Dr. Lillie Hidaji, MD
Dr. Rema Merhi, DO
702-476-2944 (p)
702-476-2958 (f)

OASIS
PEDIATRICS

www.oasispediatrics.com
8285 W. Arby Ave
Suite 255
Las Vegas, NV 89113

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

As required by the privacy regulations created as a result of the Helath Insurance Portability and Accountability Act of 1996 (HIPAA), we must provide you with the following important information:

- How we may use and disclose your protected health information (PHI).
- Your privacy rights with regard to your PHI
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your personal information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices as permitted by law. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past or that we may create or maintain in the future. Our practice will post a copy of our current Notice in a visible location, and you may request a copy of our most recent Notice at any time.

A. USES AND DISCLOSURES OF PHI

The following section describes different ways that we use and disclose your health information. Not every use or disclosure will be listed; however, we have listed various ways we are permitted to use and disclose medical information. <u>We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any authorization you provide may be revoked at any time by submitting the revocation to us in writing.</u>

1. **<u>Treatment</u>**. We may use and disclose medical information in the course of your treatment in order to provide, coordinate or manage your health care and any related services. This may include other providers, pharmacies or others who assist in your care, such as your spouse, children, parents, etc.

2. **<u>Payment</u>**. We may use and disclose your PHI, including records, to obtain payment for services and products you may receive from us. This may include activities associated with authorization of services, eligibility and coverage or obtain payment by your health insurance plan or other third parties that are responsible for such payment for information.

3. **<u>Health Care Operations</u>**. We may use and disclose your PHI to ensure accurate and appropriate business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, or licensing.

4. **<u>Disclosures Required By Law</u>**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

5. **<u>Release of Information to Family/Friends.</u>** Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you.

B. ADDITIONAL USES/ DISCLOSURE THAT MAY BE MADE WITH YOUR CONSENT / AUTHORIZATION / OPPORTUNITY TO OBJECT

We may use and disclose your PHI in the following instances - you have the opportunity to agree or object to all or part of your PHI being used or diclosed for these purposes. If you have not been able to agree or object, the provider will, using professional judgement, determine whether the use is in your best interest. In any event, only the PHI that is relevant to your health care will be disclosed.

1. **<u>Emergencies</u>**. We may use or disclose your PHI in an emergency treatment situation. If this happens, your provider will try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your provider is required by law to treat you and they have attempted to obtain consent but is unable, they may still use your PHI to treat you.

2. **<u>Others Involved In Your Helathcare</u>** Unless you object, we may disclose to a member of your family, relatives, close friends, or any other person you may identify that may be responsible for your care, your PHI that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information if we determine that it is in your best interest. We may use and disclose your PHI to an authorized public or private entity to assist and coordinate uses and disclosures to family or other individuals involved in your health care.

3. **Communication Barriers.** We may use and disclose your PHI if your provider attempts to obtain your consent but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent under the circumstances.

C. ADDITIONAL USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, YOUR AUTHORIZATION OR AN OPPORTUNITY TO OBJECT.

1. **Public Health.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate domestic violence. However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveilance.

2. **Health Oversight** We may use or disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and any disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor programs, compliance with civil rights laws and the health care system in general.

3. **Required by Law**. We may use or disclose your PHI to the extent required by law. The use or disclosure will be limited to the relevant requirements by the law. You will be notified, as required by law, of any uses.

4. **Legal Proceedings**. We may disclose your PHI in the course of any judicial or administrative proceeding, in response to a court or administrative order, discovery request, subpoena, or other lawful process by a third party involved in the dispute.

5. **Law Enforcement**. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes including:
    - Legal processes required by law
    - Limited information requests for indentification and location purposes
    - Pertaining to victims of crime
    - Suspicion that death has occurred as a result of criminal conduct
    - In the event that a crime occurs on the premises of the practice, and
    - Medical emergency (not on the practice's premises) and is likely that a crime has occurred

6. **Coroners, Funeral Directors, Organ Donation**. We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for other duties authorized by law. We may also disclose information to a funeral director, as authorized by law, in order to permit them to carry out duties. We may disclose such information in reasonable anticipation of death. PHI may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Food & Drug Administration**. We may disclose your PHI to an FDA authorized person or company to report adverse effects, product defects, biologic product deviations, track products, to enable product recalls, make repairs or replacements or conduct post-marketing surveillance, as required.

