Patient Information

Name:_____ Middle:_____ Last: _____ DOB:_____
Address;_____City:_____State:____Zip: _____
Sex: M / F Home #:_____ Cell #:_____Other #:_____
Name of Child's Previous Physician: _____Tel #:_____
How did you hear about **Ronald I. Jones Pediatrics?**_____

Parents/Guardian Information

Parent/Guardian # 1
Relationship to Patient: _____
Name: _____ Middle: _____ Last: _____Suffix: _____
Address: _____City: _____Zip: _____
SSN: _____-_____-_____Sex: M / F Marital Status: _____ DOB: _____
Occupation: _____ Employer: _____
Phone: _____ Mobile:_____ Work:_____
Email: _____

Parent/Guardian # 2
Relationship to Patient: _____
Name: _____ Middle: _____ Last: _____Suffix:_____
Address: _____City: _____Zip:_____
SSN: _____-_____-_____Sex: M / F Marital Status: _____ DOB: _____
Occupation: _____ Employer: _____
Phone: _____ Mobil:_____ Work:_____
Email: _____

Insurance Information

Primary:
Insurance Company: _____Employer: _____
Patients ID: _____Group # : _____Tel: _____
Policy Holders Name:_____ DOB: _____ SSN: _____-___-_____
Relationship to patient: _____

Secondary:
Insurance Company: _____Employer: _____
Patients ID: _____Group # : _____Tel: _____
Policy Holders Name:_____ DOB: _____ SSN: _____-___-_____
Relationship to patient: _____

Emergency Contact / Consent for Treatment

Name: _____Relationship to patient:_____
Phone #: _____work #:_____Mobile # _____
I _____ give permission to **Ronald I. Jones Pediatrics** to care for and treat my child. I understand that my child cannot be treated without my permission unless I have given written consent to an adult **OVER THE AGE OF 18 YRS** to seek such care or treatment. In my absence the

following adults may seek medical attention for my minor. I agree to hold **Ronald I. Jones Pediatrics** and its staff harmless for any disagreement between the above-named individual(s) and me regarding treatment decisions.

Name: _____ relationship to child:_____
Name: _____ relationship to child:_____
Name: _____ relationship to child:_____

Divorce / Custody

The parents and/ or legal guardian who brings the child in for a medical service will be required to pay for the bill. We do not bill third parties regardless of what the decree or custody documents indicate. Please make appropriate arrangements prior to the office visit.

"Joint Custody" means that each parent has equal access to the medical record. Without a court order, we will not stop either parent from looking at their child's chart, discuss what each parent told the doctor when they were here last, notify the other parent when a child is being treated, or call the other parent for consent prior to treatment.

Returned Checks Policy

All checks returned checks for insufficient funds, closed bank accounts, or for any other reason will be subject to a $25.00 serve charge. The service charge and other amount of the check must be paid in full within three working days by cash, credit card or certified funds. Therefore, checks will no longer be accepted for services rendered. Please make arrangements for all future payments to be made by cash, Visa, MasterCard, American Express.

Financial Policies

Co-pays: It is our policy to collect your insurance co pay at check in. This simplifies the office process and ensures the financial obligation is met at the time of service.

Co- Insurance/Deductable: It is your responsibility to pay any deductable, co-pay, co insurance or any other balance not paid by your insurance. If the balance is not paid we reserve the right to assign a collection agency.

Secondary Insurance: We will bill secondary insurance on your behalf. It is your responsibility to provide is with all secondary insurance information.

Combined Visits: If you are scheduled for a well child exam and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co pay and other charges accordingly.

Administrative Fee's

Copies of medical records:	(See "Medical Records Release form" for fee amount)
Special request physician letters/Forms:	$ 10.00 to $ 25.00 (charge based on letter/forms)
Appointment No Show Fee:	$ 25.00 must call 24 hours before appointment time.

Assignment and Release

I hereby authorize payment directly to ***Ronald I. Jones Pediatrics*** of all insurance benefits otherwise payable to me for the services rendered. **I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.**

I authorize the above doctor and/ or any providers or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurances submissions.

Signature of Responsible party:_____ **Date**: _____

Dr. Ronald I. Jones Pediatrics

Notice of Privacy Practices for Protected Health Information

This notice describes how health information about you may be used and disclosed and how you can receive access to this information. This notice is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).Dr. Ronald I. Jones Pediatrics reserves the right to make changes to this notice in the future, if any new provisions become effective.

Your rights regarding your health information:

1.You may obtain a copy of Notice of Privacy Practices for Protected Health Information upon request.

