AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

San Dimas Pediatrics

500 40th Street, Bakersfield CA 93301

Phone: (661) 327-3784 Fax: (661) 327-0164

Patient's Name: _____ Date of Birth: _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize _____to use and
(Release from)
disclose a copy of the specific health information for the individual identified above to

_____
(Release to)

The request is made for the following purposes: *(Please check which applies)*

_____Personal Use
_____Attorney Use
_____Transfer Care
_____To obtain additional benefits
_____Payment of a claim
_____Other:_____

I specifically authorize the use and/or disclosure of the following health information to the extent such information and/or medical records exist. Please specify what health information that you would like to request:

Type of Information	[X] Check if Applicable	Applicable Dates with the Information
Visit History		
Immunization Records		
Laboratory Reports		
Radiology Reports		
Diagnostic Reports		
Billing Records		
Other:		

I understand that treatment, payment, enrollment or eligibility for benefits will not be denied based solely on my refusal to provide this authorization, unless the following applies:

- the treatment is research-related and the recipient identified above is seeking to use the information to conduct such research; or
- the recipient is a health plan which seeks to obtain information (except psychotherapy notes) in connection with my eligibility or future enrollment in the health plan; or
- the sole purpose of the treatment is to create health information to provide to the recipient identified above.

I understand that:

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

San Dimas Pediatrics
500 40th Street, Bakersfield, CA 93301
Phone: (661) 327-3784 Fax: (661) 327-0164

- There may be exceptions where the revocation of the authorization may not be able to be honored.
- There is a potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected.
- Any valid written revocation received by San Dimas Pediatrics shall not apply to information that has already been released pursuant to this authorization or affect actions taken by San Dimas Pediatrics prior to such written revocation.

This authorization will expire on date: _____.

_____ _____ _____AM/PM
Patient/Parent/Conservator/Guardian Date Time

Relationship to Patient: _____

_____ _____ _____AM/PM
Office Staff Witness Date Time

PATIENT/FAMILY REGISTRATION FORM

Valley Children's MEDICAL GROUP

Date: _____

How did you hear about us? ☐ Physician ☐ Friend ☐ Current Patient ☐ Web ☐ Social Media ☐ Insurance ☐ Other _____

Interpreter needed: ☐ Yes ☐ No

Patient's Last Name	First Name	Middle	Date of Birth	Gender	Primary Language	Ethnicity /Race
1.						
2.						
3.						
4.						

Parent/Guardian: *Guarantor* ☐ Patient Residence ☐

Name: Last	First	MI	Date of Birth	Social Security Number

Street Address	City	State	Zip	Relationship to Patient

Cell Phone	Home Phone	Work Phone	Email
( )	( )	( )	

Employer	Address

Parent/Guardian: *Guarantor* ☐ Patient Residence ☐

Name: Last	First	MI	Date of Birth	Social Security Number

Street Address	City	State	Zip	Relationship to Patient

Cell Phone	Home Phone	Work Phone	Email
( )	( )	( )	

Employer	Address

Emergency Contact: *Please list someone other than parent/guardian*

Name	Relationship to Patient	Phone

Preferred Method of Contact: *Please indicate how we should contact you*

☐ Cell Phone ☐ Home Phone ☐ Work Phone

_____/_____/_____

Print Name of Parent/Guardian/Self | Signature of Parent/Guardian/Self | Date

_____ _____

Signature of Office Staff | Date

_____/_____/_____

Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

(Only sign and date if no change from previous year)

_____/_____/_____

Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

(Only sign and date if no change from previous year)

NEW PATIENT HEALTH INFORMATION

Valley Children's MEDICAL GROUP

Patient Name: _____ **Date of Birth:** _____

Patient's Past Medical History							
System	**Yes**	**No**	**If yes, describe**	**System**	**Yes**	**No**	**If yes, describe**
Genetic/Neurological				Genitourinary/Kidney			
Vision/Eyes				Bones/Muscle			
Hearing/Ears				Blood/Cancers			
Psychiatric/Behavioral				Endocrine/Glands			
Development/Learning				Infections			
Speech/Swallowing				Menstrual			
Heart/Vasculature				Past Surgeries			
Respiratory/Lungs				Past Hospitalizations			
GI/Digestive				Allergies: (specify)			
Dermatologic/Skin				Sleep Problems: snoring			
Autoimmune Disease				Frequent Headaches			
Obesity				History of Serious Injury			
Other							

Immediate Family Medical History							
Condition	**Yes**	**No**	**If yes, describe**	**Condition**	**Yes**	**No**	**If yes, describe**
Heart Disease under 55				Autoimmune Disease			
High Blood Pressure				Allergies			
Cholesterol				Asthma			
Pulmonary Disease				Eczema			
Diabetes				Birth Defects			
Cancer				Neurological			
Thyroid Disease				Developmental			
Bleeding Disorders				Psychiatric			
Behavioral				Other			

Social History	
Parent's Marital Status	
Siblings(Names)Age/Gender	
Recent visit to ER/Urgent?	**Date and location:**
Smoking in the Home?	
Regular Dental Visits	
Exposure to Lead?	

Birth History					
Birth Weight		Gestational Age?		Vaginal or C Section?	
Hospital Name			Adopted, IVF or Surrogate?		
Any complications?					
During Pregnancy did the Mother:	Use Tobacco ☐ Yes ☐ No		Use Drugs or Medications ☐ Yes ☐ No		Drink Alcohol ☐ Yes ☐ No

If patient is currently in foster care or has special care arrangements in place, such as custody arrangements, please let our staff know how we can assist you.