8. **Military Activity and National Security.** When appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate command authorities; (2) for purpose of determination by the Dept. of Veterans Affairs of eligibility for benefits; or (3) to foreign military authority if you are a member of such foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the present.

9. **Required Uses and Disclosures**. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of this notice.

D. YOUR RIGHTS REGARDING YOUR PHI

1. **Confidential Communications**. You have the right to request that our practice communicate with you regarding your health related issues in a particular manner or at a certain location. For example, you may ask that w contact you at home, but not leave a message on the answering machine or with the answering service. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer, listed below.

2. **Request Restrictions for your PHI.** You have the right to ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must make your request in writing to the Privacy Officer listed elsewhere on this Notice. You must include (1) information you wish restricted, (2) whether you are requested to limit our use, disclosure, or both, and (3) to whom you want the limits to apply.

   Your provider is not required to agree to a restriction. If the provider believes it is in your best interest to permit use disclosure of PHI, the information may not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

3. **Inspect and Obtain Copy of Your PHI**. You have the right to inspect and obtain a copy of PHI about you that is in your medical record. A medical record includes medical, billing and any other records used for making decisions about you. However, under federal law, you may not inspect or receive copies of the following: psychotherapy notes, information compiled in reasonable anticipation or, or use in civil, criminal or adminstrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. In some cases, you may have a right to have this decision reviewed. You may be required to submit your request for records in writing and a fee may be charged by the practice for the cost of the copying, mailing, labor and any supplies associated with your request.

4. **Request Amendments to your PHI**. You have the right to request an amendment of PHI about you in your medical record for as long as we maintain it. The request must be in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for an amendment. In certain cases, we may deny your request for an amendment. If your request is denied, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide a copy of such rebuttal.

5. **Request Accounting of Certain Disclosures of PHI.** This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice. You have the right to specific information regarding disclosures that occurred after April 14, 2003. This accounting is a list of certain non-routine disclosures our practice has made, if any, of your PHI. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer and must state a time period which may not be longer than six (6) years from the date of disclosure, and may not include dates prior to April 14, 2003.

6. **To Obtain a Paper Copy of This Notice**. Upon request you have the right to obtain a paper copy of this Notice even if you have previously agreed to accept this Notice electronically.

7. **Complaints/Questions**. If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to your PHI, you may send a formal complaint to us as well as the U.S. Department of Health and Humann Services Office for Civil Rights ("OCR"). We will not retaliiate in any way if you choose to file a complaint with us or with the OCR.

Privacy Officer
Oasis Pediatrics
8285 West Arby Ave #255
Las Vegas, NV 89113

U.S. Department of Health and Human Services Office for Civil Rights
Centralized Case Management Operations
200 Independence Avenue, S.W.
Room 515F HHH Bldg
Washington, D.C. 20201

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgement.

By signing this form, you further ackowledge that medical information collected at Oasis Pediatrics will be stored in a medical record system and kept securely in line with state and federal regulations.

Parent/Guardian Signature: ______________________________ **Date:** ______________

Parent/Guardian Printed Name: ____

If parent or legal guardian refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:

____

____

____

____

____

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OASIS PEDIATRICS

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Welcome to our practice! We look forward to caring for your child(ren).

Please help us serve you better by taking a few minutes to provide the following information.PLEASE PRINT CLEARLY.

PATIENT INFORMATION

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________

Race (Please Select One) ___Caucasian ___ Asian ___ Black/African American
___ Decline to Answer ___ American Indian or Alaska Native ___ Native Hawaiian/Other Pacific Islander

Ethnicity (Please Select One) ___ Hispanic/Latino _____ Non-Hispanic/Latino ___ Decline to Answer

PARENT / GUARDIAN INFORMATION (1)

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________
Relationship to Patient: ❍ Mother ❍ Father ❍ Foster ❍ Other ____________
Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widow(er) ❍ Separated
Mailing Address: ____________ **Apt/Unit Number:** ____________
City: ____________ **State:** ______ **Zip Code:** ______
Home Phone: ____________ **Mobile Phone:** ____________
Employer: ____________ **Occupation:** ____________
Preferred Method of Contact: ❍ Home ❍ Mobile ❍ E-mail: ____________
Preferred Language: ____________ **Religious Preference:** ____________