2.You have the right to review and obtain a copy of the health information that is used to make individual health care decisions. In accordance with the Arizona Revised Statutes, Title 12, Chapter 13,Article 7.1, Subsection 2295, a **fee** will be charged for obtaining a copy of medical records.

3.You have the right to appeal decisions we make regarding denial of access to your records.

4.You have the right to request amendments to your health record if you believe it is incorrect or incomplete. You must provide us with a reason or documentation that supports your request.

5. You have the right to dispute decisions we make regarding denial of amendments to your records.

6.You have the right to request restrictions on certain uses and disclosures for your health information.

7.You have the right to file a complaint. If you believe your rights have been violated, you can either file a complaint with our office or with the Secretary of the Department of Health and Human services.

The following information may require us to use or disclose your health information:

1.To public health authorities,health agencies, and legal authorities that are authorized by law to receive health information.

2.For lawsuits and similar proceedings in response to a court or administrative order.

3.To law enforcement as required by law.

4.To public authorities as allowed by law to report abuse, neglect, or domestic violence.

5.To public authorities as allowed by law to reduce or prevent a serious threat to your health or safety and for the safety and health of another individual or the public.

I hereby acknowledge that I have read and understand the Notice of Privacy Practices for Protected Health Information for Dr. Ronald I. Jones Pediatrics.

Patients Name:_____ Date:_____

Parent/Legal Guardians Name:_____Parent/Legal Guardians Signature:_____

Ronald I.Jones M.D.,P.C. Pediatrics

Dr. Ronald I. Jones Dr. Asma Jafri

Records Release Form

Please release records on the following patient(s):

1. _____ Date of Birth:_____
2. _____ Date of Birth: _____
3. _____ Date of Birth: _____
4. _____ Date of Birth: _____

RELEASE FROM:

Clinic/Name: _____
Address: _____
_____
Phone: _____
Fax: _____

PLEASE MAIL RECORDS TO:

Ronald I. Jones Pediatrics
961 N. McQueen Rd
Chandler, Arizona 85225
Tel: (480)-222-8080
Fax: (480)-222-3574

The health Information to be used / disclosed includes: (check all that apply)

___ All health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and drug abuse, if any, unless specifically accepted:_____
___ Health Information relating to the following condition: _____
___ Health information for the date (s): _____
___ Immunization Records

I understand I do not have to sign this authorization in order to get health care benefits. I understand that I may revoke this authorization in writing at any time except to the extent that Ronald I. Jones Pediatrics has acted in reliance upon this authorization. Once the office discloses health information the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

Signature of parent/legal guardian:_____ Date:_____
Relationship to patient:_____

Ronald I. Jones Pediatrics

Date: _____ Patient Questionnaire

Patient Name: _____**DOB**: _____

Pregnancy & Birth:

Mother's age at pregnancy: _____

Any illness during pregnancy? **Y / N** If yes, explain: _____

_____

Medication during pregnancy? _____

Smoking/Alcohol/Street Drugs during pregnancy? **Y/N** If so, explain:_____

Was baby Early – Late – On Time? _____ Type Of delivery? _____

Birth Weight:_____ Length:_____ Hospital/Place of Delivery?_____

Complications: **Y/N** if so, explain: _____

Problems with baby at birth? _____

Patients Past Medical History:

Allergic Reactions: **Y/N** if so, explain: _____

Immunizations up to date? **Y/ N** Serious Injuries/Hospitalizations: **Y / N**

If so, Explain:_____

Measles:	**Y / N**	Mumps:	**Y / N**	Whooping Cough:	**Y / N**
Eczema:	**Y / N**	Seizures:	**Y / N**	Chicken Pox:	**Y / N**

Recurrent Infections? (3 or more)

Ear: **Y / N** Throat: **Y / N** Eye: **Y / N**

Family Medical History:

Anemia/Blood Disorder:	**Y / N**	Epilepsy/Seizures:	**Y / N**	Muscular Dystrophy:	**Y / N**
Asthma:	**Y / N**	Heart Disease:	**Y / N**	AIDS:	**Y / N**
Mental Retardation:	**Y / N**	Cystic Fibrosis:	**Y / N**	Psychiatric Problems:	**Y / N**
High Blood Pressure:	**Y / N**	Diabetes:	**Y / N**	Migraines:	**Y / N**
Cholesterol Problems:	**Y / N**	Tuberculosis:	**Y / N**	Drug /Alcohol Problem:	**Y / N**
Cancer:	**Y / N**	Depression:	**Y / N**	Birth Defects:	**Y / N**
Sudden Infant Death:	**Y / N**	Arthritis:	**Y / N**	Other: _____	

Family Profile:

