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 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_____

_____ _____

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: _____

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 billing. 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: _____

LaTouche
Pediatrics, LLC

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of LaTouche Pediatrics, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

LaTouche
Pediatrics, LLC

LaTouche Pediatrics, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Front Desk. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

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

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after April 1, 2021.

LaTouche Pediatrics, LLC reserves the right to modify the privacy practices outlined in the notice.

_____ _____
Patient Name Date

_____ _____
Signature of Parent or Guardian Chart Number

LaTouche
Pediatrics, LLC

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

Patient Portal Registration

Please Fill Out Form and Return to the Front Desk

We are excited to offer an online tool that provides anywhere, anytime access to your child's health record! With our patient portal, you can request appointments, do prescription refills, send non-urgent messages to your provider, and review and pay your bill online – 24/7 form any computer, smartphone or tablet.

Patient(s) Information: *(Please include all children that are current patients)*

Name: _____DOB:_____ Name:_____DOB:_____

Name: _____DOB:_____ Name:_____DOB:_____

Name: _____DOB:_____ Name:_____DOB:_____

Name: _____DOB:_____ Name:_____DOB:_____

Parent Information *(all information is required)*

Name_____

Mailing Address_____

City, State, **Zip** _____

Primary Phone _____

Email_____

_____ _____

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

Fill out the above information and expect an email from noreply@followmyhealth.com. Click the registration link and follow the onscreen prompts. Click Sign Up and Connect. Enter YOUR name, email address and DOB and click "I Accept". These screens include our Terms of Service, entering your Invite Code and accepting the Release of Information. Your invite code is your 5 digit zip code. If you have any questions, we have a Patient Registrar ready to help! Just call our office and let us know you need help. We hope you enjoy our Patient Portal!

Processed by _____ Date processed _____

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

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

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 Initial 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