PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

DATE: _____

CHILD'S NAME: _____ **DOB:** _____

NAME OF PARENT/GUARDIAN: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT:

□ **PARENT**

□ **LEGAL GUARDIAN**

□ **FOSTER PARENT**

□ **SELF (OVER 18 YEARS)**

PLEASE BRING:

□ **INSURANCE CARD**

□ **IMMUNIZATION RECORD**

□ **CHILD'S BIRTH CERTIFICATE (NEWBORNS)**

□ **PHOTO ID (PARENT/GUARDIAN)**

□ **FOSTER PARENTS/LEGAL GUARDIANS MUST HAVE GUARDIANSHIP/CUSTODY AGREEMENT PAPERWORK (AT ALL TIMES)**

PLEASE PRINT CLEARLY
Write N/A if Not Applicable

Please fill ALL blanks

Patient Registration

Patients Name: _____ DOB: _____ Age: _____

Patients Social Security Number: _____ Sex: ☐Male ☐Female

Address: _____

City, State, Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Alternate Phone (____) _____-_____

Child Lives with: ☐ Mother ☐ Father ☐Other: _____

*(If **OTHER**, **MUST** provide guardianship agreement)*

Race: (optional) _____ Language(s): _____

Emergency Contact: _____ Phone Number: (____) _____-_____Relation: _____

What PHARMACY do you use? _____ On:(Cross Street) _____ Phone #: (___) ____-_____

NOTE: IF OVER 18 YEARS OF AGE, SKIP TO INSURANCE INFRORMATION

Mother's Name: _____ DOB: _____

Driver License Number: _____ Social Security Number: _____

Address: (if different from above) _____

Employer: _____ Work Phone: (____) _____-_____

Father's Name: _____ DOB: _____

Driver License Number: _____ Social Security Number: _____

Address: (if different from above) _____

Employer: _____ Work Phone: (____) _____-_____

Responsible party status: ☐Married ☐Single ☐Divorced ☐Widow

Insurance Information: Please provide reception with insurance card(s)
☐Medi-Cal ☐HMO ☐PPO ☐Other: _____

Primary Insurance: _____ ID # _____

Subscriber: _____ Relation: _____ Co-payment: $_____

Primary Insurance: _____ ID # _____

Subscriber: _____ Relation: _____ Co-payment: $_____

☐ I authorize the release of medical information necessary for the completion of insurance forms; I authorize payment directly to Dr. Khaira, M.D. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

➧ **Signature:** _____ **Date:** _____

Patient History Form

(This medical document is strictly confidential and will not be released without your written authorization)

Last Name:_____ **First Name:**_____ **Middle:**_____

Date of Birth:_____ **Birth Place(City, State, Country):**_____

MEDICAL HISTORY

AIDS/HIV	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Other:_____		
Heartburn	☐ Yes	☐ No	Low Back Pain	☐ Yes	☐ No	Other:_____		

Previous Surgeries:	**Date(s):**	**Hospital,City,State:**

Medications (please include prescription, over the counter, vitamins, herbal remedies, etc):

Name	Dose	Frequency

DRUG ALLERGIES:_____

PRINT NAME: _____

SIGNATURE: _____ **Date:** _____

Family History

(All Close Relatives of the patient, both father & mother's side)

Affected Member→ **Disease↓**	Mo.	Fa.	U.	A.	G.P.	Sis.	Bros.	Self
Tuberculosis								
Diabetes								
Asthma								
Hay Fever								
Eczema								
Allergies								
Anemia								
Leukemia								
Lead Poisoning								
Epilepsy								
Neurological Disorder								
Cerebral Palsy								
Mental Retardation								
Birth Defects								
Cancer								
Heart Defect								
Heart Disease								
High Blood Pressure								
Low Blood Pressure								
Rheumatic Fever								
Immune Deficiency								
Lupus								
Rheumatoid Arthritis								
Crohn's Disease								
Ulcerative Disease								
Psychosis								
Mental Disease								
Neurological Disease								
Early Death								
Chronic Illness								
Other								

Parent Consent to Treat a Minor

Date: _____

Being the parent or legal guardian of _____,
(Minor's Printed Name)

I _____ do consent to any x-ray, lab test, Anesthetic,
(Parent/Guardian Printed Name)
medical, surgical, or dental diagnosis or treatment that Pediatric Medical Group, Inc. may deemed necessary for my minor child.

