



Dr. Jonathan Slothower
Chad Francom PA
775-778-3437

Welcome!

Thank you for choosing Slothower Pediatrics for your child's health care needs. At this time, we would like to take a few minutes to explain our financial policy.

Insurance: Slothower Pediatrics belongs to PPO/HMO networks utilized by most of the major employers and participates with Nevada Medicaid/Nevada Check Up. It is your responsibility to call your insurance company prior to your first office visit to determine the status of your benefits with respect to the amount of your co-payment, deductible, or whether you need preauthorization, etc. Your insurance is a contract between you and your insurance company, but we will gladly bill your insurance if you supply us with your current insurance card and complete, accurate information regarding both the insured and the patient.

You will also be asked at each visit to verify your insurance information in order for us to maintain the most current information. *Once a year you will be asked to complete a new registration form.* It is your responsibility to notify our office immediately of any changes in your insurance (new insurance carrier, ID numbers, group numbers, etc.). **All charges are your responsibility including those billed to your insurance and not paid within 60 days from date of service.**

Self-Pay: For those of you who don't have insurance we ask for payment at the time of service. If you are unable to pay in full, we will set up payment arrangements, so you don't miss your appointment. If you are unable to pay for subsequent visits you will need to contact our billing office and arrange and payment plan prior to your appointment. Your previous credit history with us will be a factor in their decision.

Payment: We do require your co-payment be paid at the time of service. You may be asked to reschedule your appointment if you are unable to pay. (If we are contracted with your insurance the contract requires us to collect at time of service.)

We accept cash, Visa, and MasterCard. Statements you receive showing balances owed are your responsibility and are due and payable upon receipt. If your account goes unpaid for 60 days, collection procedures may be started. If your account had been placed with our collection agency for lack of regular monthly payments or ignored attempts for collections one of the following will apply: You will be dismissed for the practice (doctor's decision), or all future office visits will have to be paid at 100% at the time of service. This same policy will apply for all accounts that have filed bankruptcy.

If you have questions regarding our financial policy, please contact our billing office at (775) 778-3437 ext. 102.

AGREEMENTS: By signing below you acknowledge that you have read and understand our financial policy.

Signature of Parent/ Guardian/ Responsible Party

Date



Payment and Attendance Policy Agreement, Slothower Pediatrics

In order to ensure that Slothower Pediatrics receives fair compensation for medical care given to my child and the community, I agree to the following:

1. My insurance is billed out of courtesy. I am responsible for all bills and charges associated with my child's visit to Slothower Pediatrics. If my insurance does not pay Slothower Pediatrics for the visit in a timely manner (within 60 calendar days from when the charges were submitted) I will be responsible to make sure the charges are paid. If I do not pay any outstanding charges within 30 days (90 calendar days from when charges were submitted), or set up a payment plan, I can be sent to collections.
2. If my account has been sent to collections and then my insurance pays for those charges, Slothower Pediatrics can refuse payment from my insurance company. Once my account has gone to collections, I understand that I, and my insurance company, will have to deal with the collections company.
3. Slothower Pediatrics has an agreement with my insurance in terms of discounts for procedures and visits. If my outstanding balance goes to collections, the charges will revert to their original amount, and the discount given to the insurance company will be revoked.
4. If I have a family balance of more than \$250, and a payment plan is not set up, I will have to pay 50% of my outstanding balance and set up a payment plan before my child can receive services from Slothower Pediatrics.
5. Copays are due at the time of the visit. If my copay is temporarily waived (on an individual case basis) I agree to pay it in full within 14 days.
6. Any discount given to me for a payment, or a payment plan is dependent on me meeting my payment plan obligations, should I violate that agreement, the discounts are null and void.
7. For Slothower Pediatrics to recoup costs associated with collections, I agree that if my account goes to collections, Slothower Pediatrics may charge me a service fee equal to 50% of the original balance that will be added to the original balance.
8. ***If I miss an appointment without notifying Slothower Pediatrics 24 hours in advance***, I will be charged a \$50 no-show fee and agree to pay it within 30 days of receiving the bill for it. If I cancel appointments for any family member within 24 hours, I will be charged a \$50- no show fee. If I cancel more than 3 times, or if I no-show more than 3 times, Slothower Pediatrics has the right to dismiss me from the practice. ***If I am more than 5 minutes late to an appointment***, Slothower Pediatrics may require my appointment be rescheduled.

_____ **Parent Initials**

9. If I don't have my insurance card at the time of service, Slothower Pediatrics has the right to refuse service and I may need to go to the ER if it is an urgent care matter.

Signed: _____ Date: _____

Print Name: _____ Child's Name: _____



Authorization to Release Medical Records

Patient Information:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Record Requested From:

Facility Name: _____ Fax Number: _____

Phone Number: _____ City/State: _____

Record to be Sent to:

Slothower Pediatrics (775) 778-3437 phone

1780 Browning Way (775) 778-3652 fax

Elko, NV 89801

Records Requested:

- All Medical Records
- Behavioral Health Records
- Immunization Record
- Lab Results

Purpose:

- Personal Use
- Legal
- Disability
- Coordination of Care
- Transfer of Care
- Other _____

Patient Signature:

I hereby certify that I am: 1. At least 16 years of age if requesting Behavioral Health and/or Substance Use Disorder records, or at least 18 years of age if requesting medical records. 2. The parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age. I hereby authorize disclosure of health information for the above-named patients(s). This authorization is valid for one year from the date of signature. I understand that I may cancel this request with written notification, but it will not have any effect on information released prior to notification of cancellation.

