RESPONSIBLE PARTY/PARENT REGISTRATION FOR MINOR

☐ I WILL BE USING INSURANCE BENEFITS TO PAY FOR MY VISIT ☐ I WILL BE PAYING CASH FOR MY VISITS

☐ I HAVE PROOF OF INSURANCE WITH MY ID CARD

RESPONSIBLE PARTY INFORMATION (PARENT WHO CARRIES INSURANCE) **PLEASE PRINT**

Last Name ______ First Name ______ Middle ______

Home Address ______ City ______ Zip Code ______

Home Phone (______) ______ Cell Phone (______) ______

Email: ______

Employer Name ______ Occupation ______

Employer Address ______ City ______ Zip Code ______

Date of Birth: ______ ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married ☐ Divorced

Social Security # ______

How did you hear about us?
☐ Email ☐ Work ☐ Website
☐ Dr. Name ______
☐ Other ______

SPOUSE/SECOND PARENT INFORMATION

Last Name ______ First Name ______ Middle ______

Home Address ______ City ______ Zip Code ______

Home Phone (______) ______ Day Phone (______) ______

Employer Name ______ Occupation ______

Employer Address ______ City ______ Zip Code ______

Date of Birth: ______ ☐ Female ☐ Male Social Security # ______

Email: ______

DEPENDENTS (NAMES OF CHILD/CHILDREN WHO WILL BE SEEN AS PATIENTS)

	Last Name	First Name	Birthday	F/M		Last Name	First Name	Birthday	F/M
1:					4:				
2:					5:				
3:					6:				

Children live with: ☐ Mother ☐ Father ☐ Both Contact person in case of emergency ______

Relationship ______ Phone ______

PRIMARY INSURANCE COVERAGE FOR PATIENT **SECONDARY INSURANCE COVERAGE FOR PATIENT**

Insurance Card/Proof of Insurance is Required at Time of Service

Medical Group/IPA: ☐ SJHAP ☐ Monarch ☐ Regal ☐ GNP Saddleback/Orange Coast

Primary	Secondary
Insured's Name ______	Insured's Name ______
Ins. Name ______	Ins. Name ______
Ins. Address ______	Ins. Address ______
ID # ______	ID # ______
Group # ______	Group # ______

Signature ______ **Date** ______

Print Name ______ **Relationship to Patient** ______

Updated: Date ______

POS Reorder # 1709685

Irvine Doctors of Kids & Teens

Initial History Questionnaire

Name:

Birth Date:

Form Completed By:

Date Completed:

Age________ ______ Male ______Female

Household

Please list all those living in the child's home			
Name	Relationship to child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.________________

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?________________

Birth History ☐ Don't know birth history

Birth weight______ Was the baby born at term?____OR_____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain ________________

Was a NICU stay required? ☐ Yes ☐ No Explain________________

During pregnancy, did mother:
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What When

Hospital:

Was the delivery ☐ Vaginal ☐ Cesarean If Cesarian, why?

Was initial feeding ☐ Formula ☐ Breast Milk How long breast fed? ______

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ________________

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain________________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ________________

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ________________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ________________

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ________________

Biological Family History DK = Don't Know

Have any family members had the following?

Childhood hearing loss	☐Yes	☐No	☐DK	Who ________	Comments ________
Allergies	☐Yes	☐No	☐DK	Who ________	Comments ________
Asthma	☐Yes	☐No	☐DK	Who ________	Comments ________
Tuberculosis	☐Yes	☐No	☐DK	Who ________	Comments ________
Heart disease (before 55 years old)	☐Yes	☐No	☐DK	Who ________	Comments ________
High Cholesterol/take cholesterol meds	☐Yes	☐No	☐DK	Who ________	Comments ________
Anemia	☐Yes	☐No	☐DK	Who ________	Comments ________

POS Reorder # 1514983

Biological Family History (continued from front side) DK = Don't Know

Condition					
Bleeding Disorder	☐Yes	☐No	☐DK	Who ______	Comments ______
Dental decay	☐Yes	☐No	☐DK	Who ______	Comments ______
Cancer (before 55 years old)	☐Yes	☐No	☐DK	Who ______	Comments ______
Liver disease	☐Yes	☐No	☐DK	Who ______	Comments ______
Kidney disease	☐Yes	☐No	☐DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐Yes	☐No	☐DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐Yes	☐No	☐DK	Who ______	Comments ______
Obesity	☐Yes	☐No	☐DK	Who ______	Comments ______
Epilepsy or convulsions	☐Yes	☐No	☐DK	Who ______	Comments ______
Alcohol use	☐Yes	☐No	☐DK	Who ______	Comments ______
Drug abuse	☐Yes	☐No	☐DK	Who ______	Comments ______
Mental illness/depression	☐Yes	☐No	☐DK	Who ______	Comments ______
Developmental disability	☐Yes	☐No	☐DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐Yes	☐No	☐DK	Who ______	Comments ______
Tobacco use	☐Yes	☐No	☐DK	Who ______	Comments ______

