1473 N. Lee Trevino
El Paso, TX, 79936
Phone: 915-280-9267
Fax: 915-249-4262

Demographic Form

Patient information (child)

First name: _____
Last name: _____
Date of Birth: _____
Sex: ☐M ☐F
Child's relationship to responsible party:
_____

Birth Hospital: _____
Is this your first visit to our office: ☐Y ☐N
Sibling information:
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Parent Information

Parent #1
First name: _____
Last name: _____
Sex: ☐ M ☐ F
Address (if different from above): _____
Social security #: _____
Date of birth: _____
Relationship to patient: _____
Employer: _____
Phone (home/cell): _____
Email: _____

Parent #2
First name: _____
Last name: _____
Sex: ☐ M ☐ F
Address (if different from above): _____
Social security #: _____
Date of birth: _____
Relationship to patient: _____
Employer: _____
Phone (home/cell): _____
Email: _____

Insurance Information:

Primary Insurance
Policyholder's name: _____
Policyholder's DOB: _____
Relationship to patient: _____
Insurance Name: _____
SS#: _____
Employer: _____
Group Name or #: _____
Insured's ID #: _____
Address of policy holder: _____

Secondary Insurance
Policyholder's name: _____
Policyholder's DOB: _____
Relationship to patient: _____
Insurance Name: _____
SS#: _____
Employer: _____
Group Name or #: _____
Insured's ID #: _____
Address of policy holder: _____

Emergency Contact/Consent for another caregiver:

I give the following person/persons permission to obtain care for my child at Desert Bloom Pediatrics in my absence. I also give this person/persons permission to contact Desert Bloom Pediatrics to obtain any medical advice, medical information/records, and/or insurance/billing information necessary for said child.

Name	Phone number	Relationship to child

I attest that all of the above information is correct and acknowledge that it is my responsibility to let Desert Bloom Pediatrics know as soon as possible if any of my information changes.

Signature: _____ Date: _____

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Office Policies

Well Check-ups are required

At Desert Bloom Pediatrics, we feel strongly about children having routine check-ups. These visits allow us to monitor for growth, developmental, behavioral, and academic issues so that we can identify them early, intervene, and treat them effectively. Per the American Academy of Pediatrics, children should receive preventative care at the following ages:

- 3-5 days of life, 1month of age, 2mo, 4mo, 6mo, 9mo, 12mo, 15mo, 18mo, 24mo, 36mo, then 3-21 years of age on a yearly basis

We expect parents to follow these guidelines so that we can provide quality healthcare to our patients. Failure to do so may result in being discharged from our practice. Documents and school forms will not be completed for patients who are not up to date on well checks.

Vaccinations are required

Vaccinations are safe and effective in preventing diseases and health complications in children and adults. DBP requires that all patients are immunized according to the current vaccine schedule recommended by the American Academy of Pediatrics and CDC. In order to protect our patients, we do not accept families that don't vaccinate their children. Although recommended, covid and flu vaccines are not part of this requirement. If families have any questions about vaccines, they can speak directly with the doctor about them. If your family ultimately decides not to vaccinate, we will ask you to find a clinic that better aligns with your views.

Chronic medical conditions require follow up

Chronic medical conditions such as ADHD, asthma, depression, and anxiety require frequent follow up to ensure the best care possible. Patients with ADHD need follow up every 3 months once they are stable on their medication. Other chronic medical conditions need follow up every 3-6 months once stable depending on the child's care plan. Medications may not be refilled unless patients keep their follow up appointments.

Shot records are required at time of appointment

Health care providers are required by law to document in the Texas Department of State Health Services' Texas Immunization Registry (ImmTrac2) the vaccines administered to your child. To ensure that your child is in compliance with this regulation we require a copy of the immunizations administer to your child prior to establishing care with Desert Bloom Pediatrics. Without proof of vaccination history, we are unable to sign forms related to proof of immunization compliance including those required for school enrollment. Failure to provide records at time of appointment may result in cancelation and rescheduling of appointment until records are obtained.