PARENT / GUARDIAN INFORMATION (2)

Last Name: ____________ **First Name:** ____________ **MI:** ______
Date of Birth: ____________ **Gender:** ❍ M ❍ F **Social Security Number:** ____________
Relationship to Patient: ❍ Mother ❍ Father ❍ Foster ❍ Other ____________
Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widow(er) ❍ Separated
Mailing Address: ____________ **Apt/Unit Number:** ____________
City: ____________ **State:** ______ **Zip Code:** ______
Home Phone: ____________ **Mobile Phone:** ____________
Employer: ____________ **Occupation:** ____________
Preferred Method of Contact: ❍ Home ❍ Mobile ❍ E-mail: ____________
Preferred Language: ____________ **Religious Preference:** ____________

EMERGENCY CONTACT

Name: ____________ **Relationship to Patient:** ____________
Preferred Phone: ____________ (❍ Home Phone ❍ Mobile Phone ❍ Work Phone)

PREFERRED PHARMACY INFORMATION

Pharmacy Name: ____________ **Cross Streets:** ____________
Address: ____________
Phone Number: ____________ **Fax Number:** ____________

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: ______________________ Plan Phone: ______________

Policy Holder's Name: ______________________ Policy Holder Date of Birth: ______________

Relationship to Patient: ______________ Social Security Number: ______ - ______ - ______

Policy Holder's Employer: ______________ Policy/Member Number: ______________

Group Name: ______________________ Group Number: ______________

Claims Address: ____

SECONDARY INSURANCE INFORMATION

Primary Insurance Company: ______________________ Plan Phone: ______________

Policy Holder's Name: ______________________ Policy Holder Date of Birth: ______________

Relationship to Patient: ______________ Social Security Number: ______ - ______ - ______

Policy Holder's Employer: ______________ Policy/Member Number: ______________

Group Name: ______________________ Group Number: ______________

Claims Address: ____

OFFICE POLICIES

If you are not the biological/adoptive parent for the patients listed on this form, you are required to provide paperwork stating that you have legal responsibility for the above named children. Children will not be seen without legal paperwork being scanned into chart ahead of the scheduled visit.	______ **Initial**
I certify that the information provided is true and accurate. It is my responsibility to notify the staff at Oasis Pediatrics of any changes of address, phone number, legal name, insurance information, or any other status changes that affect this account.	______ **Initial**
I hereby authorize the release of all information necessary to file a claim with my insurance company(ies). I assign benefits to be paid directly to Oasis Pediatrics and understand that I am responsible for charges accrued for medical services rendered to the above named patient regardless of insurance coverage, including but not limited to, any and all immunizations. A photocopy of this form is to be considered as valid as the original.	______ **Initial**
In the event of collection proceedings, I agree to pay any and all collection and legal fees. I further understand that balances not paid within 90 days from the date of service will be referred to a third-party collection agency and I will be responsible for any attorney fees, collection expenses and interest accrued. I also understand that this account will be listed with local and national credit bureaus.	______ **Initial**
I hereby authorize the physicians and clinical staff at Oasis Pediatrics to examine, administer vaccines, provide local anesthetic, provide medical/surgical diagnoses and/or treatments when necessary. This authorization shall remain in effect for one (1) year from the date of signature unless revoked sooner in writing.	______ **Initial**
I understand that I will receive a separate bill from the laboratory contracted with my insurance for any blood or urine samples or any cultures collected at Oasis Pediatrics.	______ **Initial**
It is my responsibility to contact Oasis Pediatrics if I am unable to keep my appointment. **I understand that if I do not give the office a 24 hour notice, I will be charged a $25 "no show" fee.** I also understand that if I am more than 15 minutes late for my scheduled appointment, I may be asked to reschedule. **THERE IS A $35 FEE FOR ALL RETURNED CHECKS.**	______ **Initial**

FMLA / HEALTH STATEMENTS

FMLA packets and extensive health statements: please allow 7-10 business days for forms to be filled out by physicians. There is a $25 fee per request and payment is due at the time of drop-off. **Completed forms can either be picked up by parent or faxed/mailed directly to the requesting agencies only. FMLA documents and statements cannot be emailed.**	______ **Initial**

