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

OASIS PEDIATRICS

Phone: 702-476-2944
Fax: 702-476-2958
www.oasispediatrics.com

PATIENT INFORMATION:

Child 1: Last Name _____ First Name: _____ MI: _____

Preferred Name: _____ DOB: _____ Sex: _____ Primary Language: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Asian ☐ Black ☐ Caucasian ☐ Native Amer ☐ Pacific Islander ☐ Other

Child 2: Last Name _____ First Name: _____ MI: _____

Preferred Name: _____ DOB: _____ Sex: _____ Primary Language: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Asian ☐ Black ☐ Caucasian ☐ Native Amer ☐ Pacific Islander ☐ Other

Child 3: Last Name _____ First Name: _____ MI: _____

Preferred Name: _____ DOB: _____ Sex: _____ Primary Language: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Asian ☐ Black ☐ Caucasian ☐ Native Amer ☐ Pacific Islander ☐ Other

PARENT / GUARDIAN INFORMATION (REQUIRED):

Parent/Guardian (1): Last Name _____ First Name: _____ DOB: _____

Relation to patient: _____ Lives with patient: ☐ Yes ☐ No Social Security Number: _____

Address: _____

Primary Phone _____ Email Address: _____

☐ **Check here to make this the primary phone number on the account (only primary # will receive texts from office)**

Employer: _____ Occupation: _____ Work Phone: _____

Parent/Guardian (2): Last Name _____ First Name: _____ DOB: _____

Relation to patient: _____ Lives with patient: ☐ Yes ☐ No Social Security Number: _____

Address: _____

Primary Phone _____ Email Address: _____

☐ **Check here to make this the primary phone number on the account (only primary # will receive texts from office)**

Employer: _____ Occupation: _____ Work Phone: _____

EMERGENCY CONTACT (NON-PARENT REQUIRED):

Last Name: _____ First Name: _____ Relation to patient: _____

Primary Phone #: _____ E-mail Address: _____

INSURANCE INFORMATION (REQUIRED):

Primary Insurance _____ Policy # _____ Group # _____

Subscriber Name: _____ DOB: _____ Relation to patient: _____

Secondary Insurance: _____ Policy # _____ Group # _____

Subscriber Name: _____ DOB: _____ Relation to patient: _____

PREFERRED PHARMACY (REQUIRED FOR ALL PRESCRIPTIONS SENT):

Pharmacy Name: _____ Cross Streets: _____

Address if available: _____ Phone: _____

AUTHORIZATION FOR NON-PARENT/GUARDIAN TO ACCOMPANY PATIENT:

I, _____, give the person(s) listed below permission to bring my child to Oasis Pediatrics and to discuss and share medical information about my child(ren). I further authorize them to see all necessary medical records and make health care decisions, authorize treatment, vaccinations, medication and procedures deemed necessary by Oasis Pediatrics providers.

Name of person (allowed to accompany patient): _____ Relationship to child: _____

Name of person (allowed to accompany patient): _____ Relationship to child: _____

Name of person (allowed to accompany patient): _____ Relationship to child: _____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

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

OASIS
PEDIATRICS

Phone: 702-476-2944
Fax: 702-476-2958
www.oasispediatrics.com

OFFICE POLICIES

At every visit, front desk staff will verify patient's address, insurance plan and pharmacy on file. Please be cooperative as this helps our office in maintaining the most recent information for your family. It is the responsibility of the parent/guardian to update Oasis Pediatrics of any changes that affect your family's account.	_____ **Initial**
Most insurances require patients to assign Oasis Pediatrics or one of our providers as your child(ren)'s primary care provider in order to cover visits and allow our office to send referrals. It is parent/guardian responsibility to ensure that Oasis Pediatrics is assigned - our office is unable to self-assign as primary care provider.	_____ **Initial**
I authorize the providers at Oasis Pediatrics to examine, provide medical diagnoses and provide necessary treatments for my child(ren). It is parent/guardian responsibility to schedule and attend all medical appointments recommended by Oasis Pediatrics. It is parent/guardian responsibility to attend specialist/therapy appointments referred to by Oasis Pediatrics.	_____ **Initial**
Oasis Pediatrics advocates for disease prevention and emphasizes the importance of immunizing and safeguarding children against vaccine-preventable illnesses. Our providers will educate/guide regarding vaccines, therefore, **WE WILL NOT PROVIDE VACCINATION EXEMPTIONS OF ANY KIND**. Oasis Pediatrics will only accept patients who comply with the recommended vaccines from the American Academy of Pediatrics. All vaccines require parental consent prior to administration.	_____ **Initial**
OASIS PEDIATRICS DOES NOT ACCEPT WALK-IN APPOINTMENTS: Our office will do their best to accommodate patients until we reach our daily capacity, however, all patients MUST have a scheduled appointment time. Please call the front desk to schedule next available appointment. All voicemails left on scheduling line are returned same day.	_____ **Initial**
SICK VISITS/SYMPTOMS: To reduce the spread of illness and protect the health of all patients, especially infants, immunocompromised children, and those attending well-child visits - please proceed to the sick waiting room and use masks if you or your child have fever, cough, congestion/runny nose, vomiting, diarrhea, rash, suspected contagious illness.	_____ **Initial**
NO SHOWS: It is parent/guardian responsibility to notify Oasis Pediatrics if family is unable to keep an appointment. Parent/guardian should provide notice 24 hours prior to appointment to avoid $50 NO SHOW FEE. **TARDY: As a courtesy, there is a 15 minute grace period-if family arrives after 15 minutes, they will be asked to reschedule. Same day cancellations are considered no shows. ***PLEASE NOTE THAT THREE (3) NO SHOWS FOR ANY FAMILY MEMBER WILL RESULT IN THE ENTIRE FAMILY BEING DISMISSED FROM OASIS PEDIATRICS.**	_____ **Initial**
FMLA PACKET REQUESTS: Please allow 5-7 BUSINESS DAYS for FMLA forms to be completed by providers. There is a $35 fee for all FMLA forms, which is due prior to forms being picked up. Completed packets can either be picked up by parent, faxed or emailed directly to employer/requesting agency, or securely emailed to parent.	_____ **Initial**
RECORDING DEVICES IN EXAM ROOMS: During your appointments, we kindly request that you refrain from using any type of recording devices due to the privacy of our patients and staff.	_____ **Initial**
SOCIAL MEDIA / EMAIL: Oasis Pediatrics is not able to provide diagnoses via email or messages on social media that contain descriptions or images. Also, any questions or concerns regarding account, balances or other billing concerns should be directed to billing department at 702-948-8897 (Option 1). Such messages will not be answered.	_____ **Initial**
NON-URGENT MESSAGES may be left on the medical assistant line and will be acknowledged no later than the following business day. Please DO NOT LEAVE urgent messages on the medical assistant line. Non urgent questions will be discussed with providers before phone calls to parents/guardians are returned.	_____ **Initial**
While appointments may be scheduled for a specific time, no guarantee is made that a provider will see you at that exact time. We will make every effort to accommodate and see our families in a timely manner, however, we cannot foresee when patients may need extra time during appointments. **WAIT TIMES WILL VARY PER PROVIDER.**	_____ **Initial**
OASIS PEDIATRICS HAS A ZERO TOLERANCE POLICY FOR RUDE/AGGRESSIVE/THREATENING BEHAVIOR/COMMUNICATION TOWARD OUR STAFF. Any yelling, foul language, physical attacks or threats of harm, intimidation, damaging of property, discriminatory remarks, disrespectful or demeaning language/comments and any other unwelcomed negative behavior will not be tolerated and will result in the entire family being dismissed from Oasis Pediatrics.	_____ **Initial**

