Emilia E. Gomez M.D

22709 S ELLSWORTH ROAD STE F104 QUEEN CREEK, ARIZONA 85242
Phone: 480-792-9200 Fax: 480-792-9206

Patient Information Sheet

Today's Date: _______/______/_________

Patient's Name: ____ DOB: ________________ Sex: M F
Last First Middle

Address: ____ City: _________________ State: _____ Zip: ___________

Phone Number: _______________________________________ Insurance: _______________________________________

How did you hear about our office? ____

Mother's Name: ____ DOB: ______________ SSN: ____________________

Address: ____ City: ________________ State: _______ Zip: ______________

Phone Number: ___________________________________ Cellular/Other Phone Number: ________________________

Occupation: ________________________________ Employer: ____________________ Work Phone: __________________

Marital Status: _______________________________ Email: ____

Insurance Company: _______________________________ Group: _______________ ID: ______________________________

Is your child covered? Y N

Father's Name: ____ DOB: _____________ SSN: ____________________

Address: ____ City: _______________ State: _______ Zip: _____________

Phone Number: __________________________________ Cellular/Other Phone Number: ________________________

Occupation: _______________________________ Employer: ____________________ Work Phone: __________________

Marital Status: ______________________________ Email: ____

Insurance Company: ______________________________ Group: ______________ ID: ______________________________

Is your child covered? Y N

Emergency Contact: __________________________________ Relationship to Patient: ______________________

Address: ____ Phone #: __________________________________

Name of person completing this form: ____________________________ _ Relationship to Patient: ______________

Signature: ____ Date: ____

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Release of Protected Health Information: *For Billing/Medical Claims Purposes*

I ____ authorize **ASSIGNMENT OF BENEFITS** from any and all insurance payable for medical care
(name of parent/responsible party)
rendered to my child. **Photocopies** are valid as originals. **I authorize release of my PROTECTED HEALTH INFORMATION** required by insurance carriers for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees.

I am aware of the **Notice of Privacy Practices** which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy office. I understand that this authorization meets the needs of HIPAA (Health Insurance Portability and Accountability Act) guidelines set forth by the Federal government in regards to patient confidentiality.

____ ______________________________

Parent/Guardian/Responsible Party's Signature Date

OUR FINANCIAL POLICY:

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our FINANCIAL POLICY that we require you read and sign prior to any treatment.

- **All patients must complete our patient information forms and present their insurance card before seeing our doctor**
- **All co-pays, deductibles, and office visit fees are due PRIOR to treatment** (our office WILL NOT BILL for co-payments: this is a pre-determined amount assigned to you by your insurance company – it is your responsibility to know and understand your insurance benefits)
- **We accept cash, VISA, MASTERCARD, money order, cashier's checks** (as of 01/01/2007 we no longer accept personal checks)

Regarding insurance for which we are not a participating provider:

We may accept assignment of insurance benefits after your second visit. However, we do require 100% of the bill to be paid at the time of service. We cannot bill your insurance company unless you give us your insurance information and an original claim form.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Regarding Non-Covered Services:

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance. These services may include the following: behavior consultations, allergy immunizations, ADHD/ADD consultations, school sports physicals, nurse-only visits, and more. **In these cases, you will be held responsible for payment in full for any non-covered services**.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

Thank you for understanding our financial policy.

I have read the above **FINANCIAL POLICY** for Bethesda Pediatrics. I understand and agree to this financial policy.

____ ____________________________

Signature of Parent/Guardian **DATE**

Consent For Treatment

I ____, give permission to **BETHESDA PEDIATRICS**

(name of parent/guardian/responsible party)

(Emilia E. Gomez M.D) to care for and treat my child. I understand that my child cannot be treated without my presence unless I've given written consent to an adult **OVER THE AGE OF 18** to seek such care or treatment.