GENERAL CONSENT TO TREATMENT

Patient's Name: _____

Date of Birth: _____

I _____, am the parent or legal guardian duly authorized to give consent on behalf of the patient listed above. I understand that by signing below, I am providing a general consent for the patient listed above to receive health care services from Valley Children's Primary Care Group. I understand that I may revoke this general consent at any time. The consent will remain in full force and effect until it is revoked.

I further acknowledge that Valley Children's Primary Care Group may request that I review and execute additional informed consent documents prior to the above-named patient receiving certain treatment or undergoing certain procedures. Prior to signing an additional informed consent document, Valley Children's Primary Care Group will provide me with all information that is material to deciding whether to consent to the recommended procedure or treatment for the above-named patient. Such information will include, but not be limited to: 1) the nature of the recommended treatment; 2) the risks, complications, and expected benefits of the recommended treatment including, but not limited to, the likelihood of success; and 3) any alternatives to the recommended treatment, and the risks and benefits to the alternative treatments.

I have read the above and hereby generally consent to the above-named patient receiving health care services from Valley Children's Primary Care Group.

_____

Parent/Guardian Date

_____

Print Name Date

FINANCIAL POLICY & ASSIGNMENT OF INSURANCE BENEFITS

Valley Children's MEDICAL GROUP

Patient Name: _____ DOB: _____

Please list the types of insurance coverage which you have and provide the receptionist with your insurance cards.

	Primary	Secondary
Company		
Subscriber Name		
Subscriber DOB		
Subscriber SSN		
Policy or ID #		
Group #		
Relationship to Patient	☐ Mother ☐ Father ☐ Step-Parent ☐ Guardian	

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

- I hereby authorize payment directly to Valley Children's Medical Group of any medical/surgical benefits payable to me under the conditions of my policy for services rendered.
- I hereby consent to the release of the above-named patient's financial and medical information concerning care, treatment and charges for the purpose of completing all claims for benefits.

FINANCIAL POLICY

1. Each patient is responsible for his/her own bill. The required co-payment must be paid at the time of service.
2. As a courtesy, the office will submit claims to your insurance carriers. It is the insured's responsibility to provide current information regarding any changes with insurance carriers.
3. It is the insured's responsibility to pursue slow payment or non-payment on the part of his/her insurance company directly regarding the claim. We will be happy to assist you with any collection problems; however, the bill remains the full responsibility of the patient.
4. The following fees may be applied:
   - $15.00 service charge for all returned checks
   - $20.00 NO SHOW fee may be charged for failure to cancel an appointment at least 24 hours in advance
   - $25.00 Form fees for FMLA, medical records and other miscellaneous forms
   - $25.00 fee may apply for preparation of medical records
5. Payment arrangements must have a minimum monthly payment of $25 and must be paid within one year. Account becomes delinquent after 60 days of no activity and may be sent to collections after 90 days.
6. Patients will receive a monthly statement only when there is a balance due. Charges which have not been paid by insurance will be transferred to patient responsibility for which you will receive a statement. All patient due balances are expected to be paid within 30 days of receipt of the statement.
7. For those patients participating in a managed care plan, it is your responsibility to inform the doctor regarding limitations on referrals for service outside our facility during each visit. Valley Children's Medical Group will not be held responsible for charges on service incurred for any referral.
8. If at any time you cannot comply with policies indicated above, arrangements must be made in advance. Requests for alternative plans of payment will be reviewed and effort will be made to come to an agreeable arrangement.

The undersigned acknowledges and agrees that he/she is financially responsible to Valley Children's Medical Group for the services rendered. In the event of a collections action, the undersigned agrees and acknowledges that he/she shall be responsible for any legal fees incurred. I have read the above policy and agree to comply with its provisions.

_____ _____ _____

Signature of Parent/Responsible Party Print Name Date

THIRD PARTY CONSENT
AUTHORIZATION FOR MEDICAL TREATMENT

I, _____ (Full Legal Name of Parent/Guardian), being the parent/legal guardian of

1. _____ _____
   Child's Full Name DOB
2. _____ _____
   Child's Full Name DOB
3. _____ _____
   Child's Full Name DOB
4. _____ _____
   Child's Full Name DOB

authorize,

1. _____ _____
   Full Name of Caregiver Relationship to Patient
2. _____ _____
   Full Name of Caregiver Relationship to Patient
3. _____ _____
   Full Name of Caregiver Relationship to Patient

to seek, obtain and consent to routine medical care and treatment/emergency medical care and treatment, procedures and vaccinations for my child/children listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of the person/people listed above and is effective _____ (Date). I may revoke/edit this consent at any time.

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
(Only sign and date if no change from previous year)

_____/_____/_____
Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**
(Only sign and date if no change from previous year)

_____ _____
Signature of Office Staff **Date**

Valley Children's Healthcare

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have received the Valley Children's Healthcare Notice of Privacy Practices.

Date: _____ Time: _____ AM / PM

Patient's Name: _____ DOB (mm/dd/yy): _____

Print Name: _____ Signature:_____
(Patient or Legal Representative)

Your relationship to patient: _____

Witness: _____

[ ] Parents Refused

[ ] Failure to Obtain

For Office Use

Notation placed in EMR on _____ By: _____