Mutual respect of time

DBP strives to stay on schedule. Although there can be emergency situations that prevent us from staying on schedule, we pledge to provide quality care with minimal wait time to the best of our ability. In order to respect your time, we make the following requests:

- Arrive early or on time for your appointments. If you arrive more than 15 minutes late, we may have to reschedule you or squeeze you into a different time slot.
- If you plan on having additional children seen at your appointment, please let us know in advance so we can better accommodate you.
- If you are running late, please call the office. We may be able to accommodate you with advanced notice.
- Three (3) "no-show" appointments without notice from you in one year may result in dismissal from our practice.
- New patients who no show without notice to their first appointment may not be scheduled for additional appointments.

Assignment of Benefits

I permit payment directly to Desert Bloom Pediatrics for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance policy.

Authorization to Release Information (PHI)

I hereby authorize Desert Bloom Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Acknowledgement of receipt of notice of privacy practice

I acknowledge that I have received and read a copy of DBP's "Notice of Privacy Practices." The notice describes how DBP may use and disclose my protected health information (PHI), the restrictions on the use and disclosure of my healthcare information and the rights I have regarding my PHI.

Text Contact Consent

I authorize Desert Bloom Pediatrics to contact me via text message for communication to better serve my needs. I understand that to receive HIPAA complaint messages, I can download and use the Spruce app for these messages. I can also opt out of these messages at any time.

Consent for artificial intelligence use during office visit

As part of our ongoing efforts to enhance our services, we have incorporated a HIPAA-compliant artificial intelligence (AI) powered scribing tool, into our practice. This tool is only used for clinical documentation and note-taking purposes and not for care planning, symptom assessment, or medication management. Your healthcare provider reviews all AI-generated content to confirm accuracy and appropriateness before it becomes part of your medical record.

Consent for treatment of a minor

I hereby give consent to Desert Bloom Pediatrics and all persons acting as agents thereof to furnish all forms of diagnostic, preventative, and medical treatment to my child(ren). This authorization will remain in effect until revoked in writing by the parent or legal guardian.

I have read and understood the above policy and agree to it.

Signature: _____ Date ___/___/_____

Name: _____

Relationship to patient: _____

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Financial Policy

Billing your insurance

- Please present your current health insurance card at each office visit.
- We bill the validated primary insurance as a courtesy. You must pay for any patient responsibility.
- If you have no insurance, then payment in full is required at the time of service. For such patients, a time-of-service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Payment for services

- Co-pays, co-insurance, and deductibles must be paid at the time of service.
- We mail statements on a weekly basis and payment is due upon receipt of your statement.
- Additional fees include: nurse forms, medication forms, same day referrals, controlled substance prescriptions (when given outside of an appointment), and after-hours fee.
    - The form fee is normally $15/form for completion in 3-5 business days or $35 if completed that business day.
    - If forms need to be completed during a visit, a maximum of two forms per visit will not be charged an additional fee.
- We require a credit card to be kept on file to cover any balance that your insurance determines to be “patient responsibility” as determined by your Explanation of Benefits (EOB). Please see our full credit card on file policy for further details.
- Past due accounts will be flagged and could delay scheduling an appointment until payment arrangements have been made.

Returned checks

- The charge for a returned check is $35. You must pay in full for the check amount and the returned check fee within 10 days’ notice. In addition, all future payments will need to be made with cash or credit card.

Collection accounts

- For accounts that remain unpaid for more than 90 days, we reserve the option to refer to an outside collection agency. If your account is sent to a collection agency, there is a 40% surcharge added to your balance. If your account is sent to a collection agency, you may be asked to find another provider.

Late arrivals, cancellations, and no shows

- Please arrive 10 minutes prior to your appointment to allow for check in and any paperwork.

- We ask for 24-hour notice to cancel or reschedule a well child check and 1 hour notice to reschedule a sick appointment.
- Patients arriving 15 minutes or more past their scheduled appointment time may be rescheduled.
- Failure to give proper notice for cancellations or rescheduling may result in:
    - $35 missed appointment fee per child
- Patients with three (3) no shows in 1 year may be considered for dismissal from the practice.

Divorced/Separated Parents and Custodial Agreements

- DBP does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on someone other than yourself. We are happy to provide receipts for paid medical bills for you as requested.

I acknowledge that I have read, understand, and agree to the policies outlined in this document.

Printed name: _____

Signature: _____ Date:_____

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Desert Bloom Pediatrics Credit Card on File Policy

Desert Bloom Pediatrics requires that a valid credit card be kept on file.

