Slothower PEDIATRICS

Dr. Jonathan Slothower

1816 Pinion Rd.
Elko Nevada 89801
775-778-3437

Welcome!

Thank you for choosing Slothower Pediatrics for your child's heath care needs. At this time we would like to take a few minutes to explain our financial policy.

Insurance: Slothower Pediatrics belongs to PPO/HMO networks utilized by most of the major employers and participates with Nevada Medicaid/Nevada Check Up. It is your responsibility to call your insurance company prior to your first office visit to determine the status of your benefits with respect to the amount of your co-payment, deductible, or whether you need preauthorization, etc. Your insurance is a contract between you and your insurance company, but we will gladly bill your insurance if you supply us with your current insurance card and complete, accurate information regarding both the insured and the patient.

You will also be asked at each visit to verify your insurance information in order for us to maintain the most current information. Once a year you will be asked to complete a new registration form. It is your responsibility to notify our office immediately of any changes in your insurance (new insurance carrier, ID numbers, group numbers, etc.). **All charges are your responsibility including those billed to your insurance and not paid within 60 days from date of service**.

Self Pay: For those of you who don't have insurance we ask for payment at the time of service. If you are unable to pay in full we will set up payments arrangements so you don't miss your appointment. If you are unable to pay for subsequent visits you will need to contact our billing office and arrange and payment plan prior to your appointment. Your previous credit history with us will be a factor in their decision.

Payment: We do require your co-payment be paid at the time of service. You may be asked to reschedule your appointment if you are unable to pay. (If we are contracted with your insurance the contract requires us to collect at time of service.)

We accept cash, check, Visa, and MasterCard. Statements you receive showing balances owed are your responsibility and are due and payable upon receipt. If your account goes unpaid for 30 days collection procedures may be started. If your account had been placed with our collection agency for lack of regular monthly payments or ignored attempts for collections one of the following will apply: You will be dismissed for the practice (doctor's decision) or all future office visits will have to be paid at 100% at the time of service. This same policy will apply for all accounts that have filed bankruptcy.

IF you have questions regarding our financial policy please contact our billing office,

AGREEMENTS: By signing below you acknowledge that you have read and understand our financial policy.

_____ _____

Signature of Parent/ Guardian/ Responsible Party Date

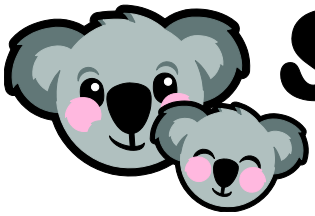
Payment Policy Agreement, Slothower Pediatrics

In order to ensure that Slothower Pediatrics receives fair compensation for medical care given to my child and the community, I agree to do the following:

1. My insurance is billed out of courtesy. I am responsible for all bills and charges associated with my child's visit to Slothower Pediatrics. If my insurance does not pay Slothower Pediatrics for the visit in a timely manner (within 60 calendar days from when the charges were submitted) I will be responsible to make sure the charges are paid. If I do not pay any outstanding charges within 30 days (90 calendar days from when charges were submitted), or set up a payment plan, I can be sent to collections.
2. If my account has been sent to collections and then my insurance pays for those charges, Slothower Pediatrics can refuse payment from my insurance company. Once my account has gone to collections, I understand that I, and my insurance company, will have to deal with the collections company.
3. Slothower Pediatrics has an agreement with my insurance in terms of discounts for procedures and visits. If my outstanding balance goes to collections, the charges will revert back to their original amount, and the discount given to the insurance company will be revoked.
4. If I have a family balance of more than $100, and a payment plan is not set up, I will have to pay 50% of my outstanding balance and set up a payment plan before my child can receive services from Slothower Pediatrics.
5. Copays are due at the time of the visit. If my copay is temporarily waived (on an individual case basis) I agree to pay it in full within 14 days.
6. Any discount given to me for a payment or a payment plan is dependent on me meeting my payment plan obligations, should I violate that agreement, the discounts are null and void.
7. In order for Slothower Pediatrics to recoup costs associated with collections, I agree that if my account goes to collections, Slothower Pediatrics may charge me a service fee equal to 50% of the original balance that will be added to the original balance.
8. If I miss an appointment (or am more than 5 minutes late to the appointment), without notifying Slothower Pediatrics, I will be charged a $50 no-show fee and agree to pay it within 30 days of receiving the bill for it. If I cancel appointments for any family member within 24 hours more than 3 times, or if I no-show more than 3 times, Slothower Pediatrics has the right to dismiss me from the practice.
9. If I don't have my insurance card at the time of service, Slothower Pediatrics has the right to refuse service and I may need to go to the ER if it is an urgent care matter.