Additional family history ______

Past History DK = Don't Know

Does your child have, or has your child ever had:

Condition				
Chickenpox	☐Yes	☐No	☐DK	When ______
Frequent ear infections	☐Yes	☐No	☐DK	Explain ______
Problems with ears or hearing	☐Yes	☐No	☐DK	Explain ______
Allergies	☐Yes	☐No	☐DK	Explain ______
Problems with eyes or vision	☐Yes	☐No	☐DK	Explain ______
Asthma, bronchiolitis or pneumonia	☐Yes	☐No	☐DK	Explain ______
Any heart problem or murmur	☐Yes	☐No	☐DK	Explain ______
Anemia or bleeding problem	☐Yes	☐No	☐DK	Explain ______
Blood transfusion	☐Yes	☐No	☐DK	Explain ______
Cancer/Malignancy/bone marrow transplant	☐Yes	☐No	☐DK	Explain ______
Chemotherapy	☐Yes	☐No	☐DK	Explain ______
Frequent abdominal pain	☐Yes	☐No	☐DK	Explain ______
Constipation requiring doctor visits	☐Yes	☐No	☐DK	Explain ______
Recurrent urinary tract infections and problems	☐Yes	☐No	☐DK	Explain ______
Congenital cataracts/retinoblastoma	☐Yes	☐No	☐DK	Explain ______
Metabolic/Genetic disorders	☐Yes	☐No	☐DK	Explain ______
Kidney disease or urologic malformations	☐Yes	☐No	☐DK	Explain ______
Bed wetting (after 5 years old)	☐Yes	☐No	☐DK	Explain ______
Sleep problems; snoring	☐Yes	☐No	☐DK	Explain ______
Chronic or recurrent skin problems (eg. acne)	☐Yes	☐No	☐DK	Explain ______
Frequent headaches	☐Yes	☐No	☐DK	Explain ______
Convulsions or neurologic problems	☐Yes	☐No	☐DK	Explain ______
Obesity	☐Yes	☐No	☐DK	Explain ______
Diabetes	☐Yes	☐No	☐DK	Explain ______
Thyroid or endocrine problems	☐Yes	☐No	☐DK	Explain ______
High blood pressure	☐Yes	☐No	☐DK	Explain ______
History of serious injury/fracture/concussion	☐Yes	☐No	☐DK	Explain ______
Use of alcohol or drugs/tobacco	☐Yes	☐No	☐DK	Explain ______
ADHD/anxiety/mood problems/depression	☐Yes	☐No	☐DK	Explain ______
Developmental delay	☐Yes	☐No	☐DK	Explain ______
Dental decay	☐Yes	☐No	☐DK	Explain ______
History of family violence	☐Yes	☐No	☐DK	Explain ______
Pregnancy	☐Yes	☐No	☐DK	Explain ______
(For girls) Problems with her periods	☐Yes	☐No	☐DK	Explain ______
Has had first period	☐Yes	☐No	☐DK	Age of first period ______
HIV/Organ transplant	☐Yes	☐No	☐DK	Explain ______

Any other significant problem ______

Financial Policy

Payment for Medical Services:

Payment in full for all services provided is expected from parents who are uninsured, or their insurance benefits could not be verified prior to the appointment due to the parents inability to provide "Proof of Insurance" with a current insurance card. Payment methods are cash, check, Visa, MasterCard, Discover , or Debit card. Please refer to your Insurance Policy to understand that your insurance benefit is a contract between the Parent/Subscriber and the selected Health Plan and not the Physician.

Your child may be evaluated resulting in the physician ordering a procedure. Procedures during the encounter are a separate charge, and are billed separately from the examination fee.

Checks or Credit/Debit cards that result in Non Sufficient Funds will result in a $50.00 fee applied to the patients account.

Irvine Doctors Provider/Insurance Affiliations:

The Irvine Doctors are contracted with the following IPA's that contract with HMO health plans:

St. Joseph Affiliated Physicians, Monarch Healthcare, Regal Medical Group, and Greater Newport Physicians.

The Irvine Doctors are contracted with most major PPO health insurance plans and selected mirror plans.

Insurance Claims for parent benefits:

The billing department will submit a claim for the services provided. In some cases the parent will be asked to sign a "Waiver" with the understanding that if payment is denied for specific services, such as vaccines but not limited to, the parent will be responsible for payment of the balance in full. Once payment is made on claim, and any co-insurance or deductible is due a statement will be sent to the parent for payment. Payment is expected within 30 days of the first statement.