The policy is designed to:

- Help avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your children and their medical care

The card information is stored electronically in an encrypted form and cannot be viewed by our office staff. Your signature will authorize the card to be used only when your balance becomes past due.

How the policy works:

1. When you register or check-in, you will be asked for your credit card information to be electronically stored in an encrypted form in our computer. Only the last four digits are visible to our staff.
2. We will bill your insurance carrier as a courtesy for all charges related to the visit.
3. When we receive an explanation of benefits (EOB) form from your insurance, a courtesy contact will be made to check your balance on your portal account prior to charging your credit card on file.
4. If the balance is >$150, we will call you as a courtesy before running your credit card on file.
5. If we attempt to use your card and it is declined or has expired, we will send you a new statement with a letter asking for current credit card information.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. If you feel that we have charged your card in error, contact our office ASAP, and if a mistake has been made, we will reverse the charges.

I have reviewed a copy of Desert Bloom Pediatrics Credit Card on File Policy. I agree to provide my credit card information to Desert Bloom Pediatrics for the sole purpose of payment for my child(ren)'s medical care. I have the right to cancel this process and use another form of payment.

_____ _____

Signature of Authorized User Date

_____ _____

Print name as it appears on your credit card Phone number of cardholder

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Waiver for Noncovered Services

Desert Bloom Pediatrics asks that patients schedule regular well child visits per the AAP guidelines. Well visits provide an opportunity for your pediatrician to make sure that your child is growing and developing normally. We follow the AAP's Bright Futures Guidelines to provide comprehensive and complete care during these visits. This document is to inform you about the services that we provide at each well check.

Screening – We perform recommended screenings based on the patient's age to detect any conditions that may need treatment. Most insurance plans cover these screenings and costs, some recommend the screening but push costs to the patient's deductible/co-insurance, and some do not cover the recommended screening at all. Again, most of the time these screening tools are covered, but it is your responsibility to understand which screening services are covered by your specific insurance plan.

Screens:	**CPT**
Edinburgh Postpartum Screening (every well check through 6mo)*	96161
Ages and Stages Questionnaire (development screening)*	96110
MCHAT (Modified Checklist for Autism in Toddlers), 18mo, 2yr*	96110
ProOptix Vision Test, (well checks at 1 and up until eye chart can be used)*	99174
Lead and TB exposure questionnaire (6, 9, 12, 18mo then yearly from 2yr)	96160
Dental evaluation and Fluoride protection (at 6mo until dentist established)	99429, 99188
Hearing and vision screening (yearly starting at 4yr)*	99173
PHQ-9 Depression screen (yearly starting at 11)*	96127

*Screenings with an asterisk are billed at a flat rate of $25 if not covered by insurance

Insurance coverage of Well versus Problem-oriented visits

Well visits may reveal problem-oriented issues that require evaluation and management (for example, ear infections, ADHD concerns, wart treatments). To comply with insurance company billing policies, this then prompts charges for both categories. While well checks/preventative services may not require a co-pay or deductible, problem-oriented services do. If you need further explanation about incurring additional fees for services provided during your visit, please speak with our billing team.

Acknowledgement of Billing Procedures

I have been informed of the routine procedures performed during my child's well visit and understand that some of the screening tools may go to my deductible or co-insurance. I acknowledge that during my child's well visit, there may be a problem-oriented service performed that will generate a separate charge to my insurance company. I understand that, alternatively, I can make a separate appointment for the problem-oriented issue at which time my co-pay/deductible/co-insurance would still apply.

Name: _____

Signature: _____

Date: _____

DESERT BLOOM PEDIATRICS

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Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I hereby authorize the entity listed below to release medical information to Desert Bloom Pediatrics:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax: _____

Medical information requested for treatment/continuing medical care:

□ All Records
□ Specific Records from_____ to _____
□ Immunizations & Physical Examinations
□ Radiology Reports (X-ray, Ultrasound, CT, MRI, etc)
□ Other (specify): _____

If you wish for certain information to **NOT** be included, please list below:

_____

_____

Signature of Parent or Legal Guardian: _____ Date: ___/____/_____

Print Name: _____ Relationship to Patient: _____

Patient's signature (if over age 18): _____

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time and that it must be done in writing unless the facility, which is to make the disclosure of information, has already done so in reliance on the statement.