PACIFIC OCEAN PEDIATRICS - FAMILY REGISTRATION

Today's Date: ________________________________ **PRIMARY PEDIATRICIAN:** ____

PATIENT INFO

Child 1: Last Name: ________________________________ First Name: ______________________ MI: _____ DOB: ____ / _____ / _____

Child 2: Last Name: ________________________________ First Name: ______________________ MI: _____ DOB: ____ / _____ / _____

Child 3: Last Name: ________________________________ First Name: ______________________ MI: _____DOB: ____ / _____ / _____

PARENT INFO

Parent 1: Name: ____ **DOB:** ____ / _____ / _____
(Please note, in our system Parent 1 defaults to mother and main point of contact unless otherwise noted.)

Cell Phone: (______) _______ - __________ **Email:** ____

Address: ____ Patient(s) Resides Here: Y / N
ADDRESS UNIT CITY ST ZIP

Employer: ____

Parent 2: Name: ____ **DOB:** ____ / _____ / _____

Cell Phone: (______) _______ - ___________ **Email:** ____

Address: ____ Patient(s) Resides Here: Y / N
(same as above leave blank)

Employer: ____

INSURANCE INFO

Insurance Guarantor: Parent 1 • Parent 2 • Other:__________________________

Insurance Carrier: __________________________ ID #: ______________________ Group #: __________________________________

CONTACT METHOD

Medical Issues: Parent 1 Cell • Parent 2 Cell

Appointment Reminders: Parent 1 Email • Parent 2 Email • Parent 1 Text • Parent 2 Text

Billing Statements: Parent 1 Email • Parent 2 Email • Parent 1 Address • Parent 2 Address • Autopay

Keep CC on file to: Autopay Co-Pays / Pay Family Balances

CC Info: # ______________________________________ Exp: ________ CCV: ______ Name on Card: ___________________________________

I hereby authorize my physician to release any information acquired in the course of my examination or treatment to my insurance company and assign benefits otherwise payable to me, to the doctor or group indicated on the insurance claim. (Initial) ___________

I understand that I am financially responsible for any balances and deductibles not covered by my insurance carrier and that a $25 monthly late fee will be assessed on all unpaid balances 30 days past due. (Initial) ___________

I understand that copays are to be paid at the time of service and any copays not paid, and therefore have to be billed, will be subject to a $15 service fee. (Initial) ___________

I understand that in order for Pacific Ocean Pediatrics to submit claims to my insurance carrier, it is my responsibility to keep Pacific Ocean Pediatrics current of any changes in my insurance coverage and/or home address within 15 days of change. (Initial) ___________

I have read and understand the above statements and by initialing each, agree to uphold the terms and conditions of the financial practice of Pacific Ocean Pediatrics:

(x) ____ Date:__________________________ P.O.P. __________________________ Date: ______________________
Responsible Party's Signature / Authorized Signature To be signed by office representative

Pacific Ocean Pediatrics
New Patient Medical History

New Patient Information:

Name: ______________________ DOB: ______________________

ALLERGIES

Any allergies to medications? ______________________

What is the reaction to the medication? ______________________

Other allergies (food/pets/environmental)? ______________________

MEDICAL HISTORY

Please list any significant illness, hospitalizations, development concerns, surgeries or injuries; please list the dates they occurred:

____

____

____

MEDICATIONS

Please list medications your child is currently taking

1.)	2.)
3.)	4.)
5.)	6.)

FAMILY HISTORY:

Please answer Y/N to the following conditions as related to your immediate family.
If you answer yes, please provide who is affected.

Seizures:	Y/N	
Allergies:	Y/N	
Asthma:	Y/N	
Heart Disease:	Y/N	
High Blood Pressure:	Y/N	
Elevated Cholesterol	Y/N	
Cancer	Y/N	
Other Childhood Illnesses	Y/N	

Pacific Ocean Pediatrics
Annual Administrative Fee Agreement

With my signature below, I agree to an annual Administrative Fee charge for the care of my child/children by Pacific Ocean Pediatrics. I understand that this fee represents an extra contractual compensation for services that are not covered by my health insurance plan. I understand this to be an annual fee.

NAME OF INSURANCE COMPANY

(circle one below)

CIGNA • BLUESHIELD • AETNA • UNITED HEALTHCARE • ANTHEM BLUE CROSS • HEALTH NET

Annual Administrative Fee Breakdown are as follows:

Families with one child:	$325.00 per year ( )
Families with two children:	$375.00 per year ( )
Families with three or more children:	$425.00 per year ( )

This annual fee is to be paid at the first visit to the office and due yearly on the same day each year thereafter.

Please list your children below:

Child's Name: ________________________________ Birth date: ____________

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Child's Name: ________________________________ Birth date: ____________

Please charge my credit card:

Card#: ________________________ Exp. Date: ____________ CCV: _________

Annual Fee Amount being paid: $ ______________________

Parent Signature: ________________________ Date: ________________

Below is for Office Use Only

Payment Year: 1)__________ 2)__________ 3)__________ 4)__________

Payment Amount: 1)__________ 2)__________ 3)__________ 4)__________

Summary of Notice of Privacy Practices

A federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") went into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice.

Your rights as a Patient. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

Disclosures of Protected Health Information Requiring Your Authorization. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring Your Authorization. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication to You of Confidential Information by Alternative Means. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions to Use and Disclosure. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Amendments to Medical Records. You may request in writing that corrections be made to your medical records. We will either accept the amendments and notify appropriate parties, or deny your request with an explanation. You have the rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses of Your Health Information. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, ____ (printed name of patient or personal representative), acknowledge that Pacific Ocean Pediatrics ha provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one) [ ] myself or [ ] specify:

____
(*If signing as a personal representative, documentation of your legal right to do so must be provided.)*

____ ____/____/20_____ ____

Signature of Patient or Personal Representative | Date (mm/dd/yyyy) | Printed Name | Relationship to Patient

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To be completed by Pacific Ocean Pediatrics

[ ] We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

____

____

____ ______________ ____________________________________ ____/____/20_____

Printed Name | Title | Signature | Date (mm/dd/yyyy)

Robert Hamilton, MD
Noel Salyer, MD
Leian Chen, MD
Kelly Sidhpura, MD

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