Mountain West Pediatrics & Bedtime Kids Care
JIM J. GOULD, MD, FAAP
2356 North 400 East, Suite 202, Tooele, Utah 84074
435.843.8380 Office / 435.843.8382 Fax

PATIENT DEMOGRAPHICS

Please complete all information so that we can bill your insurance correctly. A copy of your insurance card(s) is required for each appointment. Patients with no insurance are required to pay for the visit in full at the time of service. Co-payments or patient responsibility percentages are due at the time of service. Thank you for your cooperation.

Patient Name Last: ______________________________ First ______________________________ MI ________

Address ______________________________ City ______________________ State __________ Zip__________

Date of Birth ____________________ Sex: Male / Female

The following information is asked so that we can give personalized care to each patient:

Preferred Language ____________________

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino Unknown

Race: (circle one) American Indian or Alaska Native Black or African American Asian

Native Hawaiian or Other Pacific Islander White Other Race

1) Parent Information: (circle one) Mother Father Other (guardian, foster parent, etc)

Last: ______________________________ First ______________________________ MI __________

Date of Birth ____________________ SSN __________________ Email Address ____________________________

Home Phone ______________________ Cell ______________________ Work ______________________

Employer ____

Address: Same as patient Yes / No (please circle one)

Address ______________________________ City __________________ State _________ Zip__________

2) Parent Information: (circle one) Mother Father Other (guardian, foster parent, etc)

Last: ______________________________ First ______________________________ MI __________

Date of Birth ____________________ SSN __________________ Email Address ____________________________

Home Phone ______________________ Cell ______________________ Work ______________________

Employer ____

Address: Same as patient Yes / No (please circle one)

Address ______________________________ City __________________ State _________ Zip__________

Primary Care Physician: (PCP) ____

Emergency Contact (Person not living with patient)

Name: __________________________ Relationship to Patient ____________________ Phone____________________

How did you hear about our clinic: ___friend/relative, ___medical provider, ___phone book, ___billboard, ___ internet search

I authorize payment of medical benefits to the providers of Jim J. Gould, MD, PC. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account. The above information is complete and accurate to the best of my knowledge.

Signature of Parent/Legal Guardian/Representative ____________________________________ **Date** _______________

Relationship to Patient ______________________________

INSURANCE INFORMATION

Please complete all information so that we can bill your insurance correctly. A copy of your insurance card(s) is required for each appointment. Patients with no insurance are required to pay for the visit in full at the time of service. Co-payments or patient responsibility percentages are due at the time of service. Thank you for your cooperation.

Primary Insurance Company ____________________

Name of Insurance Holder ____________________

Address of Insurance Holder (if different from patient)____________________

Relationship to Patient ____________ Date of Birth ____________ SSN ____________

Policy Number ____________ Group Number ____________ Effective Date ____________

Claims Address ____________ City ____________ State ____________ Zip ____________

Secondary Insurance Company if applicable ____________________

Name of Insurance Holder ____________________

Address of Insurance Holder (if different from patient)____________________

Relationship to Patient ____________ Date of Birth ____________ SSN ____________

Policy Number ____________ Group Number ____________ Effective Date ____________

Claims Address ____________ City ____________ State ____________ Zip ____________

Tertiary Insurance Company if applicable ____________________

Name of Insurance Holder ____________________

Address of Insurance Holder (if different from patient)____________________

Relationship to Patient ____________ Date of Birth ____________ SSN ____________

Policy Number ____________ Group Number ____________ Effective Date ____________

Claims Address ____________ City ____________ State ____________ Zip ____________

Patient Name ____________________ **Date of Birth** ____________

Sibling's names and date of birth that these changes pertain to: ____________, ____________,

____________, ____________, ____________, ____________.

Signature of Responsible Party ____________________ **Date** ____________

Relationship to Patient ____________________

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PEDIATRIC HEALTH QUESTIONNAIRE

Patients Name: ____ Date of Birth: ________________ Age: ________ Sex: M F

Primary Care Physician: _______________________________________

Are you the parent or legal guardian for the child being seen today? Y N

If not, do you have written permission allowing us to treat the child? Y N

Is the child currently taking any medications (over the counter or prescription)? Y N

If so, please list the medication(s) and the current dosage(s)

Medication ____ Dosage ____

Medication ____ Dosage ____

Mother's Prenatal History (If Known)

Number of pregnancies: ______ Number of deliveries: ______ Number of living children: ______

Number of adopted children: ______ Number of miscarriages: ______ Have any children died? **Y N**

Please check any complications during pregnancy with this child:

____ Abnormal bleeding ____ Accidents ____ Blood transfusions ____ Elevated blood pressure

____ Elevated blood sugar ____ X-rays ____ Rash with fever ____ Premature labor

____ Hospitalization ____ Kidney infections ____ swelling (eyes, face, hands)

____ Venereal disease ____ Excessive nausea/vomiting

Were any medications other than Vitamins or Iron taken during pregnancy? **Y N**

If yes, please explain: ____

Neonatal History

Did labor last longer than 24 hours? Y N

Delivery timing: ____ On Time (full-term) ____ Early (pre-term) ____ Late (post-term)

How many weeks Gestation? _______________

Was child born: ___ C-section ___ Head first ___ Feet first ___ Buttocks first

Did child require: ___ Photo-therapy, ___ IV fluids/antibiotics, ___Oxygen, ___ Prolonged hospital stay, ___ NICU stay.

Birth weight: _______ lbs. _______ oz. Birth Length: _______ inches.

In the first six (6) weeks of life, did child have any of the following problems?

___ Difficulty breathing, ___ Blue spells, ___ Yellow Jaundice, ___ Vomiting, ___ Loose stool, ___ Colic,

___ Formula changes, ___ Fever/infections, ___ Seizures, ___ Weight loss, ___ Blood transfusions, ___ Surgery.

Nutritional History

Was child Breast fed? **Y N.** Until what age? _________ Bottle fed? **Y N**. Formula brand? ______________________________

Any feeding problems? **Y N**. If yes, please explain: ____

Does child have: ___ constipation, ___ diarrhea.

Any current concerns about the child's nutrition? **Y N**

If yes, please explain: ____

Developmental History

Did your first child develop normally? Y N If no, please explain: ____

Any history of speech/language delay? Y N

Any concerns with child's current development? Y N If yes, please explain: _____________________________________

Immunization History

Is child current on his/her immunizations? Y N. Any adverse reactions to previous immunizations? Y N

When was child's last Tetanus booster vaccination? ____

Past Medical History

Has child had any of the following:

___ ADD/ADHD	___ Allergic Rhinitis	___ Asthma	___ Autism	___ Behavioral prob.
___ Bladder problems	___ Bone problems	___ Cerebral Palsy	___ Chicken Pox	___ Down Syndrome
___ Eye problems	___ Frequent UTI's	___ Hearing problems	___ Heart problems	___ Intestinal prob.
___ Kidney problems	___ Muscle problems	___ Pneumonia	___ Rash/Eczema	___ Recurrent Ear inf
___ Roseola	___ RSV	___ Seizures	___ Sinusitis	___ Scarlet Fever
___ Spina Bifida	___ Stomach problems	___ Strep Throat	___ Diabetes	

Please list any previous Emergency Room visits, hospitalizations or surgeries with dates:

____

Medication/ food allergies and reactions: (If no known allergies, write "NONE")

____

Family History

Have any of the child's blood relatives had any of the following:

___ ADHD	___ Alcoholism	___ Allergic Rhinitis	___ Anemia	___ Asthma
___ Arthritis	___ Birth defects	___ Blindness	___ Breast Cancer	___ Cataracts
___ Childhood Cancer	___ Congenital Heart Disease		___ Cystic Fibrosis	___ Deafness
___ Drug Dependencies	___ Depression	___ Diabetes	___ Eczema	___ Heart attack
___ HIV/AIDS	___ Hypertension	___ Kidney Disease	___ Leukemia	___ Liver Disease
___ Mental Retardation	___ Lupus	___ Migraines	___ Multiple Sclerosis	___ Psychiatric
___ Sickle Cell Anemia	___ Seizures	___ Skin Cancer	___ Stroke	___ Thyroid Disease
___ Tuberculosis	___ Urinary Tract Infection			

Other

___ Information not known about biological family members____

Social History

These questions relate to the household in which the child lives:

Number of siblings _____ Birth order (first, middle, etc.) _______________ Smokers in house: Y N

Number of dogs _______ Number of cats _______ Other pets ____

Substance abuse: Y N. Discipline problems: Y N. Temper problems: Y N

Deceased parents: Y N. Divorced parents: Y N State custody: Y N

I certify that the above information is true and correct to the best of my knowledge.

Printed Name: _______________________________Relationship to Patient:__________________

Signature: __________________________________ Date: _________________________________

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Mountain West Pediatrics (MWP) to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPHO).

I have the right to review the Notice of Privacy Practices, which provides a more complete description of such uses and disclosures, prior to signing this consent. MWP reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by sending a written request to MWP at the above address.

With this signed consent, MWP may call my home and any other locations for which I have provided contact information in order to relay or gather information to assist MWP in carrying out TPHO; including, but not limited to, appointment reminders, insurance and billing items, calls regarding my clinical care and laboratory results. MWP may give the message in person, leave a message on voice-mail or send the message via email to any email address I have provided to them.

