LaTouche Pediatrics, LLC

Patient Registration Form

3340 Providence Dr., Ste. 452
Anchorage, AK 99508
Phone: 907-562-2120 Fax: 907-562-6527

IF ANY INFORMATION IS DIFFERENT FOR ANY CHILD, PLEASE FILL OUT SEPARATE FORMS

Please Fill Out Form Completely and Return to the Front Desk

Please Identify Preferred Nurse Practitioner/Doctor_____

Patient Information:

First Name_____ **Last Name**_____	**Date of Birth** _____	Gender ☐Male ☐Female	Adopted: ☐Yes ☐No If yes, at what age____

Preferred Language:		**Race:**		**Ethnicity**:	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Do not want to report

Mailing Address_____

City, State, Zip_____

Primary Phone_____ Secondary Phone_____
(used for appointment confirmation calls)

Email_____

Child primarily lives with:
☐ Both Parents
☐ Mother ☐ Father
☐ Other_____

Parent(s) or Guardian(s) *(if not the biological parent, proof of guardianship or adoption will be required)*

First Name_____ Date of Birth_____

Last Name_____ SS#_____

Relationship to Patient(s):
☐Mother ☐Father ☐Step-parent
☐Foster Parent ☐Legal Guardian ☐Other

Employer_____ Occupation_____ Work Phone_____

First Name_____ Date of Birth_____

Last Name_____ SS#_____

Relationship to Patient(s):
☐Mother ☐Father ☐Step-parent
☐Foster Parent ☐Legal Guardian ☐Other

Employer_____ Occupation_____ Work Phone_____

If parents are divorced or separated, is there a court order or other financial arrangement we need to be aware of?
_____ *(If yes, please provide a copy. Our office cannot enforce any court order that we do not have on file.)*

Biological Mother/Father's Name(s), *if different from above*: _____

Address_____ Phone #_____

In the event of an emergency, whom should we call (besides parents)?
Name_____ Relationship_____ Phone #_____

Insurance Coverage Information *(Including Medicaid or Denali KidCare)*

PLEASE SUPPLY YOUR INSURANCE CARD(S) IN ADDITION TO THIS FORM, TO BE SCANNED INTO YOUR CHILD'S RECORD

Primary Insurance: Insurance Company_____ ID#_____

Subscriber's Name_____ Date of Birth_____ Group/Plan#_____

Effective Date_____ Deductible $_____ Employer_____

Secondary Insurance: Insurance Company_____ ID#_____

Subscriber's Name_____ Date of Birth_____ Group/Plan#_____

Effective Date_____ Deductible $_____ Employer_____

_____ _____

Signature of Parent or Guardian *(unsigned forms will not be valid)* ***Today's Date***

FOR SIBLING REGISTRATION, PLEASE USE THE BACK OF THIS FORM

Sibling Registration

Only Use This Form if the Sibling Resides at the Same Address

Patient Information:

First Name________________________ **Last Name**_________________________	**Date of Birth** ___________	Gender Male Female	Adopted: Yes No If yes, at what age_____

Preferred Language:		**Race:**		**Ethnicity:**	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Do not want to report

Insurance Coverage Information *(Including Medicaid or Denali Kid Care)*

PLEASE SUPPLY YOUR INSURANCE CARD(S) IN ADDITION TO THIS FORM, TO BE SCANNED INTO YOUR CHILD'S RECORD

Primary Insurance: Insurance Company______________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________ Employer____

Secondary Insurance: Insurance Company____________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________Employer____

Patient Information:

First Name________________________ **Last Name**_________________________	**Date of Birth** ___________	Gender Male Female	Adopted: Yes No If yes, at what age_____

Preferred Language:		**Race:**		**Ethnicity:**	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Do not want to report

Insurance Coverage Information *(Including Medicaid or Denali Kid Care)*

PLEASE SUPPLY YOUR INSURANCE CARD(S) IN ADDITION TO THIS FORM, TO BE SCANNED INTO YOUR CHILD'S RECORD

Primary Insurance: Insurance Company______________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________ Employer____

Secondary Insurance: Insurance Company____________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________Employer____

Patient Information:

First Name________________________ **Last Name**_________________________	**Date of Birth** ___________	Gender Male Female	Adopted: Yes No If yes, at what age_____

Preferred Language:		**Race:**		**Ethnicity:**	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Do not want to report

Insurance Coverage Information *(Including Medicaid or Denali Kid Care)*

PLEASE SUPPLY YOUR INSURANCE CARD(S) IN ADDITION TO THIS FORM, TO BE SCANNED INTO YOUR CHILD'S RECORD

Primary Insurance: Insurance Company______________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________ Employer____

Secondary Insurance: Insurance Company____________________________________ ID#______________________

Subscriber's Name____ Date of Birth_____________ Group/Plan#________

Effective Date________________ Deductible $_______________Employer____

LaTouche Pediatrics, LLC

Family and Health History Questionnaire

Please Fill Out Form **Completely** and Return to the Nurse

Child's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to Child: _____

Previous/Referring Doctor: _____ Date of Last Physical Exam: _____

FAMILY PROFILE

Who lives in your home? (Including yourself and any significant other)

Full Name	Birth Year	Relationship to Child	Occupation

Are there any smokers in the house? ☐ No ☐ Yes If yes, do they smoke ☐ Inside ☐ Outside

Are there any pets in the house? ☐ No ☐ Yes If yes, what type and how many?

