Mama Mia
PEDIATRICS
TAX ID #: 27-230-2575

Patient's Name (Nombre Del Paciente): _____

Date Of Birth (Fecha De Nacimiento): _____

Address (Dirección): _____ Apt#: _____

City, State, Zip (Ciudad, Estado, Código Postal): _____

Phone # (Teléfono): _____

Email (Correo Electrónico): _____

OFFICE STAFF ONLY- SOLO PERSONAL DE OFICINA

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

RECORDS REQUESTING:

☐ Entire Medical Record
☐ Immunization Records
☐ Labs Only
☐ Other: _____

RECORDS RELEASED FROM:

Name: _____
Address: _____
City, State, and Zip: _____
Tel: _____ Fax: _____

RECORDS RELEASED TO:

2315 East Cheyenne Ave. #100
North Las Vegas, NV 89030
Tel: 702-633-4000 Fax: 702-633-4346

1250 South Eastern Ave.
Las Vegas, NV 89104
Tel: 702-383-4001 Fax: 702-383-4004

- This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards.
- I understand that email communications may not be secure unless encrypted.
- I hereby **CONSENT** the release of my child's medical records to Mama Mia Pediatrics at the above address or fax.
- EXPIRATION: This authorization for release of health information will expire one year from the date signed below.
- I may revoke this authorization at any time by notifying Mama Mia Pediatrics in writing. If I revoke the authorization, I understand it will have no effect on action Mama Mia Pediatrics took in good faith before receiving the revocation.
- I understand that I am not required to sign this authorization and that refusal to sign will not affect my ability to receive treatment.

_____	_____	_____
Signature (Firma)	Relationship to Patient (Relación al Paciente)	Date (Fecha)

PATIENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SEX: FEMALE MALE	S S #:
HOME #:	CELL #:	EMAIL:	
ADDRESS / CITY / STATE / ZIP CODE:			
RACE: WHITE / HISPANIC / AFRICAN-AMERICAN / OTHER:	PREFERRED LANGUAGE:		
PHARMACY NAME AND ADDRESS OR CROSS STREETS:			

PARENT (S) INFORMATION

MOTHER'S NAME:	MOTHER'S DATE OF BIRTH:	MOTHER'S S S #:
MOTHER'S EMPLOYER:	MOTHER'S OCCUPATION:	
EMPLOYER'S ADDRESS / CITY / STATE / ZIP CODE:		
FATHER'S NAME:	FATHER'S DATE OF BIRTH:	FATHER'S S S #:
FATHER'S EMPLOYER:	FATHER'S OCCUPATION:	
EMPLOYER'S ADDRESS / CITY / STATE / ZIP CODE:		

INSURANCE INFORMATION

PRIMARY INSURANCE:	POLICY #:	GROUP #:
NAME OF PERSON RESPONSIBLE:	DATE OF BIRTH:	S S #:
EMPLOYER:	OCCUPATION:	EMPLOYER TELEPHONE #
WHAT IS YOUR RELATION TO THE PATIENT:		
SECONDARY INSURANCE:	POLICY #:	GROUP #:
NAME OF PERSON RESPONSIBLE:	DATE OF BIRTH:	S S #:
EMPLOYER:	OCCUPATION:	EMPLOYER TELEPHONE #
WHAT IS YOUR RELATION TO THE PATIENT:		
OTHER INSURANCE:		

IN CASE OF ANY EMERGENCY, I'M NOT ABLE TO BRING MY CHILD

I, _____ (PARENT OR GUARDIAN NAME)
GIVE MY AUTHORIZATION TO TAKE ANY AND ALL MEDICAL DECISION TO

NAME	RELATIONSHIP TO PATIENT	TEL #

PATIENT MEDICAL HISTORY

ANY CHILDHOOD ILLNESS: _____ **[ ] NONE**

OTHER PROBLEMS (CIRCLE ALL THAT APPLY):

SKIN	CHEST	HEART
HEAD	NECK	BACK
WEIGHT	EARS	INTESTINAL
ENERGY LEVEL	NOSE	BLADDER
ABILITY TO SLEEP	THROAT	BOWEL
LUNGS	CIRCULATION	DISCOMFORT / PAIN

SURGERIES / HOSPITALIZATIONS	YEAR	REASON

1.	IS STRESS A MAJOR PROBLEM FOR THE PATIENT?	YES	NO
2.	DOES THE PATIENT FEEL DEPRESSED?	YES	NO
3.	DOES THE PATIENT PANIC WHEN STRESSED?	YES	NO
4.	DOES THE PATIENT HAVE A PROBLEM WITH THEIR APPETITE?	YES	NO
5.	DOES THE PATIENT CRY FREQUENTLY?	YES	NO
6.	HAS THE PATIENT EVER TRIED HURTING THEMSELVES?	YES	NO
7.	DOES THE PATIENT HAVE TROUBLE SLEEPING?	YES	NO
8.	HAS THE PATIENT BEEN TO A COUNSELOR?	YES	NO
9.	HAS THE PATIENT HAD A BLOOD TRANSFUSION?	YES	NO
10.	ANY MEDICATION OR FOOD ALLERGIES?	YES	NO

IF YES, PLEASE LIST: _____

_____

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

ASTHMA	HYPERTENSION	ANEMIA	EARLY DEATH
DIABETES	HEART DISEASES	KIDNEY DISEASES	BLOOD DISEASES
TUBERCULOSIS	SEIZURES	DEVELOPMENTAL DELAYS	PSYCHIATRIC PROBLEMS

ANY OTHER INFORMATION WE NEED TO KNOW ABOUT PATIENT? _____

_____

OFFICE AND INSURANCE POLICIES

This information is to assist you in understanding our policies.