SOCIAL MEDIA POLICY

Oasis Pediatrics is happy to keep its patients and families updated on insurance information, special events and milestones. While we pride ourselves in keeping contact with our families, we are not able to diagnose your child(ren) via messages on social media outlets that contain descriptions, images, or requests for prescription refills. Also, any issues regarding account status, balances or any other billing concerns should be directed to the office or the billing company directly. Social media messages regarding offical business will not be answered.	______ **Initial**

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PEDIATRICS

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Las Vegas, NV 89113

MEDICAL RECORD RELEASE

FOR RECORDS TO BE SENT TO OASIS PEDIATRICS FROM OTHER PRIMARY/SPECIALIST MEDICAL OFFICES

Patient Name: ______________________ **Date of Birth:** ____________

Patient Name: ______________________ **Date of Birth:** ____________

Patient Name: ______________________ **Date of Birth:** ____________

Patient Name: ______________________ **Date of Birth:** ____________

By signing this form, I authorize the release of confidential health information about my child(ren), by releasing a copy of medical records, or a summary narrative of protected health information, to the facility/physicians listed below.

The information you may release subject to this signed release form is as follows:

- ❍ Complete Records
- ❍ Progress Notes
- ❍ Lab Reports
- ❍ Hospital Reports
- ❍ Consultant Notes
- ❍ Radiology Reports
- ❍ Growth Charts
- ❍ Vaccination Reports
- ❍ Discharge Summary
- ❍ Other (Please Specify): ______________________

Please release my child(ren)'s protected health information to the following facility:

Oasis Pediatrics
8285 W. Arby Ave., Suite 255
Las Vegas, NV 89113
(office) 702-476-2644; (fax) 702-476-2958

Requesting release of information from:

Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code

Parent/Guardian Signature: ______________________ **Date:** ____________

Parent/Guardian Printed Name: ______________________

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702-476-2944 (p)
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PEDIATRICS

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Financial Policy

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Thank you for choosing Oasis Pediatrics as the primary health care provider for your child(ren). Our main concern is that your chid(ren) receives the proper medical care needed to maintain his or her health. If you have any questions, please do not hesitate to ask our staff and/or physicians.

All co-pays and deductibles are due at check-in, prior to being seen. Payments for services for cash visits are due at the time of the visit. We accept cash, checks and credit cards. There is a $35 fee for all returned checks.

We will submit insurance claims on your behalf if we have a contract with your insurance company. However, it is your responsibility to follow up if your claim is unpaid and to pay any remaining balances on your account.

If your insurance company is not yet contracted with Oasis Pediatrics, we will charge cash pay rates for the visit as well as any testing/labwork/vaccinations administered during the visit. **Once the necessary paperwork has been completed with your insurance carrier, we will bill them for office visits from the insurance-provided effective date for our office.** It is the guarantor's responsibility to pay for any non-covered services.

If for some reason, we are unable to obtain a contract with your insurance carrier, the collected payments will be posted to your account and visits will be considered cash pay.

Parent/Guardian Signature: ______________________________ **Date:** ______________

Parent/Guardian Printed Name: ____

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PEDIATRICS

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VISIT AUTHORIZATION

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

Patient Name: ______________________________ **Date of Birth:** ______________

I, ______________________, parent/legal guardian of the above-named minor(s), allow the following person(s) to accompany my child(ren) to Oasis Pediatrics for any health evaluations and in-house testing necessary for diagnosing present conditions. In-house testing may consist of, but not limited to, the collection of bodily specimens for laboratory analysis, procedures such as urine catheterizations, and the administration of necessary medications, both orally or via injection, for the treatment of presenting conditions. Administered medications may include but are not limited to medicated nebulizer treatments, oral medications to treat acute symptoms and the administration of routine vaccines.

Name: ______________________________ **Relationship:** ______________

Name: ______________________________ **Relationship:** ______________

Name: ______________________________ **Relationship:** ______________

Name: ______________________________ **Relationship:** ______________

Name: ______________________________ **Relationship:** ______________

Parent/Guardian Signature: ______________________________ **Date:** ______________

Parent/Guardian Printed Name: ______________________________

Visit authorization for the above named persons may be revoked at any time by the parent/legal guardian by submitting a new form to our office.

