BIGHORN
PEDIATRICS & FAMILY MEDICINE

A. Dozier Tabb, MD
Stefanie Garcia, PA-C
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Phone: (307) 620-8845 Fax: (307) 285-9029

REGISTRATION (UNDER 18)

Patient Information

Patient Name:_____ Date of Birth: _____ Male or Female

Name of School: _____ Grade: _____ SS#____-_____-_____

Patient Lives With: ☐ Mother ☐ Father ☐ Foster Parent ☐ Other Guardian:_____

Mother/Guardian Information

Full Legal Name: _____

Date of Birth: _____ SSN#: _____-_____-_____

Mailing Address: _____ City: _____ State: ____ ZIP: _____

Email: _____ Patient Portal Access: Yes ___ No ___

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Employer Phone #: _____

Father/Guardian Information

Full Legal Name: _____

Date of Birth: _____ SSN#: _____-_____-_____

Mailing Address: _____ City: _____ State: ____ ZIP: _____

Email: _____ Patient Portal Access: Yes ___ No ___

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Employer Phone #: _____

Emergency Contact Information (other than guardians - will remain on file until revoked by parent/guardian)

Full Legal Name: _____

Primary Phone #: _____ Relationship to Patient: _____

Can this Contact receive information about the patient? Yes ___ No ___

PLEASE FILL OUT BACK SIDE

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Others Authorized to Bring Child for Treatment (will remain on file until revoked by parent/guardian)

Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____

Siblings

Name: _____Date of Birth: _____
Name: _____Date of Birth: _____
Name: _____Date of Birth: _____
Name: _____Date of Birth: _____

Primary Insurance Information

Insurance Company Name: _____

Insurance Company Address (located on back of card): _____

ID #: _____ Group #: _____

Cardholder Name: _____ Employer: _____

Cardholder Date of Birth: _____ SSN: ____-____-_____

Relationship to Patient: _____

Mailing Address: _____ City: _____ State: ___ ZIP: _____

I certify that I have insurance coverage as indicated above and assign directly to Big Horn Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.

Signature: _____ Date: _____

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Patient History (6-17 Years)

Patient Name:_____ **DOB:**____/____/____

Has your child received any immunizations? ⬜Yes ⬜No
*(If Yes) Please provide an immunization record.

Medical History:

Allergies:_____

Hospitalizations:_____

Major Illnesses:_____

Injuries:_____

Surgeries:_____

Medications:_____

Other medical information you feel is important:_____

_____

_____

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Personal Medical History & Family Medical History

Check family members who have the following conditions:	Self	Mother	Father	Sibling Brother Sister	Maternal Gr.Mother	Maternal Gr.Father	Paternal Gr.Mother	Paternal Gr.Father	None
Alcoholism/Drug Abuse									
Anesthesia Problems									
Anemia									
Arthritis									
Asthma/Allergies									
Birth Defects/Inherited Disorder									
Bleeding Disorder									
Cancer									
Congenital Heart Disease									
Cardiac Anomalies									
Heart Attack Before Age 50									
Cystic Fibrosis									
Depression									
Eczema									
Diabetes Mellitus									
Genetic Disorders									
Genital/Urinary Problems									
High Blood Pressure									
HIV/AIDS									
Hyperlipidemia (high cholesterol)									
Kidney Disease									
Lung Problems									
Mental Health Problems									
Migraines									
Multiple Sclerosis									
Prematurity									
Obesity									
Osteoporosis									
Seizure Disorder									
Stomach/Intestinal Problems									
Stroke									
Thyroid Disorders									
Tuberculosis									
Other:									

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: _____ Relationship to patient: _____

Print Name: _____ Today's Date: _____/_____/_____

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I acknowledge and agree to the terms as stated below. I will be provided a copy for my records upon request.

Patient Name: _____ ***DOB:*** _____

Patient/Guardian Signature: _____ ***Date:*** _____

CLIENT BEST PRACTICES

_____ ***(initial) I acknowledge and understand policies regarding CLIENT BEST PRACTICES***

CODE OF CONDUCT:

1. Appointments must be scheduled by contacting the clinic directly. No appointments will be made by contacting staff members privately through personal phones or social media.
2. Updating patient information is vital to the healthcare process. All documents required by the clinic must be filled out when requested. Please be prepared to provide your insurance card and personal ID at every visit.
3. Patients under the age of 18 MUST BE accompanied by an adult to all appointments.
4. Patients/Guardians must give a 72 hour notice for medication refills and document requests.
5. Our clinic is a healing environment. There is zero tolerance for all forms of aggressive or unsafe behavior. Be advised that the following incidents may result in removal from this facility and possible dismissal from the practice:

- physical assault or verbal threats
- verbal harassment: abusive or foul language
- failure to respond to staff instructions
- unruly and/or destructive behavior

WELL CHECK-UPS ARE REQUIRED:

At Big Horn Pediatrics & Family Medicine we feel strongly about children having routine well check-ups. We expect our parents and patients to follow these guidelines so that we may continue to provide quality healthcare to our patients, as well as, assess medication refills and referral requests. Preventative health care should be given at the following ages:

- Newborn Period (3-5 days of life)
- 8-10 days (two weeks of life)
- 1 month, 2 months, 4 months, 6 and 9 months of age
- 12 months, 15 months, 18 months of age
- 2 years, 2 ½ years of age
- 3 years - up (yearly) - individual insurance plans may vary.