Minor's DOB: _____/_____/_____

Parent/Guardian's Signature: _____

Home Phone #: (_____) _____

Cell Phone #: (_____) _____

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for _____ to receive the health screening tests and
(Name of patient)

immunizations recommended by the CHDP Program from _____.
(Name of provider)

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

☐ School

Name

Address (number, street)	City	State	ZIP code

☒ Health care provider

Name

Address (number, street)	City	State	ZIP code

☐ Other

Name

Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.

Missed Appointment Declaration

Child's Name: _____ DOB: _____

Being the Parent/Guardian/Self, over 18 years if age. I understand Pediatric Medical Group, Inc. has a **"Three Strikes"** policy and enforces the following:

1. All appointments will be honored by the clinic staff.
2. All office visits are by appointment only, we do not accept walk-ins as they interfere with scheduled appointment times.
3. I understand that it is important to arrive ON TIME for appointments.
4. I understand at the discretion of the staff, any appointment that is 15 minutes late will be cancelled and rescheduled.
5. I understand if I am not able to keep a scheduled appointment, I will give in the very least 24 hour notice for all cancelled appointments.
6. I understand if a Well Child Exam is needed, I must plan ahead and schedule an appointment 1 to 2 months in advance.
7. I understand Pediatric Medical Group, Inc. will document missed appointments. In that if "Three" appointments are missed without informing the staff my child will or can be dropped from the clinic.

This policy is in place to provide a high level of service to those children that need care. Appointments that are missed compromise other children's health.

I understand this policy and will adhere to these rules.

Print Name: _____

Signature: _____ Date: _____

Policy Regarding Patient Financial Responsibility

Providing quality pediatric care for our patient is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. **We ask you to read and sign the following acknowledging that you have been advised of your financial responsibilities for medical services provided here at Pediatric Medical Group, Inc.**

We accept most insurance plans; therefore **please provide us with your insurance card**. We will let you know if your plan is one for which our doctors are designated provider. If you wish to be seen here, you are responsible for payment of **ALL co-pays** and or **deductibles required by your insurance** if any, **are due at time of service.**

Please be aware that not all insurance policies cover all conditions and fees. To be fully aware of your schedule of benefits please read your insurance policy or contact your insurance representative.

Some elective procedures, such as circumcisions, may not be covered by your insurance, or your insurance may only cover part of the charge. **Please be aware that you may be responsible for any charges not fully paid by your insurance.**

We accept most forms of payment, including **cash, credit cards, or checks**. If you are not going to be able to attend a scheduled appointment, 24 hours' notice is mandatory. Please be aware you may be charged for a missed appointment. **Three (3) missed appointments may result in discharge from the clinic.**

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided at this office. I hereby assume and guarantee payment of expenses incurred during any visit. Should legal action be required to secure payment, I agree to pay the legal expenses incurred by this clinic.

Patient Name: _____

Signature of Parent or Responsible Party: _____

Date: _____

Chaperone Consent to Treat

Why Your Child Should Have a Consent Form on Record

Parents/Legal guardians are not always available to take their children to their medical appointments. For example, if they are on vacation or are at work. Pediatric Medical Group, Inc. will not provide care to a minor patient under the age 18 if a parent or legal guardian is not present; unless a parent has granted permission.

Date: _____

I, _____ Parent /Legal Guardian of

Child's Name: _____ DOB: _____

I authorize _____ & _____ to bring my child to Pediatric Medical Group, Inc., to receive ALL medical care needed including immunization(s). I understand the above named party is responsible for informing me of all information related to services received.

Printed Name of Parent/ Guardian: _____

Signature of Parent/Guardian: _____

Phone Number: (_____) _____

Alternate Phone Number: (_____) _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS RELEASE REQUEST

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I, _____, AUTHORIZE THE USE AND / OR RELEASE

OF MY PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) FROM:

_____
(Doctor's name or office)

_____
(Address)

_____
(City) (State) (Zip)

_____ _____
(Phone#) (Fax#)

TO BE RELEASED TO:

PURPOSE OR NEED FOR DISCLOSURE:

EXPIRATION: This authorization is effective immediately and will remain in effect until _____, or for one year from the date of signature below.

REVOCATION: This authorization is subject to revocation by written notice by the undersigned below. Revocation of this authorization will not effect any action taken in reliance to this authorization before receipt of the revocation notice. REDISCLOSURE: The request may not lawfully further the protected health information unless another authorization is obtained or required by law.

SIGNATURE: I have had full opportunity to read and consider the contents of this authorization, and I confirm the contents with my direction to the health provider. I understand that by signing this form, I am confirming my authorization that the health care provider may use and / or disclose to the person / organization mention in this form the protected health information described in this form. I understand that I have the right to receive a copy of this authorization.

SIGNATURE: _____ DATE: _____