I have the right to request MWP restrict how it uses or discloses my PHI in order to carry out TPHO. Any such request must be submitted in writing to MWP. I understand that MWP is not required to agree to my requested restrictions, but if they does so in writing, they are bound to such agreement.

By signing this form, I am consenting to MWP the use and disclosure of my PHI in order to carry out TPHO. I may revoke my consent at any time in writing, to the extent that MWP has already made disclosures in reliance upon my prior consent. If I do not sign this form, or revoke it at a later date, MWP may decline to provide treatment to me.

____ _____________ _________________________________
Signature of Parent or Legal Guardian Date Patients Patients Name (Please Print)

____ ____________________________________
Name of Parent or Legal Guardian (Please Print) Relationship to Patient

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MOUNTAIN WEST PEDIATRICS FINANCIAL POLICY

- Insurance companies are not designed to pay the entire fee associated with an office visit. All co-payments, deductibles, and non-covered services must be paid in full at the time of service by the person accompanying the patient regardless of health insurance coverage arrangements or court directives (in the case of estranged or divorced parents). For those with a deductible plan, $70.00 toward the balance is due at the time of service. You will be billed for the remaining balance. A $10.00 charge may be added to your account for billing costs of the required co-payment that is not made at the time of service.

- Patients without insurance will be Self-Pay. A $95.00 payment for service is due prior to services being rendered.

- Our office will submit claims to your insurance company as a courtesy service to you. It is important and your responsibility to know what services your insurance plan covers; we take no responsibility to know what services your insurance plan covers. Services that we render that are not covered by your insurance plan are your financial responsibility. We emphasize, as your health care providers, that our relationship is with you, not your insurance company.

- If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab(s). Locally we can send labs to LabCorp, Quest, or the lab at Mountain West Medical Center. Please make us aware when labs are ordered before leaving the office.

- I authorize payment of medical benefits directly to Jim J Gould, MD dba. Mountain West Pediatrics.

- I authorize use of my signature on all insurance claim submissions.

- I understand that a finance charge of 1.5% per month (18%APR) of unpaid balances will be added to my account. If there is a delinquent balance (3 statements sent after insurance payment or 3 statements after a self-pay visit) the account may be sent to Express Recovery Collection Services. I agree to pay up to an additional 40% collection fee and all associated court costs/legal fees with or without suit. If I have opted out of receiving a final notice for delinquent accounts by text or email, see contact options below, I understand a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the additional collection fee.

Contact Options:

- We want to stay in touch with you regarding your account and its collection status. In order for us to contact you regarding all past due accounts and any collection status you may have, you expressly authorize us to contact you by the telephone by sending text messages or emails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and /or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Yes, I authorize this (initials) _________ No, I do not authorize this (initials) ________

Child's Name ____

FINANCIAL POLICY (CONTINUED)

- I understand a bounced check charge of $20.00 will be applied for all returned checks.

- I authorize Jim J. Gould, MD or any assistants to take my detailed medical history and to perform any necessary examination to confirm the condition for which I seek medical attention and to perform such procedures that are in their professional judgment necessary and or desirable for your child's well-being. Parents will be very involved in this decision making process.

- I authorize the release of information necessary to process insurance claims and to request payment of benefits to be made for services rendered.

- **No show appointments:** We are in the business of taking great care of your children and their healthcare needs. A missed appointment is a missed opportunity for someone else's child that may need to be seen. Our policy, as a benefit for you, is to call and remind you the parent (guardian) of your child's upcoming appointment 1 weekday prior to the appointment. We can only provide this service if we have correct phone numbers on file. I agree to give 24 hours' notice for any cancellation of appointments. A fee of $50.00 will be applied to your account for missed appointments without prior cancellation. If you have made an appointment for the same day and you do not show for the appointment, a $50.00 fee will be applied to your account.

- I understand that if I am more than 15 minutes late for the scheduled appointment for my child, I may be asked to reschedule.

- If you are experiencing a financial hardship, please discuss this with the billing office staff. We will gladly work with you to make payment arrangements. Our billing company, **Alta Billing** can be reached at **1-844-714-8690**.

- If you are bringing your child in for a preventative visit and an acute issue is addressed, be advised that an acute issue may be billed to your insurance as a separate encounter and you may incur additional charges that will be your responsibility. Preventative and sick visits should be scheduled separately so that adequate time is spent on each visit.

By signing this form, I acknowledge that I fully understand and agree with the above policies and procedures.

____ _________________________________

Signature of Parent or Legal Guardian Date

____ _________________________________

Parent or Legal Guardian (Print) Relationship to Patient

Child's Name _____________________________________