Current housing situation: ☐ Single Family Home ☐ Apartment/Condo ☐ Group Home ☐ Shelter ☐ Homeless

Utilities available in current housing: ☐ Electricity ☐ Running Water ☐ Natural Gas ☐ Telephone ☐ Outhouse

Are there any cultural or religious beliefs that may affect healthcare choices? ☐ No ☐ Yes If yes, please explain:

For children under 5 years:

What style car seat are you currently using? ☐ Rear Facing ☐ Forward Facing ☐ Booster Seat ☐ None

Is the child in childcare? ☐ No ☐ Yes If yes, what type: ☐ Daycare Facility ☐ In-home Daycare ☐ Family Member ☐ Other:

For children over the age of 5 years:

What grade is the child currently in and what school are they attending? Grade: School:

How would you describe their performance in school? ☐ No problems ☐ Academic Difficulties ☐ Poor peer relationships ☐ Behavioral Problems

PATIENT'S HEALTH HISTORY

Allergies to medications or foods: ☐ No Known Allergies

Medication/Food	Reaction (examples: rash, hives, wheezing, etc.)

List all the medications your child takes including vitamins, creams, inhalers, etc: ☐ No Current Medications

Medication	Strength	How Often?

List any of the patient's medical problems that have been diagnosed and when it was diagnosed: ☐ No Pertinent Medical History

Surgeries and Hospitalizations: ☐ No Surgical or Hospitalization History		
Year	Reason	Hospital

PATIENT'S BIRTH INFORMATION

Due Date:		**Birthplace:**		**Obstetrician:**	
Delivery Type:		**Birth Weight:**		☐ **Breast Milk** ☐ **Formula**	
Length of stay at delivery		**MOM- How many pregnancies have you had?**			
Do you know the APGAR scores?	_____ /_____	**MOM- How many live births have you delivered?**			
Any complications during birth?					

FAMILY HEALTH HISTORY

Please let us know who in the child's family has any of the conditions listed below

☐ History Unknown – Patient is adopted or in foster care

Paternal:	Father (Dad) Grandfather (PGF) Grandmother (PGM)	Uncle (PU) Aunt (PA) Cousin (PC)	**Maternal:**	Mother (Mom) Grandfather (MGF) Grandmother (MGM)	Uncle (MU) Aunt (MA) Cousin (MC)	**Siblings:**	Brother (BRO) Sister (SIS)

Yes	**No**	**Condition**	**Who:**
☐	☐	Asthma	
☐	☐	Blood Disorders (Anemia, Sickle Cell, Hemophilia)	
☐	☐	Bone Problems	
☐	☐	Cancer (Please specify who and what type)	
☐	☐	Diabetes	
☐	☐	Digestive or Intestinal Problems (please specify condition)	
☐	☐	Eczema	
☐	☐	Hearing Problems	
☐	☐	Heart Attack	
☐	☐	Heart Disease	
☐	☐	High Blood Pressure	
☐	☐	High Cholesterol	
☐	☐	Joint Problems	
☐	☐	Kidney or Bladder Problems	
☐	☐	Mental Health (Ex: Depression, Anxiety, Bipolar, Schizophrenia)	
☐	☐	Seizures or Epilepsy	
☐	☐	Stroke	
☐	☐	Substance Abuse (Alcohol/Drugs)	
☐	☐	Thyroid Problems	
☐	☐	Vision Disease/Problems	
☐	☐	Any other conditions of concern in this child's biological family?	

Signature of Parent or Guardian ***(unsigned forms will not be valid)***

Today's Date

For office Use Only: This information has been entered into the patient chart Initials: _____

Account Number (for office use)_____

LATOUCHE PEDIATRICS, LLC
HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

A copy of this notice will be made available for you to read, sign, and have entered into your child's electronic chart.