Signed:_____ Date: _____

Print Name: _____ Child's Name:_____



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Every child's care is very important to us here at Slothower Pediatrics. It is the goal for Dr. Slothower and his staff to provide a comfortable and personal environment for everyone. To ensure that each child receives adequate time due for their medical care, we will be implementing the following policies:

- In consideration of others, we may reschedule your appointment if you are more than 5 minutes late for your appointment.
- We require 24 hours' notice for cancellations
- A $50.00 fee will be billed for missed appointments
- If you fail to show up for your appointments and/or same day cancel 3 or more times you will be dismissed from our practice.

AGREEMENTS: By signing below you acknowledge that you have read and understand our attendance policies.

_____ _____

Signature of Parent/ Guardian/ Responsible Party Date

Slothower PEDIATRICS

HIPPA Authorization Form

Patient Authorization for Use and Disclosure of Protected Heath Information

By signing I authorize Slothower Pediatrics and its employees, including Dr Jonathan Slothower, to use and disclose certain protected health information (PHI) about my child, or the minor for whom I am the legal guardian (also known here after as “my child”).

This authorization permits Slothower Pediatrics to access and/or disclose the individually identifiable heath information about my child during the course of medical care, as well as any information collected following medical care or consultation given to my child in a hospital, emergency room, newborn nursery, or via telephone interaction with any employees of Slothower Pediatrics.

Disclosure of such information will be for the purpose of referral to a subspecialist or another general practitioner, after discussing and documenting the need for such a referral. The information may also be shared with a medical provider who, at the time the information is requested, is actively participating in the medical care of the child represented by this form. The purpose(s) will be provided so that I can make an informed decision whether to allow release of the information.

Slothower Pediatrics will not receive payment from a third party in exchange for disclosing the PHI, except in the case where such information is requested by the insurance company or third party payer that is financially responsible for part or all of the medical expenses that my child has accrued while being associated with Slothower Pediatrics.

By signing, I authorize Slothower Pediatrics to access my child’s previous prescription medication history. With this consent, Slothower Pediatrics may telephone/e-mail my home, or other locations that I designate, any items that may assist the practice in carrying out treatment plan options, such as appointment reminder cards and patients statements.

I do not have to sign this authorization in order to receive treatment from Slothower Pediatrics. I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to:

Slothower Pediatrics
1816 Pinion Rd
Elko NV 89801

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

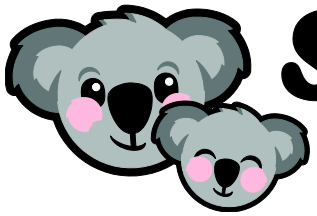
_____ _____

Print Patient’s name Date

_____

Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of the authorization form if requested.



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Patient Information

Name(Last/First/MI):_____DOB:_____

Sex: [ ] Male [ ] Female

Street Address:_____City:_____State:_____Zip Code_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address:_____

Mother's name and occupation:_____

Father's name and occupation:_____

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] Native Hawaiian/Pacific Islander

[ ] Black/African American [ ] White [ ] Hispanic [ ] Other [ ] Declined

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined

Primary Language: [ ] English [ ] Spanish [ ]
Other:_____

Referred by: [ ] Hospital [ ] Insurance [ ] Family/Friend

[ ] Internet/Phone Book [ ] Promotional Ad [ ]Other:_____

Preferred Pharmacy:_____

Other family members seen here:_____

Previous Provider and their location:_____

Responsible Party Information

Name:_____Phone:_____

Street Address (If different from above):_____

City;_____ State:_____ Zip Code:_____

Employer's Name:_____ Employer's Phone:_____

Employer's Address:_____

Insurance Information

Does you child have healthcare coverage? [ ] Yes Insurance Name:_____ [ ] No

Name of Primary Insurance Holder:_____Birth Date:_____

Emergency Contact Information

Name (Last/First):_____Relationship to Patient:_____

Home Phone Number:_____Other Phone Number:_____

Signature of the patient (or person authorized to sign for patient):_____

Relationship to Patient:_____Date:_____

Slothower PEDIATRICS

Alternative Caregiver Consent Form

I authorize the following individual(s) to bring my child to his or her appointments:

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

I attest that the above named individual(s) are all 18 years of age or older as of this date

I authorize the above named individual(s) to consent to treatment for the below named child. This may include, but is not limited to, consent for necessary medications, procedures, and hospitalization. Slothower Pediatrics may relay any medical information necessary for the about name individual(s) to provided informed consent for treatment.

