Advanced Adolescent Pediatric Gastroenterology

Date_____ **PATIENT NO.**_____

PATIENT INFORMATION – INFORMACION DE PACIENTE

PATIENT INFORMATION

PATIENT NAME (LAT, FIRST, MI) – NOMBRE DE PATIENTE (APELLIDO,NOMBRE,MI)				SSN – SEGURO SOCIAL
HOME NUMBER – TELEFONO	SEX - SEXO	DOB – FECHA DE NACIMIENTO	AGE - EDAD	MARTIAL STATUS – ESTADO MATRIMONIAL
ADDRESS – DIRECCION				APT/SPACE/UNIT#
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL
RACE- RAZA __African American __American Indian __Asian __Pacific Islander __White		ETHNICITY- ETNICO __Latino __Non-Latino		LANGUAGE- LENGUAJE
PATIENT'S EMPLOYER – NOMBRE DEL EMPLEADOR		OCCUPATION – OCUPACION		
EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR				TELEPHONE – TELEFONO
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL

ER

NOTIFY IN CASE ORF EMERGENCY	PHONE – TELEFONO	RELATIONSHIP – RELACION	
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL

RESPONSIBLE PARTY – REPRESENTABLE DE RESPONSIBLE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, MI) – PERSONA RESPONSIBLE		SSN – SEGURO SOCIAL
ADDRESS – DIRECCION		TELEPHONE – TELEFONO
CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
GUARANTOR EMPLOYER – EMPLEADOR	OCCUPATION – OCUPACION	
GUARANTOR EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR		TELEPHONE – TELEFONO
CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL

ER

REASON FOR VISIT – RASON POR SU VISITA	REFERRING PHYSICIAN – DOCTOR DE FREFERENCIA	HOW DID YOU HEAR ABOUT OUR OFFICE?

INSURANCE INFORMATION – ASEGURANZA INFORMACION

PRIMARY INS

PRIMARY INSURANCE CO – PRIMARIA ASEGURANZA		TELEPHONE – TELEFONO	
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB – FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

SECONDARY INS

SECONDARY INSURANCE CP – ASEGURANZA SEGUNDARIA	TELEPHONE – TELEFONO		
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

PHARMACY

PHARMACY- FARMACIA	PHONE NUMBER- NUMERO DE TELEFONO
PHARMACY ADDRESS- DIRECCION DE FARMACIA	FAX NUMBER- NUMERO DE FAX

EMAIL: _____

The above information is complete and correct. I hereby authorize release of information neccessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is as valid as the original.

La informacion obtenida es completa y cortecta. Por este medio usted autoriza el desclosamiento de informacion necesaria al hacer reclamos con mi aseguranza. Tambien asigno benefecios que de otra manera serian pagados a mi a que sean asignados a mi doctor o grupo indicado en el relamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios medicos prestados independientemental tipo de aseguranza.

PATIENT SIGNATURE	DATE	GUARANTOR SIGNATURE	DATE

ADVANCED
ADOLESCENT
PEDIATRIC
GASTROENTEROLOGY

Ajaz Ahmad Sheikh, M.D.
Board Certified Pediatric Gastroenterology

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____
Relation: _____

Please list any authorized adults to bring child in for treatment:

Name: _____
Relation: _____ Contact#: _____

Name: _____
Relation: _____ Contact#: _____

Name: _____
Relation: _____ Contact#: _____

In Case of Emergency Contact Information: (please print)

Name: _____

Relation to Patient: _____

Contact #: _____ Contact#: _____

Address: _____

Additional Comments:

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date:

653 Town Center Drive, Suite 208, Las Vegas, NV 89144 • Ph. (702) 851-9383 • Fax (702) 851-9380

ADVANCED ADOLESCENT PEDIATRIC GASTROENTEROLOGY

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Board Certified Pediatric Gastroenterology

Child's Name: _____ **Date of Birth**: _____

Name of Person Accompanying Patient: _____
Relation: _____

Any Known Allergies?

_____

_____

Medications: (list all over the counter medications, vitamins, as well as prescriptions; *include dosing and strength of rx if known*)

_____

_____

Child's Medical History: (check all that apply)
___Diabetes ___Asthma ____Anemia ___Crohn's ___Ulcerative Colitis ___Heart Dz
___Thyroid Dz ____GERD(*reflux*) ___Autoimmune Disease
___Neurological Disorder, if yes what type(s):_____

___Thalassemia ___Congenital Heart Defect ___Down Syndrome ___Tay-Sachs
___Sickle-Cell Disease/Trait ___Hemophilia or Blood Disorder ___Hepatitis
___Muscular Dystrophy ___Cystic Fibrosis ___Mental Retardation/Autism
___Genetic or chromosomal disorder (*if yes what type*) _____
Does child live with someone with TB or exposed to TB (*tuberculosis*)? Yes / No
OTHER: _____

Any Hospitalizations or Emergency Room visits in past 12 months?
Reason(s):_____

_____

Where: _____ Year: _____

Any Surgical Procedures? (*Include type of procedure and year for each*)

_____

_____

_____

Family History (*First Degree Relatives aka Immediate Family Only*) Indicate any illnesses. If no longer living indicate age and cause of death:

_____

_____

_____

Gallstones: _____ Liver Disease: _____
GERD: _____ Ulcer: _____
Polyps: _____ Cancer: _____

Signature of accompany parent/guardian: _____ Date: _____

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Welcome to the Advanced Adolescent Pediatric Gastroenterology. Please fill out the following information to improve the efficiency of our office.