Non Payment of Account Balance:

The debt for services rendered is the responsibility of the parent when services are rendered. As stated above we will bill your insurance as a courtesy. Every attempt will be made to notify the parent with three statement and a telephone call. If the parent does not respond with payment, the account will be given to an outside collections service.

Appointment Availability:

The Irvine Doctors ensure that the sick patient receives a same day appointment. The physician that may have an appointment available is the covering physician for the day. In the event that the parent is late for any appointment, the physician will make the decision whether he/she can see the patient, or request a rescheduling. Timeliness of arrival is strongly recommended.

Appointment Cancellations are to made 24 hours in advance. There will be a Cancel/ No Show Fee of $50.00 if no advanced notice is made.

We care for our patients by appointment only.

I have read and understand my financial responsibilities.

______________________________ Date______________20________

4950 Barranca Pkwy, STE 306, Irvine, CA 92604

Medical Information HIPPA Release Form

Release of Information

I, the Legal Guardian [] Mother [] Father, of my child ______________________________

Authorize the **Irvine Doctors of Kids and Teens** to release information from my child's personal medical record including the diagnosis, examinations rendered, medication prescribed and claims information.

This information may be released to my:

[] Spouse ______________________

[] Children ______________________

____

[] Other ______________________

[] INFORMATION IS NOT TO BE RELEASED TO ANYONE

Messages

Messages may be left at the following telephone numbers;

Home (____)______________________

Cell (____)______________________

Work (____)______________________

[] Email Address______________________@______________________

[] Medical Staff may leave a detailed message.

[] Medical Staff may only leave a request for a call/back.

Best time of day to call__________, Best Day to call __________

Signature______________________ Date __________ 20_____

Print Name______________________

This release of information and message instructions shall remain in effect until terminated by me in writing.

Confidential Health Information
Notice of Privacy Practices

OUR COMMITMENT TO YOU !
We at Orange & Irvine Doctors of Kids & Teens, would like to inform you of our compliance to the new federal HIPAA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of health information. We want to assure you that personal health information will not be unnecessarily made available outside of our office.

CHANGES?... PRIVACY POLICY?
ALL GOOD QUESTIONS

The most significant variable that has motivated the Federal government to enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines and charts. This has been an important exercise for us as it disciplines us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.
It is our intention to let you know about the policies and procedures we developed to make sure your health information will not be shared with anyone who does not require it. We are subject to State & Federal laws regarding the confidentiality of your health information and in keeping with those laws, we want you to understand our procedures and your rights as our patient.
We will use your Health Information only for the purposes of providing your treatment, obtaining payment and conducting health care operations.

YOUR HEALTH INFORMATION AND HOW IT MAY BE USED!

<u>To Provide Treatment</u>
Information obtained by our office will be recorded in your record and used to determine the course of treatment that should work best for you. In that way the physician will know how you are responding to treatment. In addition we may share your health records with referring physicians, clinical and pathology labs, pharmacies or other health care personnel providing your treatment.

<u>To Obtain Payment:</u>
We will use your health information for Payment. Example: A bill may be sent to a third party payer. (Insurance carrier) The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies.

<u>To Conduct Healthcare Operations:</u>
Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare we provide.

<u>Abuse or Neglect:</u>
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Communication with Family, Caregivers or friends:
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Medical Research:
We may disclose information to researchers when an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena

Law Enforcement, Cont.
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney. Provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Coroners, Funeral Directors and Medical Examiners:
We may be required by law to provide information to coroner's funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Authorization to Use or Disclose Health Information:
Other than is stated above or where Federal, State or local law requires us, we will not disclose your health information other then with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

Restrictions:
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communication:
You have the right to request that we only communicate your health information privately, with no other family member present or through mailed communications that are sealed. We will make every effort to honor your request for confidential communication.

Inspect and Copy Your Health Information:
You have the right to review and copy your health information including your complete chart, x-rays and billing records. We may need to charge you a fee for this request.

Amend Your Health Information:
If you believe your health information records are incorrect or incomplete you may ask us to update or modify them. Please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information:
You have the right to ask us for a description of how and where your information was used by our office for any reason other then those described commencing from April 14 2003 forward. Please let us know in writing the time period you are interested in. There may be a small charge for this request.

Request a Paper Copy of this Notice:
You may obtain a copy of this Notice of Privacy Practice from our office at any time.
We do reserve the right to amend the terms of this notice. If we amend this notice we will give our patients a copy of the amended version.

Irvine Doctor's of Kids & Teens.
4950 Barranca Parkway, Suite 306 • Irvine, CA 92604
Phone 949-559-5601 • Fax 949-733-0680

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of: Irvine Doctor's of Kids & Teens.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949-559-5601.

I acknowledge receipt of the ***Notice of Privacy Practices*** of: Irvine Doctor's of Kids & Teens.

Signature: ______________________________ Date: ________________
(parent/patient/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: ______________________ Date: ______________

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

____

____

____