I understand that a well child visit, vaccinations and sports physicals will require a parent or legal guardian present.

I understand that Dr. Slothower will communicate his findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for service requested by the above-named individual(s).

I agree to hold Slothower Pediatrics and its staff harmless for any disagreement between the above named individual(s) and me regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke the authorization for any of all these individual(s) at any time. Revocation must be submitted in writing.

Children covered by this Consent:

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Parent/Guardian's Name:_____ Relationship to child:_____

Signature:_____ Date:_____

We send out Announcements if we are Closed via Text , Email and Phone calls.

Please choose your preferred method of communication.

Email _____

Phone _____

Text _____

Childs Name:_____

Slothower PEDIATRICS

New/Annual Patient Questionnaire

Name:_____ Date of Birth/Age:_____

Mailing Address:_____

Phone: _____

Ins Name:_____

Sex: [ ] Male [ ] Female Name of person accompanying child:_____

Medical History:

Previous Pediatrician's Name and Location:_____

Your child's immunization status: [ ] Up to Date [ ] Not Up to Date [ ] Unimmunized [ ] Unsure

Is your child allergic to anything?_____

List all of your child's medications, including frequency and dosage (including over-the-counter medications, vitamins/supplements, and alternative therapies):

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Please list any **medical problems, past or present**, that your child has been treated for by a medical provider (examples: asthma, allergies, ADHD, congenital malformations, diabetes):

_____

_____

_____

Please list any surgeries and approximate dates:

_____

_____

Please list the approximate dates and reasons for any hospitalizations:

_____

_____

Please check any illnesses, if known, pertaining to the relatives listed below:

**If your child was adopted or family's medical history is unknown, please check here : [ ]

	Deceased	Diabetes	High Blood Pressure	Heart Disease	Autoimmune Diseases	Psychiatric Problems	Congenital Disease	Asthma	Other (please list)	History Unknown
Mothers Family										
Fathers Family										

Social History

Please list all people included in your household:_____

_____

Parents Marital Status: [ ] Married [ ] Divorced [ ] Separated [ ] Remarried [ ] Never Married

Does anyone that lives in the child's home smoke? [ ] Yes [ ] No If yes, who?_____

Are there pets in the home? [ ] Yes [ ] No If yes, what kinds and how many?_____

What school does your child attend? _____ [ ] Home schooled

What grade is your child in? _____ School Performance: [ ] Above average [ ] Average [ ] Below average

Have the teachers noted any discipline problems? [ ] Yes [ ] No If yes, please explain:_____

_____

Does your child receive any additional support at school: [ ] Yes [ ] No If yes, please explain:_____

_____

Please list on average the number of hours per day your child spends doing the following activities:

Playing Sports_____ Doing homework _____ Playing outside _____

Watching TV_____ Talking/texting/playing on cell phone_____ Playing video games/Ipad_____

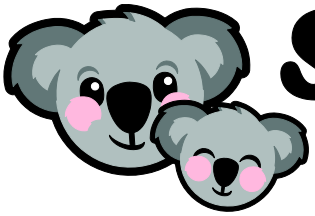
Computer/Internet_____ Sleeping _____

Does your child have a computer/TV in his or her bed room? [ ] Yes [ ] No

Please list any sports your child actively participates in:_____

Please list anything else that you would us to know about your child: _____

_____



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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below. Name:_____Dob:_____

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:___Slothower Pediatrics_____

Address:__1816 Pinion Rd, Elko, NV 89801_____

Phone: ___(775) 778-3437_____ Fax: ___(775) 778-3652_____

Purpose: I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☒ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

- ☐ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20___.
- ☒ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at USC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the USC Office of Compliance for answers to my questions about the privacy of my health information at 3500 Figueroa, Suite 105, Los Angeles, CA 90089-8007, or by telephone at (213) 740-8258.

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness