Juniper Pediatrics

62930 O.B. Riley Road Ste. 300 Bend, Oregon 97703 Ph: 541-323-5515 Fax: 541-323-3505

First Name_____Middle_____Last_____ Age_____ ☐ Male ☐ Female

Date of Birth_____ Social Security #_____ Marital Status: ☐ M ☐ D ☐ S ☐ Other

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Which is best # to reach you? ☐ Home ☐ Cell

Email_____ Language_____ Race_____ Ethnicity_____

Employed: ☐ Yes ☐ No Patient's Employer_____ Position_____ Wk Ph_____ Ext_____

PARENT/RESPONSIBLE PARTY INFORMATION

Parent/Responsible Party/Legal Guardian_____ Relationship_____

Address (if different than patients)_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Social Security #_____

Employer_____ Work Phone_____ Date of Birth_____

OTHER INFORMATION

Spouse's Name_____ Spouse's Phone_____

Emergency Contact (if other than Spouse) _____ Relationship_____

Home Phone_____ Cell_____ Work Phone_____

INSURANCE INFORMATION

Primary Insurance Plan Name_____ ID#_____ Group #_____

Person who carries plan: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Name of person who carries plan_____ Date of Birth_____ Social Security #_____

Secondary Insurance Plan Name_____ ID#_____ Group#_____

Person who carries plan: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Name of person who carries plan_____ Date of Birth_____ Social Security #_____

TELEPHONE CONTACT INFORMATION

Do you have voicemail? Yes No May we leave a message with medical information? Yes No

May we contact you at work? Yes No May we leave a message with accounting information? Yes No

I hearby authorize Juniper Ridge Developmental and Behavioral Pediatrics, to furnish the insured's insurance company all information, which said insurance company may request concerning my present illness or injury. I hereby assign to said healthcare providers, all monies to which they are entitled for medical and/or surgical and/or counseling expenses relative to the services performed from time to time, but not to exceed my indebtedness to said providers. I understand I am financially responsible to said healthcare providers for all charges for services received.

X_____ X_____ Date_____

Guardian Signiture (if patient is under 18) Patient's Signiture

Today's date_____

Juniper Pediatrics

Patient Health History

Name_____DOB_____Age_____

Previous Physician_____Primary Care Physician_____

Present Health Concerns_____

Please list all medications currently taking:

Name of medication	Month/Year Started	Current Dose	Side Effects?

Herbs/Home Remedies_____

Allergies/Reactions to Medications/Food/Vaccinations_____

Place of Birth_____ If this is for a child, is this child yours by:

□ Birth □ Adoption □ Step-Child □ Other_____

Any difficulties during pregnancy/birth? □ No If yes, Specify_____

Delivery: □ Vaginal □ Caesarean If C-Section, why?_____

Birth Weight_____ Birth Length_____ APGAR Score 1 min_____5 min_____

Any medical problems during the child's newborn period?

□ None If yes, Specify_____

If premature, how early?_____

Other problems_____

SLEEP: Hours per night_____ Naps (number & Length)_____

Any sleep problems?_____

DEVELOPMENT: At what did child: Sit alone_____ Walk alone_____ Say words_____ Toilet train (day)_____

Girls only, Age to start menstruation_____

DENTAL: Has child been seen by a dentist? □ No □ Yes

IMMUNIZATIONS/INFECTIOUS DISEASES: **Please bring your child's immunization records.*

Has your child had: □ Chicken Pox □ Measles □ Mumps □ Rubella □ Meningitis □ Tuberculosis(TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (Old home/plumbing/peeling paint) □ No □ Yes

Do any household members smoke? □ No □ Yes Hours per Day: Computer_____Video games_____TV_____

Hospitalization/operations (with dates):_____

Broken bones or severe sprains:_____

SOCIAL: Who lives at home? Name Age Relationship Highest Education

_____

_____

_____

_____

Are your child's parents:

□ Married □ Unmarried □ Separated □ Divorced If divorced or separated, when?_____

Mother's occupation_____Mother's employer_____

Father's occupation_____Father's employer_____

Child care situation: □ Parents □ Others (specify who and hours per day) _____

_____

Concerns about your child: □ Alcohol □ Tobacco □ Sexual activity □ Aggressive Behavior

Is violence in the home a concern? □ No □ Yes Are there guns in the home? □ No □ Yes

Drug use? □ No □ Yes Do you have a smoke alarm? □ No □ Yes

SCHOOL: Did/does your child attend school or preschool? □ No □ Yes Current grade_____

Name of school_____Any concerns about school performance?_____

_____

Any concerns about relationship with: Teachers?_____

Students?_____

If more than 4 years old: Does your child have a best friend? □ No □ Yes

Sports/exercise: Type_____ How often?_____ How long (minutes)_____

REVIEW OF SYMPTOMS: Please check (✔) any current problems your child has on the list below:

Constitutional

_____Fevers/chills/excessive sweating

_____Unexplained weight loss/gain

Eyes

_____Squinting/"crossed eyes"/ Asymmetric gaze

Ears/Nose/Throat

_____Unusually loud voice/hard of Hearing

_____Mouth breathing/snoring

_____Bad breath

_____Frequent runny nose

_____Problems with teeth/gums

Cardiovascular

_____Tires easily with exertion

_____Shortness of breath

_____Fainting

Respiratory

_____Cough/wheeze

_____Chest pain

Gastrointestinal

_____Nausea/vomiting/diarrhea

_____Constipation

_____Blood in bowel movement

Genitourinary

_____Bedwetting

_____Pain with urination

_____Discharge: penis or vagina

Musculoskeletal

_____Muscle/joint pain

Skin

_____Rashes

_____Unusual moles

Allergy

_____Hay fever/itchy eye

Neurological

_____Headaches

_____Weakness

_____Clumsiness

Psychiatric/Emotional

_____Speech problems

_____Anxiety/stress

_____Problems with sleep/ nightmares

_____Depression

_____Nail biting/thumb sucking

_____Bad temper/holds breath jealousy

Blood/Lymphs

_____ Easy bruising/bleeding

_____Unexplained lumps

PAST MEDICAL HISTORY: Please describe any major problems and their dates:

Illness/Injury	Month/Year	Comments

Please mark beside the medical condition who in the family had this condition by using the following numbers:

1. Dad **2**. Mom **3**. Brother **4**. Sister **5**. Dad's Mom **6**. Dad's Dad **7**. Mom's Mom **8**. Mom's Dad

9. Dad's Brother **10**. Dad's Sister **11**. Mom's Brother **12**. Mom's Sister

Admin use only	**Medical Condition**	**Whom**
	Alcoholism	
	Anemia	
	Asthma	
	Attention Deficit Disorder	
	Autoimmune disorder	
	Bleeding problem	
	Cancer, Breast	
	Cancer, Melanoma	
	Cancer, Ovary	
	Congenital Anomaly/birth defect	
	Heart Attack/Heart Disease	
	Depression	
	Diabetes, on insulin shots	
	Diabetes, not on insulin	
	Eczema	
	Food Allergy	
	Genetic Disorders	
	Hay Fever	
	Hearing Disorder	
	High Cholesterol	
	High Blood Pressure	
	Immune Disorder	
	Kidney Disease	
	Learning Disability	
	Mood Disorders/Bipolar	
	Stroke	
	Substance Abuse/Addiction	
	Schizophrenia	
	Thyroid Disorders	
	Tobacco Use	
	Tuberculosis	
	Death before age 58 for reason not listed	
	Other:	

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DBA: Juniper Ridge Developmental and Behavioral Pediatrics

Fee Schedule for Consultation and Courtroom Testimony

by Deborah Coehlo PhD, C-PNP, PMHS, CFLE

Introduction

This agreement memorializes the terms of me being your expert in Developmental and Behavioral Sciences. I have extensive experience serving as an expert witness in a variety of legal proceedings in the area of family and child health with children experiencing special health care needs.

I set forth the terms of my engagement in writing in order to avoid misunderstandings. I ask that you indicate your agreement by executing your copy of this letter and returning it to me.

Services

A developmental and behavioral specialist uses a variety of techniques to determine and then document the psychological and physical health of children and their families. These techniques include, but are not limited to clinical interviews, psycho-diagnostic testing, interviews with collateral sources and preparation of written reports and letters if requested. Once the evaluation is complete, I may be asked to provide testimony in a court.

Location of Provision of Services

Except where special arrangements have been made, all services will be provided at my clinic at the above stated address.

Fees

Courtroom testimony is billed at a rate of $300 per hour. If I have to wait, the waiting time will be billed at $80 per hour.

Consultation via telephone, e-mail, or in-person meetings will be billed at $200 per hour.

A written statement, report, or letter costs $100 per page.

Travel will be billed at $80 per hour plus .50 cents per mile.

**Time will be calculated in 15 minute increments.*

Cancellation Policy

I have to make room in my schedule for courtroom testimony, so please provide as much time as possible in advance to schedule appointments to do so.

Late cancellations are highly disruptive to my schedule and my other patients. If an appointment is cancelled too late for me to reschedule my day, you will be billed at $200 per hour for the time I blocked for you.

Acknowledging Signatures

If these terms are acceptable to you, please sign where indicated below on the enclosed copy of this letter and return it to me.

By signing below, you agree these terms are acceptable to you and you agree to be bound by them. Thank you for your confidence. I look forward to working with you on this matter.

_____

Parent/Guardian Date

_____

Attorney of Record Date

_____

Deborah Coehlo, Ph.D., Expert Witness in Psychology Date

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Patient Contract and Financial Policy

Thank you for choosing Juniper Ridge Development and Behavioral Pediatrics as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our clinic and financial policies is important to our professional relationship. Please understand that payment for services is a part of that relationship and please ask if you have any questions about our fees, policies, or your responsibilities.

Patient Contract

Prescription Refills
Our office requests that you provide us with *at least* a 7-day notice regarding any prescription refills, especially with medications that cannot be called into a pharmacy.

Financial Policy

Copayments
The patient, including a minor, is expected to present an insurance card at each visit. All copayments as well as past due balances are due at time of check-in. If we have to bill you for your copay, there will be a $20 charge. We accept cash, in-state checks or credit cards.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment at the time of service.

Many insurance companies require us to obtain a waiver or a Medicare Advance Beneficiary Notice (ABN) before providing you services we expect might be denied for coverage. This waiver or ABN documents that you are aware coverage for services might be denied and you agree to be financially responsible for the charges. In these cases, refusal of signature will result in cancellation of your visit.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay $250 at the initial appointment and $100 for each subsequent appointment. Patients will be asked to make payment arrangements for the balance. Extended payment arrangements are available if needed. Please ask to speak with our billing coordinator to discuss a mutually agreeable payment plan.

Refunds
Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received.

Missed Appointments
Juniper Ridge Developmental and Behavioral Pediatrics requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled will be charged a fee of $50.00. If there have been multiple cancellations, the patient may be discharged from the practice or they may be required to pay $100.00 prior to rescheduling an appointment.
NOTE: New patient 2 hour appointments require a 3 day notice of cancellation. New patient appointments missed and not previously cancelled within 3 business days will be charged $100.00. Self pay accounts will require $250.00 paid within 3 business days of the appointment.

Returned Checks
The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) must be present for treatment, following state laws. The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. Unaccompanied minors to an office visit must show ability to pay for services with cash or supply contact with responsible parent(s) or guardian(s) who must authorize charges and make any payments due at time of service.

