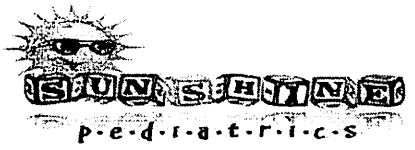

Parental Consent to the Use and Disclosure of my child's Health Information
For Treatment, Payment or Healthcare Operations.

Print Child's Name	D.OB.	Print Caregiver's Name

I understand that as part of my child's health care, Sunshine Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment.
- A means of communication among the many health professionals who contribute to my child's care.
- A source of information for applying diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a copy of Sunshine Pediatrics' Privacy Practices that describes a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Sunshine Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Sunshine Pediatrics may refuse to treat my child as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Sunshine Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Sunshine Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided (U.S. mail or, if agree, email).

I wish to have the following restrictions to the use or disclosure of my child's health information:

_____

_____

I understand that as part of Sunshine Pediatrics treatment, payment or healthcare operations, it may become necessary to disclose my child's health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Caregiver Signature	Date

SUNSHINE pediatrics

INFANCY, CHILDHOOD, ADOLESCENCE HISTORY

Date:_____

I

Child's Name _____ (last) (first)

Date of Birth _____ M F (circle)

Child Lives With_____

Address _____ (street)

_____ (city) (state) (zip)

Telephone No. _____

Previously Seen/Treated By _____ (Name of Doctor)

Address _____ (street)

_____ (city) (state) (zip)

Child's School _____ (name)

Child's AHCCCS ID Number _____

II. CHILD'S BIRTH HISTORY

During your pregnancy with this child, did you:

	Circle One			Circle One	
1. Have high blood pressure?	Yes	No	8. Get treatment for gonorrhea or syphilis?	Yes	No
2. Have diabetes or sugar in your urine?	Yes	No	9. Drink Alcohol?	Yes	No
3. Have albumin or protein un your urine?	Yes	No	10. How long was your pregnancy?	____ months	
4. Have a urinary infection?	Yes	No	11. How early did you start seeing the doctor?	____ months	
5. Have German (3 Day) measles?	Yes	No	12. Have this child early (premature)?	Yes	No
6. Take any medicines?	Yes	No	13. Have more than one baby delivered?	Yes	No
7. Smoke cigarettes?	Yes	No	14. Have a difficult labor/delivered?	Yes	No
			Was it a breech (bottom first) delivery?	Yes	No
			Was it a cesarean delivery?	Yes	No

III CHILD'S PAST/PRESENT MEDICAL/NUTRITIONAL HISTORY

1. Did your baby breathe/cry immediately at birth? Yes No
2. Was the baby jaundice at birth? Yes No
3. Did the baby have an RH problem? Yes No
   Receive blood? Yes No
4. At birth, did the baby appear normal? Yes No
5. Was Sickle cell Testing done at birth? Yes No
6. Was PKU Testing done at birth? Yes No
7. During baby's FIRST year, did you breast feed? Yes No
   How long?_____
8. During baby's FIRST year did you formula feed? Yes No
   How long?_____ (Weeks/Months)
9. If feeding problems, explain_____
10. Weaning from breast complete at_____ (Child's Age)
11. Whole milk started at _____ (Age)
    Problems/Allergies? _____
12. Solid food started at _____ (Age)
    Problems/Allergies? _____

INFANCY, CHILDHOOD, ADOLESCENCE HISTORY (CONTINUED)

IV. IMPORTANT MEDICAL INFORMATION

ILLNESS/ACCIDENT/SURGERY	COMPLICATIONS/SEVERITY	ALLERGIC REACTIONS TO: DRUGS, FOOD?	AGE OF CHILD
1.			
2.			
3.			
4.			

V. IMMUNIZATION INFORMATION

Dates if known:

NAME	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-5 yrs	11-12 yrs	13-18 yrs
1. Hepatitis B												
2. Hepatitis A												
3. DTAP/DTP/DT-TD												
4. TOPV (Polio Vaccine)												
5. HIB												
6. MMR(mumps, Measles, Rubella)												
7. Varicella (Chicken pox)												
8. PCV7(pneumococcal)												
9. TB (test)												

VI. SOCIAL/DEVELOPMENTAL HISTORY

1. Child has how many sisters_____ brothers?_____
2. Child is _____ (oldest, youngest, middle) in family?
3. Who spends most time caring for child? _____ (mother, father,etc.)
4. Does child go to day care, baby sitter or preschool on a regular basis? Circle one: Yes No
5. Child sat up at _____ (age)
6. Child crawled at _____ (age)
7. Child walked at _____ (age)
8. Child started talking at_____ (age)

VII. FAMILY HISTORY

Has any blood relative of your child never had or been treated for:

	Circle One		Circle One
1. Allrgies	Yes No	5. Heart trouble	Yes No
2. Blood disease	Yes No	6. Diabetes (Sugar in urine)	Yes No
3. Cancer	Yes No	7. Tuberculosis (TB)	Yes No
4. Lung disease	Yes No	8. Mental Illness	Yes No

VIII. CONCERNS/PROBLEMS

Does your baby/child have any on-going problem that concerns you? If yes, put an X in box

- ☐ Eats too little
- ☐ Eats too much
- ☐ Speaks unclearly
- ☐ Always has runny nose and/or cough
- ☐ Cries a lot
- ☐ Has frequent temper tantrums
- ☐ Doesn't always respond to noise or spoken word
- ☐ Sees poorly
- ☐ Won't sleep
- ☐ Frequently constipated
- ☐ Seems small for age
- ☐ Wets bed
- ☐ School problems
- ☐ Behavior Problems

Are there any other problems? Please write them down _____

_____

Signature_____ Reviewed by :_____

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a 'Notice of Privacy Practice' statement. The following is a generic 'Notice of Privacy Practice' statement designed to provide you with an idea of what you should expect to be receiving from your health care provider.

Sunshine Pediatrics

NOTICE OF PRIVACY PRACTICES

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.

Sunshine Pediatrics is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with sunshine pediatrics."*

> *"It is our policy to provide a substitute health care provider, authorized by sunshine pediatrics to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> "*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to sunshine pediatrics for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your*

scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Comeau Health Care Associates sponsored fund-raising events."

Change of Ownership.
In the event that Sunshine Peds is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however,that Sunshine Pediatricsis not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Sunshine Pediatrics amend your protected health information. Please be advised, however, that Sunshine Pediatrics is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Sunshine Pediatrics.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Sunshine Pediatrics reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, sunshine pediatrics is required by law to comply with this Notice.

Sunshine Pediatrics is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Guillermo Frietz by calling this office at 623-245-0505. If Guillermo Frietz is not available, you may

make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Sunshine Pediatrics has handled your health information should be directed to Guillermo Frietz by calling this office at 602-245-0505. If Guillermo Frietz is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of __01____/__01____/___2014____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Sunshine Pediatrics with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name :_____
   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:_____
   Last Name First Name MI

4. Primary Provider's Name:_____
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

Please be advised:

If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines for Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You.

Please sign below indicating that you understand and agree with the above statement.

Signature: _____ **Date:** _____

Vacunas para la Niñez (VFC)
Expediente de Elegibilidad del Paciente

El expediente de todos los niños de 18 años de edad o menores que reciben vacunas debe mantenerse en el consultorio del médico durante 6 años. El expediente puede ser llenado por el padre, tutor, el individual del expediente, o por el proveedor de atención médica. En cada visita de inmunización del niño se debe determinar su elegibilidad VFC y presentar documentación del estatus de elegibilidad para asegurar que su estatus de elegibilidad del niño no ha cambiado. Aunque no se requiere verificación de las respuestas, es necesario mantener este expediente similar para cada vacuna del niño. Los proveedores utilizando un formulario similar (electrónica o en papel) deben capturar todos los elementos de información incluidos en este formulario.

1. Nombre de Niño:_____
   Apellido Primer Nombre IM

2. Fecha de Nacimiento de Niño: __ __/__ __/__ __ __ __

3. Padre/Tutor/Individual de Expediente:_____
   Apellido Primer Nombre IM

4. Nombre del Proveedor Primario:_____
   Apellido Primer Nombre IM

5. Para determinar si un niño (0 a 18 años de edad) es elegible para recibir vacunas federales a través de programas de VFC y estatales, en cada visita de inmunización se registra la fecha y marque de categoría de elegibilidad apropiada. Si la columna A-D está marcada, el niño es elegible para el programa de VFC. Si la columna E, F o G está marcada el niño no es elegible para la vacuna federal de VFC.

	Elegible para VFC Vacuna				No elegible para VFC Vacuna		
	A	B	C	D	E	F	G
Fecha	Medicaid Inscrito	No Seguro de Salud	Nativo Americano o Nativo de Alaska	*Seguro Insuficiente servido por FQHC, RHC o proveedorers delegado	Tiene seguro medico que cubre las vacunas	**Otro seguro insuficiente	***Inscrito en KidsCare

** Seguro insuficiente incluye a los niños con seguro de salud que no incluye vacunas o sólo cubren ciertas vacuna especificas. Los niños sólo elegibles para las vacunas que no están cubiertos por el seguro. Además, para recibir la vacuna de VFC, los niños con seguro insuficiente deben ser vacunados a través de un Centro de Salud Federalmente Calificado (FQHC) o Clinica de Salud Rural (RHC) o en virtud de un proveedor delegado aprobado. El proveedor delegado debe tener un acuerdo por escrito con un FQHC / RHC y el programa de inmunización estatal / local / territorial con el fin de vacunar a los niños con seguro insuficiente.*

*** Otros insuficiente son niños que están con seguro insuficiente, pero no son elegibles para recibir la vacuna federal a través de programa VFC porque el proveedor o centro médico no es FQHC / RHC o proveedor delegado. Sin embargo, estos niños pueden ser atendidos si las vacunas son con tal que el programa estatal para cubrir los niños que no son elegibles para el programa de VFC.*

**** Los niños inscritos en el Programa de Seguro de Salud del estado separadas para Niños (CHIP). Estos niños se consideran asegurados y no son elegibles para las vacunas a través del programa VFC. Cada estado ofrece orientación específica sobre cómo se compra CHIP y administrado a través de los proveedores participantes.*

Por favor sea aconsejado:
Si su compañía de seguros no cubre las vacunas y no nos dejó saber en el momento de su visita, usted tiene la responsabilidad de pagar costo implicado. No podemos hacer el Programa de Vacunas para Niños retroactiva y sólo son elegibles para el Programa de Vacunas para Niños en el momento de la visita. Si no está seguro si la inmunización y chequeos anuales están cubiertos, por favor contactar su compañía de seguros. Gracias.

Por favor firme abajo indicando que usted entiende y está de acuerdo con la declaración anterior.

Firma: _____ **Fecha:** _____