Name: _____ Date_____

DOB: _____ Social Security Number: _____

Have you had any of the following tests recently?

BLOOD TESTS Yes No

If yes, when and where? _____

RADIOGRAPHIC STUDIES (circle all that apply) Yes No

Upper GI Barium enema CT scan Ultrasound

If yes, when and where? _____

ENDOSCOPIC STUDIES (circle all that apply) YES NO

EUD Colonoscopy Flexible Sigmoidoscopy ERCP

If yes, when and where? _____

RECENT HOSPITALIZATION YES NO

If yes, when and where? _____

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Advanced Adolescent Pediatric Gastroenterology

653 Town Center Dr Suite 208 Las Vegas, NV 89144 (702)851-9383 phone (702) 851-9380 fax

MEDICAL RECORDS RELEASE

DATE: _____

TO: _____

_____

_____

_____

I hereby authorize you to release my medical information to:

Advanced Adolescent Pediatric Gastroenterology

653 Town Center Drive Suite 208

Las Vegas, NV 89144

(702) 851-9383 phone (702) 851-9380 fax

I hereby authorize you to release the following records of any treatment or examination rendered to me during the period from _____ to _____

____ Endoscopy Reports
____ X-Ray Report
____ Pathology Reports
____ Hospital Consultation
____ Discharge Summaries
____ Progress Notes

Other: _____

I understand that this will include information relating to:
- Human Immunodeficiency Virus (HIV) infection
- Behavioral Health services/psychiatric care
- Treatment for alcohol and/or drug abuse

Signature: _____ Date: _____

Printed Name: _____ DOB: _____

Witness: _____ Title: _____

ADVANCED ADOLESCENT PEDIATRIC GASTROENTEROLOGY

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about your child may be used and disclosed and how you get access to this information. Please review carefully.

I _____ Parent/Guardian of_____,
give my authorization for **Advanced Adolescent Pediatric Gastroenterology** to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, insurance identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments, and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies, and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at **Advanced Adolescent Pediatric Gastroenterology.**

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Requested by Law, Public Health issues as requested by Law, communicable Diseases: Health oversight Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings: Enforcement: Coroner, Funeral Directors, and Organ Donation: Inmates; Required uses and Disclosures: under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or Determine our compliance with the requirements of sections 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you chose not to sign this consent it may be difficult for Advanced Adolescent Pediatric Gastroenterology to provide treatment. You will be provided with a copy of this signed authorization upon you request.

Parent/Guardian Signature:_____ **Date:** _____

Name of Child:_____ **Child's DOB:** _____

Witness: _____

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Billing Policies

- All co-payments and /or deductible payments are due on the day of the visit.
- Patient's parents/guardians are responsible to supply complete insurance information or pay in full on the day of the visit.
- Patients participating in an HMO insurance plan must have an authorization prior to their visit or must agree to pay for the appointment in full if not authorized by insurance.
- There is a fee for any appointments not cancelled one business day in advance ($100 for Consultation Appointments and $50 for Follow-Up Appointments). Cancellation fee for Procedures will be $150.00

Billing Office
If you have any questions with regards to billing, please call:
Accurate Billing Solutions, LLC
P.O. Box 33100
Las Vegas, Nevada 89133
Phone Number: (702) 659-7765
Fax Number: (702) 659-7805

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Cancellation Policy

- **A fee will be charged** for failure to cancel your appointment with sufficient notice. The fee is a minimum of $50 and may be up to the full billable amount of the appointment. All Procedures require 48 hr cancellation notification other wise there will be $150.00 fee.
- We require **1 full business day advance notice.** We do not accept cancellation notifications after business hours, on weekends, or via the after-hours answering service.
- It is the parent's responsibility to keep appointments for his/her child. We understand there are occasional circumstances that might keep you from the appointment. Cancellations without notice are extremely unfair to other patients that are waiting for timely appointments. **We may dismiss a patient from the practice who cancels or does not show to more than 2 appointments** without advance notice.
- As a courtesy to you, we will call you with an appointment reminder 24 – 48 hours before your appointment.
- **A legal guardian must attend all appointments unless a previous written arrangement has been made in writing.** We will not accept the guardian on a cell phone as the guardian being present. Older siblings and babysitters are not legal guardians.
- **Parents who attend an appointment without a patient will be charged a missed appointment fee.** Advance Adolescent Pediatric Gastroenterology has no obligation to honor an appointment if the patient is not present.

Please Call (702) 851-9383 to cancel or reschedule your appointment

Patient Name: _____ **DOB:**_____

Patient /Guardian Signature: _____

Date: _____

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