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

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: (check one) Hispanic or Latino Not Hispanic or Latino Unknown
Race: (check one) American Indian or Alaska Native Black or African American Asian
Native Hawaiian / Other Pacific Islander White Other Decline to Specify

1) Parent Information: (check 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 (if No, please list below)
Address _____ **City** _____ **State** _____ **Zip**_____

2) Parent Information: (check 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 (if No, please list below)
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

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 current insurance card(s) is required for each appointment. Patients with no insurance are required to pay 50% of their charges at time of service. Co pays or patient responsibility percentages are due at 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

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 ____ Pre-mature 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

___ Information not known about biological family members

Other: _____

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 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, 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). 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. All self-pay charges are due on the same day services are rendered. A fee schedule is available upon request.

- 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 provides. Services that we render based upon provider/responsibility party agreement 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 the 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 regarding balances due. In order for us to contact you regarding all past due accounts and any collection status they may have, you authorize us to contact you by 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.

No, I do not authorize this (initials) _____

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. 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 or appointments cancelled less than 4 hours in advance. If you have made an appointment for the same day and you do not show up for the appointment, a $50.00 fee will be applied to your account. **The no-show fees must be paid in full prior to any future appointments.**
  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 **435-215-7901**.

- 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, sick visits and medication checks should be scheduled separately so that adequate time is spent on each visit.

- The providers and office staff will not be put in the middle of domestic issues or disagreements over the phone or in the office. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice. Either parent can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. (Subject to medical records fee.) It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. If there are written legal orders that need to be followed, please bring a copy to the clinic so that we may add it to the chart.

- Our providers **will not** call the non-attending parent following visits. Additionally, we will not call a parent to notify of an appointment scheduled, rescheduled or canceled by the other. The responsibility of the bill for minors is with the parents or legal guardian. It is our policy to collect payment at the time of service from the parent, guardian or caretaker who brings the child in for the appointment. We reserve the right to charge an administrative fee for copying records should the requests become excessive. Should the issues that come between parents become disruptive to our organization or there is non-compliance with this policy, we reserve the right to discharge the family from the practice.

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

** The financial policy must be adjusted yearly based upon clinic/legal policy changes.
For ease, please include the names of all your children so this only has to be completed once.
Thank you for your cooperation!

NAME:	DATE OF BIRTH:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____