ELK GROVE PEDIATRICS, INC.
PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____
(Last) (First) (MI)

Address _____ City _____ State ____ Zip _____

Phone Number _____

Patient Lives With: ❑ Mother ❑ Both ❑ Other
❑ Father ❑ Guardian

Mother / Guardian Name _____ Date of Birth _____

Mother / Guardian Address _____ City _____ State ____ Zip _____

Phone _____ Social Security Number _____ Driver's License _____

Occupation _____ Employer _____

Employer Address _____ City _____ State ____ Zip _____

Work Number _____ Cellular Number _____

Father / Guardian Name _____ Date of Birth _____

Father / Guardian Address _____ City _____ State ____ Zip _____

Phone _____ Social Security Number _____ Driver's License _____

Occupation _____ Employer _____

Employer Address _____ City _____ State ____ Zip _____

Work Number _____ Cellular Number _____

Brothers / Sisters Name _____ DOB _____ M / F Health Problems? Yes / No

Name _____ DOB _____ M / F Health Problems? Yes / No

Name _____ DOB _____ M / F Health Problems? Yes / No

Primary Health Insurance _____ Insured's Name _____

Policy ID Number _____ Group Number _____ Phone Number _____

Other Health Insurance _____ Insured's Name _____

Policy ID Number _____ Group Number _____ Phone Number _____

Emergency Contact (other than parents) _____ Relationship to Patient _____ Phone Number _____

Address _____ City _____ State ____ Zip _____

Referred By: ❑ Name of Person _____ Phone Number _____

_____ ❑ Other

- I hereby authorize Elk Grove Pediatrics, Inc. to release information and/or receive medical insurance payments generated in the course of medical examination and treatment. Parent or Guardian who request treatment for the child is responsible for all charges incurred during the visit.
- All unpaid balances over 30 days will accrue finance charges at a rate of 1.5% monthly.
  Returned Checks are subject to a $25.00 service charge.
  All deductibles and co-payments are due at the time of service. If co-payment is billed, a $25.00 service charge will be added.
- In the event an account is turned over to an attorney for collection, the undersigned agrees to pay those reasonable attorney's fees and court costs, which might be associated with the collection process including collection agency fees.
- My son/daughter has my permission to be seen and to receive medical care/medication/immunizations that might be necessary.
  This permission is good until cancelled in writing.

Thank you for letting us serve you.

Signature _____ **Date** _____
Parent or Guardian if Minor

6/09

ELK GROVE PEDIATRICS, INC.

9727 ELK GROVE FLORIN ROAD, SUITE 250
ELK GROVE, CALIFORNIA 95624
(916) 686-5003

PATIENT HISTORY

NAME _____ BIRTHDATE _____

BIRTH HISTORY

Obstetrician Name _____
Type of Delivery ❑ Vaginal ❑ C. Section
Hospital _____ City _____ State _____
Full Term _____ Preterm _____ Birth Wt. _____
If Preterm, Weeks Gest. _____
Pregnancy Number _____
Mother's Age at Birth _____
Apgar Score _____
Circumcision ❑ Yes ❑ No
Blood Type (if known) _____
Feeding: ❑ Breast ❑ Formula
Appetite: ❑ Good ❑ Fair ❑ Poor
Other _____

PAST MEDICAL HISTORY

General Health _____
Allergies to Medication _____
"Hay fever" type allergies _____
Asthma _____
Pneumonia _____
Ear infection _____
Chicken Pox _____ Date _____
Serious Injuries _____
Hospitalized _____ Date(s) _____
Operations _____ Date(s) _____
Medications taken on a regular basis _____
_____

DEVELOPMENT HISTORY

AGE

Held Up Head _____
Smiled _____
Sat Alone _____
Reached for Objects _____
Transferred Objects from One Hand to Another _____
First Teeth _____
Crept _____
Stood Alone _____
Walked _____
Said Words _____
HABITS Sleep _____
Naps _____
Play _____
School _____
Other _____
_____
_____

FAMILY HISTORY

How long has your family lived in this area? _____
Moved from _____
Any smokers living at home? ❑ Yes ❑ No
If yes, Father, Mother, Other _____

List all blood relatives of your child who have had the following problems: (use abbreviations)

(F)	Father	(M)	Mother
(B)	Brother	(S)	Sister
(MM)	Mother's Mother	(MF)	Mother's Father
(FM)	Father's Mother	(FF)	Father's Father
(A)	Aunt	(U)	Uncle
(C)	Cousin		

Allergies _____
Drug Allergies _____
Asthma _____
Epilepsy / Seizures _____
Heart Attack Before 55 yrs _____
High Cholesterol _____
High Blood Pressure _____
Migraine / Headache _____
Other _____
_____

INOCULATION HISTORY

Please give your immunization record to the receptionist for a copy to be made.