In my absence the following adults **OVER THE AGE OF 18** may seek medical attention for my minor child:

Name: _________________________________ **Relationship to Child:** _______________________

Name: _________________________________ **Relationship to Child:** _______________________

Name: _________________________________ **Relationship to Child:** _______________________

I may be reached at the following phone number to discuss my child's care and/or treatment: (________) __________ - ______________

Emilia E. Gomez M.D
22709 S Ellsworth Rd Ste F104
Queen Creek, AZ 85242

UPDATED Patient Payment Policies *UPDATED*

Thank you for choosing BETHESDA PEDIATRICS as your primary care provider! We are looking forward to partnering with you, the parent, in ensuring that your child will become a healthy individual. We are committed to providing you with quality, affordable healthcare. Because some of our patients have inquired about patient and insurance responsibility for services rendered, we have been advised to develop the following policies. Please read the following carefully and affix your signature in the space provided *(you may request a copy of this form for your records).*

1. Insurance: We participate in most insurance plans, including AHCCCS. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you *are* insured with a plan we do business with but do not have an up-to-date insurance identification card, payment in full is required for each visit until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-Payments and Deductibles: ALL co-payments and deductibles must be paid at the time of service. Our office **WILL-NOT** bill for any co-payments. Your co-payment is an arrangement which is part of your contract with your insurance company. We are not a party to that contract. Failure on our part to collect co-payments/deductibles can be considered fraudulent. Please help us in upholding the law by paying your co-payment/deductible at the time of visit.
***In cases where deductible or co-insurance amount remain undisclosed until we receive your child's claim and invoice for their visit, Bethesda Pediatrics will then mail you a letter in which your patient balance due will be included. The balance of your child's account is expected to have been fully paid within 30-days from the date postmarked on your letter.*

3. Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may not be covered or considered reasonable or necessary by AHCCCS or other insurance plans. If a claim has been denied by your insurance company for these reasons you will be responsible for full payment for these services.

4. Proof of Insurance: All patients MUST complete our patient information form before seeing the doctor. We must obtain a current valid insurance card in order to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission: We will submit your claims and assist in a reasonable way to ensure the payment of your child's visit. Your insurance company may require you to supply certain information directly. It is your responsibility to comply with their request. Please be aware the balance of your claim is your responsibility whether or not your insurance company pays your child's claim. Your insurance benefits are a contract between you and your insurance company; **we are not a party to that contract**.

6. Coverage Changes: If your insurance changes, please notify us PRIOR to your child's next visit to assure that the appropriate changes will be made in order for you to receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Non-payment: If you account is over 60-days past-due, your will receive a letter stating that you have 15 days to pay your account in-full. Partial payments will no longer be accepted unless otherwise negotiated (upon agreement between our management and Dr. Gomez exceptions may be made). Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and your and your immediate family may be discharged from our practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed / No-Show Appointments: Our policy is to charge a fee of $20.00 for any/all missed appointments not cancelled within a reasonable amount of time (**Our practice REQUIRES a 24-hour cancellation notice prior to your child's scheduled appointment – unless an *emergency***). These charges will be your responsibility and will be billed directly to you. For patients under AHCCCS insurance plans, your child will immediately be removed from our patient roster after 3 subsequent missed appointments – in which you will have 30 days to find alternative medical care.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our patient payment policies. Please inform us if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE PATIENT PAYMENT POLICIES AND AGREE TO ABIDE BY ITS GUIDELINES:

____
Signature of Parent/Guardian/Responsible Party DATE

____
Received by: DATE

Emilia E. Gomez M.D

VERBAL LEAD SCREENING

Child's Name: ____ DOB: __________________________

____

____

Name of Person completing Questionnaire Relationship to Child

PLEASE ANSWER ALL THE QUESTIONS. THIS WILL HELP THE DOCTOR DECIDE IF YOUR CHILD NEEDS A SPECIAL BLOOD TEST.

	YES	NO
1. Does your child live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, the house of a baby-sitter or a relative, etc.	___	___
2. Does your child live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?	___	___
3. Does your child have a brother or sister, housemate or playmate being treated for lead poisoning?	___	___
4. Does you child live with an adult or frequently come in contact with an adult whose job or hobby involves exposure to lead? (Construction, welding, pottery, brass/copper foundry, automotive repair shops)	___	___
5. Does your child eat food, drink juice or punch that has been stored in pottery from Mexico or that has been stored in open cans, particularly if the cans are imported?	___	___
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (valve and pipe fittings, pottery, chemical and chemical preparations, industrial machinery and equipment)	___	___
7. Do you give your child any home or folk remedies or traditional medicines that may contain lead?	___	___
8. Does your child live near a heavily traveled major highway where soil and dust may contain lead?	___	___
9. Does your home's plumbing have lead pipes or copper with lead joints?	___	___
10. Do you have any questions about this survey for your doctor?	___	___