Outstanding Balance Policy
If an account becomes past due and no payment arrangements have been made with Juniper Ridge Developmental and Behavioral Pediatrics or if a payment plan agreement has not been kept, the account will be turned over to a collection agency. If this should occur, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. In addition, your provider may choose not to see you for future services if you have an outstanding balance and are not current with a payment plan.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the patient contract and financial policies of Juniper Ridge Developmental and Behavioral Pediatrics.

Print Name of Patient:_____DOB_____

Print Name of Responsible Party:_____

Signature of Responsible Party:_____Date:_____

Juniper Pediatrics

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DBA: Juniper Ridge Developmental and Behavioral Pediatrics

Patient Acknowledgement and Consent

I understand that Juniper Pediatrics DBA: Juniper Ridge Developmental and Behavioral Pediatrics will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status and similar types of health-related information.

I understand and agree that Juniper Pediatrics may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among and manage along with other healthcare providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my healthcare provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

I understand I have the right to receive and renew a written description of how Juniper Pediatrics will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Juniper Pediatrics and my rights regarding my health information.

I understand the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of Juniper Pediatrics' Notice of Privacy Practices in effect will be available in the waiting or reception area.

I understand I have the right to ask that some or all of my health information is not to be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Juniper Pediatrics is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices to review.

Patient Name (Please Print): _____ DOB: _____

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

This authorization must be written, dated and signed by the person authorized by law to give the authorization.

Patient Name: _____ DOB: _____

I authorize the following individual or agency:

Facility or Provider Name: _____

Address: _____

Phone #:_____ Fax#: _____

Parent Name and Phone #: _____

To provide information to:

Juniper Ridge Developmental and Behavioral Pediatrics
2275 NE Doctors Drive Suite #1
Bend, OR 97701
Phone: (541)323-5515
Fax: (541) 323-3505

By **initialing** the space below, I specifically authorize the release of the following medical records, if such records exist:

____ Entire medical record
OR
___ Mental health records
___Drug and alcohol treatment
___Transfer of care
___ Other (Specific Record Request) _____

I agree that the agencies and individuals listed above may share and exchange information about my family and child.
Yes____ No____

___ Parent ___ Guardian ___ Legal Custody

Signature: _____ Date: _____

I understand that this authorization may be revoked at any time. The only exception is when action has been taken in reliance on this authorization. Unless revoked earlier, this consent will expire in 180 days from the date signed. I also understand the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

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Juniper Ridge Developmental and Behavioral Pediatrics
2275 NE Doctors Drive Suite #1
Bend, OR 97701
Phone: (541)323-5515
Fax: (541) 323-3505

To provide information to:

Facility or Provider Name: _____

Address: _____

Phone #:_____ Fax#: _____

Parent Name and Phone #: _____

By initialing the space below, I specifically authorize the release of the following medical records, if such records exist:

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Bend, OR 97703

Phone: (541) 323-5515 Fax: (541) 323-3505

Patient Name:_____ DOB:_____

Medical Records Request Fee

The office of Juniper Pediatrics will provide your records to you once you have completed the Patient Authorization for Use/Disclosure of Protected Health Information (PHI) form. You can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20	$25.00
Pages 21+	$ 5.00 per each page after page 20

Form and Letter Fee

This is to notify you that the office of Deborah P. Coehlo, PhD, PNP, PMHS, CFLE, will apply a fee of $50.00 to your account for patient, companies, family members, insurance carriers or other person requesting form and/or letters to be completed.

Forms include, but not limited to FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, insurance companies, employers, schools, airlines, travel agents, gyms, etc. This does not include summaries of diagnosis and treatment to residential treatment programs, or to attorneys/judges. The fee for extended reports will be $250.00.

In order to comply with federal laws including HIPAA, as well as Oregon state and federal statues, this office must have a signed authorization from the patient/responsible party stating who we are authorized to release information to. You can contact our office and we can mail or fax the form to you. Please be sure to sign the form.

Unsigned requests cannot be processed.

_____ _____

Signature of patient or responsible party Date