Centennial:
6850 N. Durango Dr.
Ste 120
Las Vegas, NV 89149
Fax (702)826-4244

Warm Springs:
8352 W. Warm Springs Rd.
Ste 210
Las Vegas, NV 89113
Fax (702)944-4019

Bright Futures Pediatrics

Phone: (702)944-4028

Patient's Name: _____ **Date of Birth:** _____/_____/_____ **Gender: M / F**

Address:_____ **Apt:**_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Phone #:_____ **Secondary phone #:**_____ **Email:**_____

Pharmacy Name & Address:_____ **Phone #:**_____

Emergency Contact Name: _____ **Phone #:** _____ **Relationship:**_____

Sibling(s)

Name: _____ DOB____/_____/_____ Name: _____ DOB____/____/_____

Name: _____ DOB____/_____/_____ Name: _____ DOB____/____/_____

Mother's Name:_____ **Date of Birth:**_____/_____/_____ **Phone #:**_____
Address:_____ Apt:_____ City:_____ State:_____ Zip:_____
Employer/Occupation:_____ **Work #**_____ **SSN #** _____-_____-_____

Father's Name:_____ **Date of Birth:**_____/_____/_____ **Phone #:**_____
Address:_____ Apt:_____ City:_____ State:_____ Zip:_____
Employer/Occupation:_____ **Work #**_____ **SSN #** _____-_____-_____

Primary Insurance: _____ **Insurance ID #:**_____ **Group #:** _____
Subscriber's Name: _____ **DOB:** _____/_____/_____ **SSN #:** _____-_____-_____
Relationship to Patient: Self Mother Father Other: _____

Secondary Insurance:_____ **Insurance ID #:**_____ **Group #:** _____
Subscriber's Name: _____ **DOB:** _____/_____/_____ **SSN #:** _____-_____-_____
Relationship to Patient: Self Mother Father Other: _____

I HAVE READ AND UNDERSTOOD THE FOLLOWING FINANCIAL STIPULATIONS:

1. Payment is expected at the time of service.
2. Insurance Claims will be filed only for those insurance plans we are contracted with as a participating provider.
3. Co-pay's, Deductibles, and non-covered services are to be paid at the time of service.
4. If you are unable to keep your appointment please give a 24 hour notice or there can be a $25 fee.
5. I understand that my signature is valid for the purpose of filing my insurance and authorizing payment of benefits to Bright Futures Pediatrics and that the information provided above

PERMISSION TO TREAT

Bright Futures Pediatrics has permission to diagnose and to treat my child.

This consent will remain in effect until it is revoked by notifying Bright Futures Pediatrics in writing.

When he/she is accompanied by the following person(s) *Must be 18yrs or older*:

Name:_____ **Relationship:**_____ **Phone:**_____
Name:_____ **Relationship:**_____ **Phone:**_____
Name:_____ **Relationship:**_____ **Phone:**_____
Name:_____ **Relationship:**_____ **Phone:**_____

Printed Name:_____ **Relationship:** _____
(Parent or Legal Guardian)

Signature: _____ **Date:** _____
(Parent or Legal Guardian)

Missed Appointment / No-Show Policy

Quality care for our patients is our priority.

Please take a few minutes to review our no-show policy and sign at the bottom of the form.

Our staff works hard to offer you an appointment that is convenient for both you and your child. If circumstances prevent you from keeping your appointment, please call the office at least **24 hours in advance** to reschedule or cancel your appointment.

The goal of Bright Futures Pediatrics is to provide quality care to our patients. The relationship between doctor and patient is an equal commitment. When you make an appointment for your child/children to see one of our pediatricians, that time is set aside just for your child. Missed appointments prevent us from caring for another child that may need our services at that time. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice.

****Please remember that confirmation calls are a courtesy. It is the parent's responsibility to keep up with your scheduled appointment date and time, and to notify the office in advance when there is a need to cancel or reschedule.****

We attempt to confirm appointments 1 day in advance, however, **ultimately you are responsible to mark your calendar to assure you are available to keep the appointment.**

To ensure timely and efficient care for all our patients, we require the following:

- **Arrival Time:** Established patients are required to arrive 15 minutes prior to their scheduled appointment time and new patients are required to arrive 30 minutes prior to their scheduled appointment time.
- **No Grace Period:** If a patient arrives late, they may need to reschedule their appointment as we do not offer a grace period.
- **Cancellations, Reschedules and No-Shows:** If you are unable to make your appointment, please notify us at least 24 hours in advance to avoid a fee.

No Show Fees: Multiple patients scheduled will be subject to multiple no-show fees.

- **$25 no-show fee** may be charged to the account for any missed appointment.
- **$50 no-show fee** may be charged to the account for any missed procedures or evaluations appointments.
- **$100 no-show fee** may be charged to the account for a missed circumcision appointment.

Dismissal / Termination of Care: Patients having 3 or more no-shows within a 12-month period will be considered for dismissal.

Families who no-show for 2 or more patients scheduled at the same time, may be restricted from scheduling double appointments in the future.

Bright Futures Pediatrics Fees

Please note that there will be additional charges for documents completed by **Bright Futures Pediatrics.**

Your insurance company will not pay for these forms. Payment **must** be made prior to completing the forms, forms must be picked up, we **Do Not Fax forms.**

All payments are expected at the time of service. We **DO NOT** bill for patient co-pays.

Our office accepts cash and credit cards as payment **(We do not take personal checks)**

****If any forms such as health statements, sports physicals, or daycare forms that require to be filled out after 3 months from the last WELL CHECK we do charge $50.00 for visit and additional charge for corresponding form.****

Health Statements / Physical Forms / Medical Records / Etc.	Fee
Health statement, daycare forms, letters (Appointment needed)	$100
Sports Physical (appointment needed)	$100
FMLA Forms (**please allow 7-10 business days to complete**)	$100
Immunization Records	$5
Medical Records (**Fee is per page, please allow 7-10 business days to complete**)	$0.60

Please sign below that you read and understand our office policies.

Printed Name of Parent / Guardian: _____

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