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

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

OASIS PEDIATRICS

Phone: 702-476-2944
Fax: 702-476-2958
www.oasispediatrics.com

FINANCIAL POLICIES

Oasis Pedaitrics is contracted with many insurance plans. It is the parent/guardian's responsibility to understand their child(ren)'s benefits, including copays, deductibles and covered services. Staff will verify if plans are active and if any copays, and/or deductibles are due prior to your child(ren)'s appointment.	_____ **Initial**
I authorize the release of all necessary information in order to file a claim with my insurance company. I assign benefits to be paid directly to Oasis Pediatrics and understand that I am responsible for charges accrued for medical services rendered to my child(ren) . Not all services billed to insurance may be covered - it is parent/guardian responsibility to know what benefits and services are offered/covered by insurance plans.	_____ **Initial**
In the event my insurance company is not contracted with Oasis Pediatrics or family loses coverage, parent/guardian may opt for cash pay rates for visits and services. Cash pay rates vary by service and are available upon request.	_____ **Initial**
Office fees are for provider services that take place at Oasis Pediatrics ONLY. Parent/guardian is responsible for informing providers of preferred lab or radiology offices and whether lab/radiology services are subject to copays, deductibles, coinsurance, or separate billing. Oasis Pediatrics is not responsible for lab/radiology billing.	_____ **Initial**
The parent or guardian who brings the child to the visit is responsible for payment, regardless of any custody arrangements. This includes all copays, co-insurances, deductibles AND PAST DUE BALANCES.	_____ Initial
It is my responsibility to keep my COORDINATION OF BENEFITS current with all insurance providers. Failure to do so may result in lack of payment from your carriers. Oasis Pediatrics is not responsible for non-payment from your plan due to missing COB and any balances incurred will become subscriber responsibility - due in full.**FAILURE TO DISCLOSE A COMMERCIAL INSURANCE AS PRIMARY WHEN YOU HAVE MEDICAID CONSTITUTES MEDICAID FRAUD**	_____ **Initial**
If any charges incurred by you or your dependents are submitted to a collection agency, you agree to pay all fees including, but not limited to, both collection agency fees and the account balance due to Oasis Pediatrics. Once the account has gone to collections, we cannot waive the collection agency's fees. Parent/guardian also understands that this account will be listed with local and national credit bureaus.	_____ **Initial**
Oasis Pediatrics accepts cash, all major credit cards and personal checks. Parent/Guardian agrees to pay a $35 fee for any returned checks, in addition to the original amount of the check. Phone payments with our front desk are also acceptable - you may request a receipt to be emailed or printed at your next visit if payments are done over the phone.	_____ **Initial**
While most insurnace plans do not require a copay for a routine well-child examination, addressing concerns outside the preventive scope of the visit may result in additional charges. In these cases, your insurance plan may apply a copay, deductible, or coinsurance as patient responsibility. Non-preventative concerns include, but are not limited to, illness symptoms, pain, behavioral concerns, or other issues not related to annual preventive care. **Coverage determinations are made by the insurnace carrier, not the practice.**	_____ **Initial**
Oasis Pediatrics reserves the right to discharge a family from our practice if balances older than 6 months old are left unpaid. Families may contact our billing offing at 702-948-8897 (Option 1) to discuss any questions regarding any balances due. Balances and any copays are due prior to any appointments and must be paid by the adult who accompanies the child(ren) to the appointment(s), or arragned to be paid ahead of time by parents.	_____ **Initial**

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____