Pimri Pediatrics

"A Modern Approach to Pediatrics"

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: _____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: □ Parent □ Spouse □ Self □ Other: _____

Policy Number: _____ Group Number: _____

Customer Service #: (____)_____

Secondary Insurance (if applicable): _____

Policy Holder's Name: _____ Date of Birth: _____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: □ Parent □ Spouse □ Self □ Other: _____

Policy Number: _____ Group Number: _____

Customer Service #: (____)_____

Assignment of Benefits

I hereby authorize direct payment to PIMRI, LLC d/b/a Pimri Pediatrics of any medical benefits payable to me for the services provided at Pimri Pediatrics. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to my appointment. I will be responsible for the unpaid balance due for any bills if this is not done.

_____ _____

Patient/Parent/Guardian Signature Date

455 N Mesa Dr, Suite 8E, Mesa, AZ 85201
p 480-485-5166 • f 877-991-6652 • PimriPediatrics.com

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Financial Responsibility

I understand that payment is due at the time of service, unless other arrangements have been made. If needed, an insurance form if available in order to file for reimbursement. If, for any reason I am unable to pay the copay, due at the time of service, a $5.00 fee will be applied to my bill.

I hereby assign my insurance benefits to be paid directly to be paid directly to PIMRI, LLC d/b/a Pimri Pediatrics. I understand that I am financially responsible for any non-covered services.

I also authorize Pimri Pediatrics to release any information required to process any claims. I understand and agree that this office may release records pertaining to treatment to my insurance company, or other third parties responsible for the payment of my medical charges, including review activities related to my physician's participation with my plan.

_____ _____

Patient/Parent/Guardian Signature Date

Cancellation and No-Show Fees Agreement

I understand that Pimri Pediatrics requires a 24 hours notice when cancelling an appointment. If I choose to not call within the time frame allowed, Pimri Pediatrics has the right to charge me a $25.00 "late cancellation" fee.

If I choose to not show up to my scheduled appointment, Pimri Pediatrics has the right to charge me a $25.00 "no-show" fee as well.

_____ _____

Patient/Parent/Guardian Signature Date

Medical Records Policy

Our office will make every attempt to release your records in a timely manner. Most records are copied and sent within 30 days. Please advise us of any extenuating circumstances.

1. Medical records requested by a physician's office for continuity of care are provided at no charge, if picked up. There is a $5.00 charge for mailing medical records. The record release forms must come directly from the requesting physician's office.
2. For medical records to be released directly to patients, there is a $25.00 charge, if picked up. If said records are to be mailed, there is an additional $5.00 fee.

_____ _____

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NOTICE OF PRIVACY PRACTICES

Uses and Disclosures

This notice describes how your/your child's medical information may be used or disclosed and how you can get access to this information. Please review it thoroughly.

Your personal health information collected by our office may be used for three primary purposes:

1. Treatment: We will prepare a record of information each time we see you in, or out, of the office while you are under our care. This medical record is used to keep track of changes in your condition as well as to remind us of your past care, treatment, allergies, and other important facts related to your overall health. This information may be passed on to other providers as part of a coordinated healthcare program for you.

2. Payment: We must report elements of your personal health information, such as specific treatments, visits, tests, and surgeries along with related diagnosis to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum information necessary to process the claim.

3. Health Care Operations: In order to provide you with high quality healthcare, we often need to be able to use your personal health information for purposes such as pre-registering at the hospital if you ever need to be admitted or providing your pharmacy with the prescription so that it is ready for pick-up when you arrive. Again, we are committed to reporting the minimum information necessary to achieve these purposes.

In addition, we will use or disclose your personal health information under the following circumstances:

- When we receive a valid authorization from you
- If you give us an oral authorization
- If we are required by law to disclose your personal health information to others such as public health agencies

Required Disclosures

We are required to disclose the information to you if you request it and, we are required to disclose the information to US Department of Health and Human Services for compliance determinations of this practice. We may disclose information about you without your authorization for the following reasons:

1. When required by law, for judicial proceedings or law enforcement
2. For Workers Compensation
3. For uses and disclosures about decedents
4. For uses and disclosures for cadaveric tissue donation
5. To avert a serious health threat to public health or safety
6. Disclosures about abuse, neglect, or domestic violence

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization at any time in writing by mailing to our address or delivering a written revocation in person.

We may periodically call you to remind you of appointments, and we may advise you of treatments, alternatives, and benefits that may be of interest to you based on your health condition and status.

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Your Rights

1. You have the right to request restrictions on the use and disclosure of your/your child's personal health information. Though, our practice is not obligated to accept your restriction. However, if we do accept your restriction, it must be fully complied on our part.

2. You always have the right to inspect and have copies of your/your child's health information. If you would like a copy, please request the information in writing.

3. You have the right to request amendments to your/your child's personal information. We will not amend any information we did not create. We are not obligated to make an amendment to any personal health information, but we will include your request for the amendment as a part of your/your child's health information.

4. You have the right to an accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosures for purposes other than the treatment, payment, and healthcare operations of this practice.

5. You have the right to a paper copy of this notification. The current version will be provided to you at your request.

Our Duties

We are obligated by law to protect your privacy, and we will always do our utmost to fulfill that duty to you. We will abide by all the terms in this notification, but we reserve the right to change any part of this notice and the personal health information it protects. You are entitled to a copy of those changes. We will include updated copies with statements mailed to our patients. We will do our best to make certain that your rights are protected and that we carry out our responsibilities to you. We encourage you to contact us with any complaints. We will take no retaliatory action against any person for exercising their right to the resolution of a grievance. To the contrary, we encourage your comments and criticisms to better our office for its patients and families.

To make a complaint or ask any question(s) concerning this policy, please contact us directly at (480) 485-5166 and ask for Dr. Peters. If we cannot resolve the issue(s) you have, you have the right to file a grievance and make a complaint to the US Department of Health and Human Services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name(s)	Date of Birth
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

I acknowledge that I have received a copy of the practice's notice of privacy practices.

_____ _____

Patient/Parent/Guardian Signature | Date

_____ _____

Print Name if Representative of Patient | Relationship to Patient

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Please list all the names and phone numbers of those individuals involved in your care or with whom you will allow us to share your health and treatment information.

Name	Phone number	Relationship

	Check one: Yes	No
I give consent for appointment reminders and messaging by **E-mail**	☐	☐
I give consent for appointment reminders and messaging by **Text/SMS** (text/data rates apply)	☐	☐
I give consent for appointment reminders and messaging by **voice calls**	☐	☐
I give consent for **prescription history** to be retrieved electronically	☐	☐
I give consent for information to be uploaded to the **immunization registry** (ASIIS, NMSIIS, etc)	☐	☐

_____ _____

Patient/Parent/Guardian Signature | Date

_____ _____

Print Name if Representative of Patient | Relationship to Patient

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you consent to the use and disclosure of your protected health information by PIMRI, LLC d/b/a Pimri Pediatrics, our staff, and our business associates strictly for the purpose of treatment, payment, and healthcare operations.

You acknowledge you have had the opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practices carefully. It provides more details on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested when you are being seen as a patient.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny the request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke the consent in writing. However, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or healthcare operations. Refer to the Notice of Privacy Practices for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information for the purposes of treatment plans, payment, and healthcare operations.

_____ _____

Patient/Parent/Guardian Signature Date

For Office Use Only

Failure to obtain consent, check the appropriate reason:

□ Indirect Treatment Relationship □ Emergency Treatment

□ Substantial Communication Barrier □ Refusal to Sign

□ Other

Description: _____

_____

Office Personnel Signature: _____ Date: _____

Witness: _____ Date: _____

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