1) The patient needs to update their demographics information yearly or as needed.
2) **Consent to Treat**: I hereby give consent for appropriate diagnostic testing and treatment that are deemed necessary to my medical condition. **I understand my insurance may not cover testing/treatments and I hereby agree to be financially responsible for paying any and all balance fees.**
3) The patient is responsible for **ALL FEES** and understanding of their insurance coverage/benefits. **PAYMENTS ARE DUE** at the time of service, such as **COPAYS, OUTSTANDING BALANCE**, and/or **DEDUCTIBLES**.
4) **Insurance Authorization and Assignment:** I hereby authorize **MAMA MIA PEDIATRICS, LLC** to provide information to my insurance carrier (s) concerning my medical condition and treatment**. I understand that I am RESPONSIBLE for ANY and ALL AMOUNT NOT covered by my insurance.** Knowingly withholding all active insurance coverage at the time of visit is considered a fraudulent behavior. Any fee not paid or recouped by insurance companies will be due from patient/parent/guardian. In case of Medicaid patients, we have the option to report this incident to the state.
5) I hereby agree to be financially responsible for paying account balance that is not covered by my insurance. **In the event of my account is referred to a collection service/agency due to non-payment, I agree to be responsible for all charges related to the collection and/or legal fees that may be added and charged to my account.**
6) I agree to receiving statements/invoice/ letter electronically through text messages and/or email

   EMAIL: _____ CELL #:_____

7) **No Call, No Show to Appointments**: Cancellation of any appointment requires a minimum of 24 hour notice before your appointment. **I understand after a 4th time of no-call, no-show to an appointment. I will be discharged from all Mama Mia Pediatrics locations. You will have to find a new primary care provider.**
8) **Medical Records**: An Authorized Release Form will need to be signed by the patient if any medical records need to be obtained. The **Fee for medical records is $5.00 deposit and $0.60 cent per page**. It will take up to **7 business days of processing**.
9) **Lawyers**: We **DO NOT** work with liens. **Medical and Billing records will ONLY be released personally to the patient or to an authorized parent/guardian after payment of appropriate fees.** NO RECORDS will be released to any Law Office electronically or by mail. The patient is responsible to fill out an Authorized Release Form to obtain records and itemized bills. The **Fee for records is $5.00 deposit and $0.60 cent per page**. It will take up to **7 business days of processing.**
10) **Disability / FMLA Forms:** There is a **$50.00** fee once forms are complete. It could take up to 7 business days to compete forms. *(with the exception of members of the Culinary Health fund)*
11) **No Insurance Fees:** **New Patient $100.00 – Established Patient $85.00**
    Includes immunizations only – All other procedures will have an extra charge.

By signing below, I acknowledge that I have read and understand and agree to all the above statements.

Patient Name: _____ **Date Of Birth:** _____

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describe how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realized that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:
The following circumstances may require us to use or disclose your health information.
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuit and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensations and similar programs.

Your rights regarding your health information:
1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to medical records department (Mama Mia Pediatrics).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to medical records department (Mama Mia Family Pediatrics). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint without practice or with the secretary of the department of health and human services. To file a complaint with our practice, contact privacy officer, (Mama Mia Pediatrics). All complaints must be submitted in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our patient will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies please contact

2315 EAST CHEYENNE AVE. SUITE 100
NORTH LAS VEGAS, NV 89030
(TEL) 702-633-4000 (FAX) 702-633-4346

1250 SOUTH EASTERN AVE.
LAS VEGAS, NV 89104
(TEL) 702-383-4001 (FAX) 702-383-4004

If you would like a copy of this document please ask front desk receptionist.

Signature: _____ **Date:** _____

Medicaid Policy

I _____ testify
(Parent or Guardian)

Patient _____ Date of Birth _____

ONLY has insurance through Medicaid/Medicaid Plans. I understand I am FULLY responsible for ANY and ALL balances not covered due to any other additional insurance.

Signature _____ Date: _____

Poliza Para Pacientes bajo Medicaid

Por medio de este documento yo _____testifico
(Padres o Guardian Legal)

que El Paciente _____ Fecha De Nacimiento _____

solo tiene cobertura por parte de Medicaid / Planes De Medicaid, cualquier balance no cubierto por causa de otra aseguranza sera mi responsabilidad.

Firma _____ Fecha _____