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Las Vegas, NV 89113

Authorization for Use and Disclosure of Protected Health Information (PHI)

FOR RECORDS TO BE SENT TO OTHER MEDICAL SPECIALIST OFFICES FROM OASIS PEDIATRICS

Last Name: ______________________ **First Name:** ____________________ **MI:** ________

Date of Birth: ______________________ **Social Security Number:** ______________________

Address: ____ **Apt/Unit Number:** ______________

City: ____________________________________ **State:** __________ **Zip Code:** ____________

Facility Authorized to Release Medical Records (PHI):

Oasis Pediatrics (Dr. Lillie Hidaji and Dr. Rema Merhi)

8285 W. Arby Ave * Suite 255 * Las Vegas * NV * 89113 (O) 702-476-2944 (F) 702-476-2958

Medical Records to be released to:

Facility / Physician Name:	Office Phone Number:	Office Fax Number:	
Address	**City**	**State**	**Zip Code**
Facility / Physician Name:	**Office Phone Number:**	**Office Fax Number:**	
Address	**City**	**State**	**Zip Code**
Facility / Physician Name:	**Office Phone Number:**	**Office Fax Number:**	
Address	**City**	**State**	**Zip Code**

Description of information to be used or disclosed:

❍ All PHI in Records
❍ History and Physical Reports
❍ Physician / Progress Notes
❍ Consultation Reports
❍ Discharge Summary
❍ Itemized Billing Statements
❍ X-Ray / Radiology Reports
❍ Laboratory Reports
❍ Patient Information Forms

The following PHI WILL BE released when included in the above medical information unless otherwise indicated:

● Psychiatric/Mental Health Information ● AIDS/HIV/Genetic Information ● Alcohol/Drug/Substance Abuse Information

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- If I do not sign this form, the care provided to my child(ren) and the payment for services rendered will not be affected unless stated otherwise.
- I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider(s) authorized to release the PHI.
- I understand if I do revoke this authorization that it will not apply to information that has already been released.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy of my child's information described on this form for a reasonable fee, should I request it.

Parent/Guardian Signature:	Date:
Parent/Guardian Printed Name:	

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Policy for Divorced or Separated Parents *(if applicable)*

Oasis Pediatrics' providers and staff are dedicated to our patient and to providing quality medical care to your child(ren). Our focus is on the medical, emotional, psychological and physiological health of our patients. We are not party to, nor can we be involved in any legal issues including divorce, separation, or custody agreements.

Please read and agree to the following so that we may provide quality care to your child(ren):

- Please make decisions regarding your child(ren)'s appointments, vaccinating, education and office procedures PRIOR to your scheduled appointment.
- Either parents or legal guardian can schedule an appointment for their child(ren), be present for the visit and/or obtain a copy of the visit summary. Unless there is a court order in the child(ren)'s record that restricts a parent's rights, please do not ask us to limit the other parent's involvement in the child's care.
- If there is no court order on file with our office, either parent/legal guardian can sign a "visit authorization" form that names individuals, such as other adult family members, to bring your child(ren) to our practice, be present during the visit and provide consent for any treatment during that visit. We will NOT be involved in any disputes regarding named individuals on the consent forms unless instructed by the court.
- Payments (co-pays, deductibles, account balances, etc) are due at the time of service and prior to the visit regardless of which parent is responsible for medical coverage. We cannot be party to your divorce or separation agreement. **We will collect payment due from the parent who brings the child to the visit.**
- It is both parents' responsibility to communicate with each other about the child(ren)'s care, office visit, date and any other pertinent information relevant to the patient. Is is not the responsibility of the providers and/or staff to communicate visit information to each custodial parent separately. Our office will not routinely call the non-attending parent following office visits.
- Oasis Pediatrics will not tolerate appointment schedule patterns of behavior between parents/ legal guardians. Please coordinate scheduling/canceling accordingly between parents. There is a strict no-show fee of $25 regardless of which family member initially scheduled the visit.
- Should any of the issues that come between parents become disruptive to our practice or impede the care of the child(ren), we reserve the right to discharge your family from the practice.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice. We appreciate your understanding with this matter.

Parent/Legal Guardian Signature	Parent/Legal Guardian Printed Name	Date
Parent/Legal Guardian Signature	Parent/Legal Guardian Printed Name	Date