Your Child's Health Record/Information

Your child's healthcare record contains symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information serves as a:

- basis for planning your child's care and treatment
- means for communicating with other health professionals who may contribute to your child's care.
- legal document describing the care your child received
- means by which you or a third-party payer can verify that services billed were actually provided
- source of information for public health officials charged with improving the health of the nation
- source of data only for our planning and marketing
- tool by which we may assess our processes and continually work to improve the care we render

Your Rights Regarding Your Child's Health Record/Information

Although your child's health record is the physical property of the healthcare facility that compiled it, the information belongs to you and your child. You have the right to:

- request a restriction on certain uses and disclosures of the information as provided by
- 45 CFR 164.522
- obtain a paper copy of the notice of the office privacy policy upon request
- inspect and copy the health record as provided for in 45 CFR 164.524
- amend the health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your child's health information as provided in
- 45 CFR 164.528
- request communications of your child's health information by alternative means or at alternative locations. (i.e. on paper, in person, on CD, and at any of our office locations)
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

LaTouche Pediatrics, LLC is required to:

- Maintain the privacy of your child's health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about your child
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will make available a revised notice on our website and printed copies at our office locations.

We will not use or disclose your child's health information without your authorization, except as described in this notice.

LaTouche Pediatrics LLC is permitted to make uses and disclosures of protected health information for treatment, payment, and health care operations, as described in the following examples:

- For treatment - referral to specialists
- For payment - release of chart note copies to an insurance company in order to facilitate reimbursement for procedures performed
- For health care operations – processing of patient information by staff into the Electronic Medical Records, appointment scheduling by our staff.
- LaTouche Pediatrics, LLC may be permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization such as in the case of a Public Health emergency.

If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, we are required to comply with the most stringent law.
Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization

Latouche Pediatrics, LLC may contact the parent or guardian to provide appointment reminders or information about treatment alternatives and other health-related benefits and services that may be of interest to the individual or patient. Authorization forms are available if you wish for this information to be released to anyone other than the parent, guardian or patient.

LaTouche Pediatrics, LLC requires a signed authorization for someone other than the parent or guardian to accompany a patient under 18 years of age for treatment in our facilities.

For More Information or to Report a Problem

Individuals may complain to LaTouche Pediatrics, LLC, and/or to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

LaTouche Pediatrics, LLC's contact person for matters relating to complaints is:

Chad Jensen, Office Manager/Privacy Officer
3340 Providence Dr., Ste 452, Anchorage, AK 99508
Phone: (907) 562-2120

I have read and understand this Privacy Policy:

X_____ _____ _____
Signature of Parent or Responsible Party Relationship to Patient Date

Patient Name: _____ Account Number: _____

This Revised Privacy Notice is in effect as of October 09, 2008

LaTouche
Pediatrics, LLC

LATOUCHE PEDIATRICS, LLC
FINANCIAL POLICY

Thank you for choosing us as your health care provider! We are committed to your treatment being successful. The following is a statement of our Financial Policy. Please read and sign this prior to any treatment in our clinic.

All patients (parents or guardians) must complete our Patient Information and Financial Policy before seeing the Provider.

- **PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER.**
- **WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL**
- **THERE WILL BE A $25.00 SERVICE CHARGE ON ALL NSF CHECKS.**

Regarding Insurance:

As a courtesy, we bill most insurance plans on your behalf. You authorize the clinic to release any information to process your claims, and insurance benefits to be paid directly to our providers. It is our goal to provide fast and efficient billi ng. In order to achieve this goal, **it is imperative that we are provided with complete, accurate, and timely insurance information.** It is your responsibility to inform us of any changes in your insurance coverage. *Many plans have a limited amount of time in which they will allow for billing of claims*. Knowledge of your deductible, co-pays, and plan benefits is your responsibility. **All deductibles and co-pays are due and payable at the time of treatment.** *Please have your insurance card at every visit in the event it may be required.* Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Please be aware that you are responsible for any charges not covered by your insurance for any reason.

We are **Participating Physicians with Blue Cross of Alaska, and Preferred Providers for Federal Blue Cross, Aetna, Great West, Cigna and United Healthcare.** Our providers are credentialed to provide services to **Medicaid/Denali Kid Care recipients.** As Medicaid/Denali Kid Care recipients, you are expected to provide proof of eligibility at every visit and to be aware of your (child's) eligibility dates to avoid any lapse in coverage. In the event coverage has lapsed, you may be asked to reschedule any non-acute visits until eligibility is obtained. You are responsible for payment of any services provided to your child if they are not eligible at the time of service.

Usual and Customary Rates

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.**

Minor Patients

The adult accompanying a minor, (parent, guardian or authorized representative) is responsible for payment. Anyone other than parent or legal guardian should have written authorization on file to accompany minor child for treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concern.