Father's Age:_____ Highest School Grade: _____

Mother's age:_____ Highest School Grade: _____

List child's siblings:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Feeding And Nutrition:

Food Allergies: **Y / N** If so, explain: _____

Appetite usually good? **Y / N** Colic or feeding problems during first 3 months? **Y / N**

Breast Fed? **Y /N** How Long? _____ Formula? **Y/N** Brand? _____

Vitamins? **Y / N** Special Diet? **Y / N** If so. explain:_____

Developmental and Behavior:

Age when: Sat Alone:_____ Walked: _____Toilet Trained:_____ Bicycle:_____

Developmental compared to other children? Behind Similar Advanced

Learning problems? Y / N If so, explain:_____

Behavior Problems? Y / N If so, explain: _____

Bedwetting Problems ? Y / N Sleeping Problems? Y / N

Hobbies/ sports/ Social Activities: _____

Ronald I. Jones Pediatrics

Tuberculosis (TB) Questionnaire

Patient's Name:_____ Patients DOB:_____ Date:_____

Please answer the following questions by checking Yes or No.

	Yes	No
1.Does anyone in your home have Tuberculosis (TB) or has tested positive for TB?	____	____
2.Does anyone in your home have contact with persons with Tuberculosis (TB) ?	____	____
3.Does anyone is your home have contact with persons diagnosed with AIDS or are HIV positive?	____	____
4.Is there anyone in your home who is from or was born in Africa, Asia, Latin America, Mexico, Caribbean or the Middle East?	____	____
5. Do you or your child travel to Africa, Asia, Latin America, Mexico, Caribbean or the Middle East?	____	____
6.Has your child ever been tested for Tuberculosis (TB)?	____	____
7.Has your child ever been tested positive for Tuberculosis (TB)?	____	____

Ronald I. Jones Pediatrics

Verbal Lead Screen

Please answer all the questions below. This will help the doctor decide if your child needs a special blood test.

Date_____

Patients Name_____ DOB: _____

	Lead Screening Questionnaire	Yes	No
1.	Does your child live in, often visit, or play near a house or building built before 1978 **with** recent remodeling? (This could include a day care center, preschool, and the home of a babysitter or a relative.)		
2.	Does your child live in or visit often a house with peeling or chipping paint built before 1960?		
3.	Has your family or child ever lived outside the United States, or has just arrived from a foreign country?		
4.	Does your child have a brother, sister, housemate or playmate being followed or treated for lead poisoning?		
5.	Does your child often put things in his/her mouth such as toys, jewelry, or keys? Does your child eat anything that is not food?		
6.	Does your child often come in contact with an adult whose job or hobby involves exposure to lead? (Jobs include house painting, plumbing, remodeling, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.)		
7.	Does your child live near an active company that melts lead, battery recycling plant, or another industry likely to release lead?		
8.	Does your family use cosmetics from other countries like kohl, surma, or sindoor?		
9.	Do you give your child any home remedies or traditional medicines that may contain lead?		
10.	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?		
11.	Does your child live near a busy roadway where soil and dust may be contaminated with lead?		
12.	Does your home's plumbing have lead pipes or copper with lead joints?		

Patient Eligibility Screening Record
Vaccines for children Program

This record must be kept in the provider's office to reflect the current status of all children 18 yrs of age or younger declared eligibility to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual of record, or by the health care provider. This same record can be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of 3 yrs.

Please print or type:
Initial screening Date: _____
Child: Last name: _____Name: _____M.I:___
Child's Date of Birth: _____
Parent/Guardian: Last Name: _____Name:_____
Provider: _____

This child qualifies for vaccination through VFC program because he/she (check only 1 box):

(0) [ ] is enrolled in KidsCare; or
(1) [ ] is enrolled in AHCCCS; or
(2) [ ] does not have health insurance; or
(3) [ ] is American Indian or Alaskan native (no matter what insurance situation is); or
(4) [ ] has health insurance that does not pay for vaccines.
(5) [ ] this child does not have quality for VFC – see bottom of page.

Date of Eligibility Changes and Updates

KidsCare	AHCCCS	Un - Insured	Native American./Alaska	Under - Insured

[ ] Check here if this child has health insurance that pays for vaccines.

PLEASE BE ADVISED:
If your insurance company does not cover immunizations and you do not let us know at the time of visit, it is your responsibility to pay the cost involved. We cannot make the Vaccine for Children's Program retroactive and you are only eligible for the Vaccine for Children Program at the time of the visit. If you are unsure if immunizations and check ups are covered, please contact your insurance company.
Thank You.

Please sign below that you understand and agree with the above statement.

Signature: _____ Date:_____