Authorized Signature: _____ Date: _____

Disclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.



HIPPA Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing I authorize Slothower Pediatrics and its employees, including Dr Jonathan Slothower and Chad Francom, to use and disclose certain protected health information (PHI) about my child, or the minor for whom I am the legal guardian (also known here after as “my child”).

This authorization permits Slothower Pediatrics to access and/or disclose the individually identifiable health information about my child during the course of medical care, as well as any information collected following medical care or consultation given to my child in a hospital, emergency room, newborn nursery, or via telephone interaction with any employees of Slothower Pediatrics.

Disclosure of such information will be for the purpose of referral to a subspecialist or another general practitioner, after discussing and documenting the need for such a referral. The information may also be shared with a medical provider who, at the time the information is requested, is actively participating in the medical care of the child represented by this form. The purpose(s) will be provided so that I can make an informed decision whether to allow release of the information.

Slothower Pediatrics will not receive payment from a third party in exchange for disclosing the PHI, except in the case where such information is requested by the insurance company or third-party payer that is financially responsible for part or all of the medical expenses that my child has accrued while being associated with Slothower Pediatrics.

By signing, I authorize Slothower Pediatrics to access my child’s previous prescription medication history. With this consent, Slothower Pediatrics may telephone/e-mail my home, or other locations that I designate, any items that may assist the practice in carrying out treatment plan options, such as appointment reminder cards and patient statements.

I do not have to sign this authorization in order to receive treatment from Slothower Pediatrics. I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to:

Slothower Pediatrics
1780 Browning Way, Ste A
Elko NV 89801

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient’s name Date



Dr. Jonathan Slothower

Chad Francom PA

775-778-3437

Patient Information

Name (Last/First/MI): _____ DOB: _____

Sex: Male Female

Street Address: _____ City: _____ State: _____ Zip Code _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

Mother's name and occupation: _____

Father's name and occupation: _____

Race: American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander

Black/African American White Hispanic Other Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Primary Language: English Spanish

Other: _____

Referred by: Hospital Insurance Family/Friend

Internet/Phone Book Promotional Ad Other: _____

Preferred Pharmacy: _____

Other family members seen here: _____

Previous Provider and their location: _____

We send out Announcements if we are Closed via Text, Email and Phone calls.

Please choose your preferred method of communication.

Email _____ Phone _____ Text _____

Responsible Party Information

Name: _____ Phone: _____

Street Address (If different from above): _____

City; _____ State: _____ Zip Code: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

Insurance Information

Does your child have healthcare coverage? [] Yes [] No

Insurance Name: _____

Member Id: _____ Group #: _____

Name of Primary Insurance Holder: _____

Policy Holder's Birth Date: _____

Insurance Name: _____

Member Id: _____ Group #: _____

Name of Primary Insurance Holder: _____

Policy Holder's Birth Date: _____

Emergency Contact Information

Name (Last/First): _____ Relationship to Patient: _____

Home Phone Number: _____ Other Number: _____



New/Annual Patient Questionnaire

Name: _____ Sex: Female [] Male [] Date of Birth: _____

Medical History:

Is your child allergic to anything? _____

List all your child's medications, including frequency and dosage (including over-the-counter medications, vitamins/supplements, and alternative therapies):

Please list any **medical problems, past or present**, that your child has been treated for by a medical provider (examples: asthma, allergies, ADHD, congenital malformations, diabetes):

Please list any surgeries and/or hospitalizations with approximate dates:

Please check any illnesses, if known, pertaining to the relatives listed below:

	Deceased	Diabetes	High Blood Pressure	Heart Disease	Autoimmune Diseases	Psychiatric Problems	Congenital Disease	Asthma	Other (please list)	History Unknown
Mothers Family										
Fathers Family										

Social History

Please list all people included in your household that child lives with: _____

Does anyone that lives in the child's home smoke? [] Yes [] No If yes, who? _____

Are there pets in the home? [] Yes [] No If yes, what kinds and how many? _____

Please list on average the numbers of hours per day your child spends doing the following activities:

Doing homework ____ Playing outside ____ Watching TV ____ Cell Phone ____ Computer/Internet ____ Sleeping ____

Please list anything else that you would us to know about your child: _____



Alternative Caregiver Consent Form

I authorize the following individual(s) to bring my child to his or her appointments:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

I attest that the above-named individual(s) are all 18 years of age or older as of this date

I authorize the above-named individual(s) to consent to treatment for the below named child. This may include, but is not limited to, consent for necessary medications, procedures, and hospitalization. Slothower Pediatrics may relay any medical information necessary for the about name individual(s) to provided informed consent for treatment.

I understand that a well child visit, vaccinations and sports physicals will require a parent or legal guardian present.

○ _____ (Parent Signature)

I understand that Slothower Pediatrics will communicate their findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for service requested by the above-named individual(s).

I agree to hold Slothower Pediatrics and its staff harmless for any disagreement between the above-named individual(s) and me regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke the authorization for any of all these individual(s) at any time. Revocation must be submitted in writing.

Children covered by this Consent:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Relationship to child: _____

Signature: _____ Date: _____