I have read, understand and agree to this Financial Policy:

X_____ _____ _____

Signature of Parent or Responsible Party | Relationship to Patient | Date

Patient Name: _____ Account Number: _____

Consent and Authorization for Treatment of a Minor

3340 Providence Dr., Ste. 452
Anchorage, AK 99508
Phone: 907-562-2120 Fax: 907-562-6527

Today's Date_____

Patient's Name_____ Date of Birth_____

This is my authorization and consent for the below named person or persons to bring my child to LaTouche Pediatrics, LLC., to be treated by any of our medical providers. Treatment may include any necessary or routine medical treatment including examination, injections, immunizations and/or diagnostic procedures including ordering X-ray or laboratory analysis. I understand that in unusual circumstances, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

Please <u>Initial</u> all that apply (signature at bottom of page is also required)

_____ Bring patient for treatment

- _____ Sick Visits
- _____ Well Child Checks (Physicals)

_____ Request/Receive Medical Records

_____ Pick up prescriptions *(excluding controlled substances)*

_____ Pick up controlled substance prescriptions

_____ Speak to Triage Nurse

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered and acknowledge that no guarantees have been made as to the effect of such treatment rendered.

Person(s) authorized for the activities initialed above:

Name	Relationship to Patient:
_____	_____
_____	_____
_____	_____

This authorization will remain in effect for one year unless so designated in writing that such consent is cancelled. Expiration Date *(less than one year)*: _____

_____	_____
Print your Name (Parent or Guardian)	Relationship to Patient
_____	_____
Signature of Parent or Guardian	Date

Anchorage
3340 Providence Dr., Suite 452
1301 Huffman Road, Suite 110

LaTouche Pediatrics, LLC

Eagle River
17101 Snowmobile Dr., Suite 203

LaTouche Pediatrics is currently attempting to gain recognition as a Patient Centered Medical Home (PCMH) for the great care that we already provide to our patients and families.

But what does being a recognized PCMH mean for you?

It means that we have been through a rigorous process to ensure that we provide the best care possible for our patients.
It means that we are committed to working with you, the patient and the family, to make sure that all needs are met.
It means that we are here to partner with you to provide your child with the best all-around care that we can.

How can you help to ensure that we provide the best care for your child?

In order to provide the best care, we need to be kept informed about your child's medical needs and health status. Please make sure to provide us with accurate family medical history information. Also, if your child was seen anywhere other than our clinic (urgent care, ER, hospitalization, or specialist) be sure that you ask them to send us a report so that we can be kept informed. Without all this key information, we may miss something!

In this packet is a release of information, please fill it out and send it to your childs previous care provider so that we can obtain all their medical and immunization records prior to thie first appointment with us. This will ensure that we are informed about your child prior to meeting them!

What services are provided to exemplify the PCMH model of care?

Same Day Appointment Availability – We reserve time in all of our providers schedules for same day appointments for those unexpected illnesses.

After Hours Medical Advice – This service we have provided for quite some time and there is no change to this. 24/7 clinical advice is available for all of our active patients when you have questions regarding home treatments or if you need to seek care.

Patient Portal Access – This service provides you with access to your child's medical record electronically. You can view past appointments, print off immunization records, request medication refills, request appointments, and send your provider a secure message from any tablet, computer, or smartphone.

Care Coordination – We strive to provide great patient care. You and your physician are the center of the care team. Beyond that, we have other medical staff in the office who work closely to coordinate your care. They follow up on lab, imaging studies, referrals, and hospital care just to name a few. We also work closely with many specialists including behavioral health physicians and counselors.

Evidence Based Care – All of our providers base their recommended treatments on the most current scientific research. Evidence based medicine is the conscientious and reasonable use of modern evidence in making decisions about the care of individual patients.

We look forward to providing you and your family with the best care we can.
If you have any questions regarding this care model, please feel free to call our office and speak to one of our managers. We are always here when you need us!

Telephone (907) 562-2120 • Fax (907) 562-6527
E-mail puffin@latouchepediatrics.net • www.latouchepediatrics.com

LaTouche
Pediatrics, LLC

Patient's name_____Date_____

We would like to take this opportunity to welcome you to LaTouche Pediatrics, LLC.
Please take a moment to tell us how you learned about our practice. If more than one apply, please check all.

_____Friend/Family Member
Name_____
Child's name_____

_____Internet Search

_____Website (*www.latouchepediatrics.com)*

_____GCI Yellow Pages _____ACS Yellow Pages

Newspaper Advertisement:
_____Anchorage Daily News _____Alaska Star
_____Eagle River/Valley Cache _____Other Advertisement

Event Sponsor/Community Program:
_____Ski for Women (supports AWAIC)
_____Relay for Life (supports American Cancer Society)
_____Heart Run (supports American Heart Association)
_____Alaska Junior Theatre
_____Imaginarium
_____Other_____

_____Sign
( ) Huffman location ( ) Providence Hospital location ( ) Eagle River location

_____Patient of Dr Brand

_____Physician or other health care professional referral
Name_____

_____Other
Please explain_____