Your Doctor was/is _____

City _____ State _____

_____
Signature (Parent or Guardian)

_____
Date

Elk Grove Pediatrics, Inc.

No-Show / Missed Appointment Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Impact of No-Show/Missed Appointments:
No-show or missed appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient no-shows or misses a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is denying appointments to other patients in need of care
- Disrupts patient flow and affects other families

1. Appointment Confirmation Elk Grove Pediatrics, Inc. will attempt to contact you two business days before your scheduled appointment to confirm your visit.
Please remember confirmation calls are a courtesy, ultimately it is your responsibility to know your appointment date and time.* *

2. Always Arrive 5-10 Minutes early when you schedule an office visit with us. This allows time for you and our staff to address any insurance/billing issues or to complete any necessary paperwork or the registration process in our EMR system before the scheduled visit.

3. Give 24 hours notice if you need to cancel an appointment. When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

4. If you miss **3 or more appointments within a year you may be dismissed from the clinic**. Once dismissed, only urgent medical treatment will be scheduled for 30 days. You will need to contact your medical group and select a new primary care office.

I have read and understand the Elk Grove Pediatrics, Inc. No-Show/ Missed Appointment Policy as described above.

_____ Patients/Guardians Signature _____ Date

*Definition of a "No-Show" Appointment Elk Grove Pediatrics, Inc. defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 15 minutes late and is consequently unable to be seen

How to Avoid Getting a "No-Show"

1. Write down your appointment in your calendar and feel free to call to confirm
2. Arrive 5-10 minutes early
3. Give 24 hours notice to cancel appointment

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ELK GROVE PEDIATRICS, INC.

9727 ELK GROVE FLORIN ROAD, SUITE 250
ELK GROVE, CA 95624-2266
BUSINESS PHONE 916.686.5003
FAX 916.686.5015

Thank you for choosing Elk Grove Pediatrics, Inc. for your child's medical care.

On the day of your child's appointment please bring the following documents with you:

1. **Child's most current insurance card (please bring your child's insurance card to all visits)**
2. **Child's current vaccination records**
3. **List of any medications that your child is currently taking**
4. **Please be aware that a legal guardian must accompany a child less than 18 years of age to all appointments and must have photo ID**

<u>Please be advised of our office policies:</u>

1. **All co-pays and deductibles are due at the time of your visit.**
2. **If we are unable to verify insurance coverage, payment must be made in full prior to being seen.**
3. **Any unpaid balances over 60 days will be forwarded to an outside agency for collection.**
4. **Returned checks are subject to a $25.00 service charge.**
5. **Arriving more than 15 minutes late to a scheduled appointment will significantly delay your processing time or we may reschedule the appointment.**
6. **All requests of copies of medical records, completion of forms, and/or billing may have a charge associated with each and most requests will be processed within 3 to 5 business days.**
7. **Continuous missed appointments may result in dismissal from practice.**
8. **We require the courtesy of a 24 hour notice when canceling appointments. Any missed appointments may be assessed a fee.**

_____ _____

Parent/Guardian Signature Date

ELK GROVE PEDIATRICS, INC

FINANCIAL STATEMENT

IMPORTANT - PLEASE READ

In order to help control the high costs of medical care, we require that you provide us with proof of insurance coverage at the time of visit. This includes new patients and established patients who have changed insurance coverage. If verification is obtained, then you will only be responsible for co-pays, deductibles and non-covered services, all of which must be paid in full at the time of service. If for any reason we are unable to verify insurance coverage, payment must be made in full at time of service. Once eligibility is obtained, we will gladly refund all but the patient responsibility to you.

Please remember that your insurance coverage is between you and your insurance carrier. As a courtesy, we will bill your insurance company but you are ultimately responsible for any outstanding balances on care received by our office. In addition, we do not get involved with legal disputes over financial or parental responsibility. The insurance policy holder and/or the legal guardian listed will be held responsible for any outstanding balances owed to the office.

For your convenience, we accept cash, checks, visa and master card as forms of payment in the office.

I have read and understand the information above and by my signature agree to abide by this policy.

_____ _____

Signature Date

ELK GROVE PEDIATRICS, INC.
INFANTS, CHILDREN & YOUNG ADULTS

9727 ELK GROVE FLORIN ROAD
SUITE 250
ELK GROVE, CA 95624-2266
FAX 916.686.5015
PHONE 916.686.5003

HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain heath care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

Signature _____ Date _____