Despite the recent health care law changes, there are some insurance plans that still require a copay for well visits, or that may not cover components of the visit in it's entirety. Some plans may not provide vaccine coverage or coverage for behavioral assessments. If the patient has symptoms for illness (example: sore throat, earache) at the time of the wellness exam, additional charges may apply. All portions of the wellness visit not covered by your insurance plan will become personal balances.

MUTUAL RESPECT OF TIME / MISSED APPOINTMENT / LATE FEE:

Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. **You will be assessed a late fee of $50 if you arrive 10 minutes past your appointment time.** It may be necessary to reschedule you if there are no appointment times available when you arrive.
2. Appointments that are not canceled within 2 hours of your scheduled appointment time will be categorized as a missed appointment. **A fee of $50 will be administered to any person who misses an appointment.** It must be paid before any future appointments will be scheduled. Patients/Guardians will be responsible for balances resulting from late fees and/or missed appointment fees. Amounts WILL NOT be submitted to insurance providers as they are not covered services.
3. If you plan on bringing an additional child to be seen during an appointment, please notify us in advance so that we can provide sufficient time for your appointment.
4. When scheduling appointments please indicate all of the symptoms or needs that the patient will be addressing at the appointment in order to schedule enough time to address all of your needs and concerns.

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HIPAA NOTICE OF PRIVACY POLICIES

_____ ***(initial) I acknowledge and understand the following HIPAA Notice of Privacy Practices:***

BHPFM may use and disclose health information about you (or your child) for treatment, payment, and health care operations. We may request, use or disclose your health information to a physician, pharmacy or other healthcare office(s) providing treatment to you for continuation of care, or if required to do so by law. We may share your information with the following contacts:

1. Specified by you: schools or daycares, pharmacies and designated personal contacts, via fax, phone or email. (i.e. Faxing immunization records, return to school/P.E./work excuses, medical records, prescription requests, etc.)
2. If we are required to do so by law: The use or disclosure will be made in compliance and relevant requirements of the law. These may include, but are not limited to, communicable diseases, abuse or neglect, Food and Drug Administration, legal proceedings, law enforcement, coroners or funeral directors and military.
3. Third party business associates that perform various activities for the practice: (i.e. billing, transcription, collection, and accounting services) if necessary. BHPFM will uphold confidentiality if it is necessary to disclose any personal information in any form, whether electronically, on paper or verbally.

PATIENT FINANCIAL POLICY

_____ ***(Initial) I acknowledge and understand the following Patient Financial Policy items:***

INSURANCE PLAN COORDINATION: We bill participating insurance companies as a courtesy to our patients. Please bring current insurance cards with you to each visit. If your insurance changes, it is your responsibility to provide us with the new information. If we have not received payment from your insurance company within 30 days, you will be required to pay the balance due, in full. Whenever necessary, the insured agrees to assign insurance benefits to BHPFM. All patients 18 and older are responsible for charges made on their account regardless of insurance type (private, Medicaid, or Medicare) or personal payment arrangements made with other individuals. Payees are responsible for resolving insurance coordination of benefits discrepancies with their insurance.

WYOMING MEDICAID: Patients who are covered under a private health insurance, in addition to the WY Medicaid policy, must provide all additional plan details to BHPFM. WY Medicaid has the right to retract payment from previously paid claims. If this occurs then the entire balance will be the responsibility of the patient's parents and/or guardians (regardless of divorce decree).

COPAYS & DEDUCTIBLES: Copay and deductible amounts are your financial responsibility, and must be paid at each visit (by the patient or person bringing in the patient). Payment via phone can be made PRIOR to the appointment. A minimum payment of $50 may be requested for deductible plans.

SELF-PAY ACCOUNTS/OUT OF NETWORK INSURANCE: If you do not have insurance, please come prepared to pay for your visit in full. We offer a 20% discount for all self-pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a payment plan may be established.

ACCOUNT DEFAULT: Outstanding balances must be paid within 30 days. If you are unable to pay an outstanding balance, in full, a payment plan can be established to avoid collections. If you should default on an established payment plan, it may become necessary to forward your account to a collection agency. If you should default on your account once sent to collections, you will be financially responsible for all court costs and reasonable attorney fees, in addition to the outstanding BHPFM balance and fees associated with your account incurred from the collection agency.

DIVORCE: As we are not a party to your divorce, we cannot be involved in the financial arrangements determined by your divorce decree. The parent who brings the child to the office is responsible for time of service billing. Payment for these charges will be collected at the time of service, a reasonable payment plan may be established for past-due balances. If payment arrangements are not made, it may become necessary to forward your account to a collection agency. Wyoming State Law designates that divorced and separated parents are mutually responsible for account balances should an account go to collections, regardless of court agreements, divorce settlements, or other individual financial arrangements.

NEWBORNS: Insurance companies generally allow ONLY 30 DAYS to add your newborn to your insurance plan. Please call ASAP to get this done. Once you have received the child's card, please provide us with a copy. If you fail to add the baby to a plan, you will be financially responsible for all visits prior to insurance coverage.