnosis or treatment outcomes**.
- I agree to participate in telehealth visits from a **safe, private, and confidential location**. Telehealth visits should not be conducted while driving or in situations that could compromise safety or privacy.

Patient Rights

I understand that:

- Participation in telehealth is voluntary.
- I may ask questions about telehealth at any time.
- I may withdraw my consent for telehealth services at any time by notifying Ponderosa Pediatrics.

Insurance coverage for telehealth services may vary by plan. The policy holder is responsible for understanding the insurance benefits and any associated out of pocket costs.

Acknowledgment

I have read and understand the information provided above and consent to telehealth services for my child.

Patient's Name: _____

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____