How did you hear about us? _____

Child 1: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: *Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White*

Child 2: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: *Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White*

Child 3: Last Name: _____ First Name: _____ MI: _____

D.O.B.: _____/_____/_____ Sex: _____ Primary Language: _____

Ethnicity: *Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White*

Mailing Address:

_____

(Street or PO Box) (City) (State & Zip)

Home Phone: (_____) _____ - _____

Who lives in this household? _____

Insurance: Primary Policy: Policy Holder's Name:_____

Policy Holder's Birth Date: _____ Policy Holder's Sex: Male / Female

Insurance Carrier: _____

ID# _____ Group # _____

Our office does NOT accept Secondary Insurance except for the following: Nevada Medicaid (all plans), Tricare Military, Double Culinary, Champ VA, Double Sierra Health and Life/Health Plan of Nevada. If you have any of these Secondary Plans, please fill out the information below.

Secondary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Insurance Carrier: _____

ID# _____ Group # _____

Parent/Guardian Name: _____ Relation to Patient: _____

Lives with patient? *Yes / No* Date of Birth: _____ Social Security # _____

Cell Phone: (____) _____ - _____ Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding Medical Issues, appointment reminders and billing (please circle one) : *Phone call / Text / Email*

Parent/Guardian Name: _____ Relation to Patient: _____

Lives with patient? *Yes / No* Date of Birth: _____ Social Security # _____

Cell Phone: (____) _____ - _____ Email: _____

Employer: _____ Occupation: _____

How would you ideally prefer to be contacted regarding Medical Issues, appointment reminders and billing (please circle one) : *Phone call / Text / Email*

May all contacts have access to the patient's records electronically?

If parents are divorced or separated, please fill out this section*:*

Who has custody? _____

Are there any legal restrictions that would restrict 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.

Emergency Contacts, other than parents:

Name: _____ Phone: (_____) _____ - _____

Does this person have permission to bring in the child for treatment and be allowed to make decisions pertaining to the patient's care and management? *YES / NO*

Name: _____ Phone: (_____) _____ - _____

Does this person have permission to bring in the child for treatment and be allowed to make decisions pertaining to the patient's care and management? *YES / NO*

I understand that it is my responsibility to keep all above information up to date and current with the office Kids 360 Pediatrics. I understand that to keep a good relationship between my provider and my child that appointments should be kept and maintained for the benefit of the child's medical care. I understand that if I have multiple NO SHOW or multiple cancellations my provider has the right to discharge my family from their care. I understand that it is my responsibility to make sure that my insurance information is up to date with the office Kids 360 Pediatrics for proper billing. I understand that any money due is required to be paid up front such as copays, deductibles, coinsurance or balances unless other arrangements have been made with the billing department. I understand that if my insurance requires additional information from me such as COB or updated information requested, I will submit that no later than 30 days from when EOB was processed by my insurance or I will be responsible for the bill. I understand that I am responsible for any extra charges that may accrue if an outside collection agency is utilized to collect balances due on account, may be but not limited to attorney fees, interest fees, late fees.

By signing below I acknowledge that I understand the statement above and will comply with Kids 360 Pediatrics policies.

Print Parent/Guardian Name:_____

Signature of Parent/Guardian_____

Date:_____

Child Name:_____

DOB:_____

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Kids 360 Pediatrics for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kids 360 Pediatrics. I understand that analysis, diagnosis or treatment of me by Kids 360 Pediatrics may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Kids 360 Pediatrics is not required to agree to the restrictions that I may request. However, if Kids 360 Pediatrics agrees to a restriction that I request, the restriction is binding on Kids 360 Pediatrics. I have the right to revoke this consent, in writing, at any time, except to the extent that Kids 360 Pediatrics on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Notice of Privacy Practices of Kids 360 Pediatrics prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kids 360 Pediatrics. The Notice of Privacy Practices for Kids 360 Pediatrics is also posted at the front desk at 3140 S Rainbow Boulevard Suite 403 Las Vegas, NV 89146. This Notice of Privacy Practices also describes my rights and duties of Kids 360 Pediatrics with respect to my protected health information. Kids 360 Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Kids 360 Pediatrics and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Parent/Guardian Name_____

Signature of Parent/Guardian_____

Print Patient Name If Minor_____

Patient DOB_____Date_____