
**Family Choice Pediatrics, Inc.**
**3801 Katella Ave # 221**
**Los Alamitos, CA 90720**
**Tel. (562) 431-6548 Fax. (714) 761-2086**
**Email: info@familychoicepediatrics.com**

| **CHILDREN** | | |
|---|---|---|
| Name (last, first, middle initial) | Sex **M / F** | Date of birth |
| Name (last, first, middle initial) | Sex **M / F** | Date of birth |
| Name (last, first, middle initial) | Sex **M / F** | Date of birth |
| Name (last, first, middle initial) | Sex **M / F** | Date of birth |

| **MOTHER OR LEGAL GUARDIAN** | | |
|---|---|---|
| Name (last, first, middle initial) | Date of birth | Social Security # |
| Address Apt # | City | ZIP code |

| Home phone | Cell phone | Email |
|---|---|---|

| Employer | Occupation | Work phone |
|---|---|---|
| Address Apt # | City | ZIP code |

| **FATHER OR LEGAL GUARDIAN** | | |
|---|---|---|
| Name (last, first, middle initial) | Date of birth | Social Security # |
| Address Apt # | City | ZIP code |

| Home phone | Cell phone | Email |
|---|---|---|
| Employer | Occupation | Work phone |
| Address Apt # | City | ZIP code |
| **INSURANCE** | | |
| Insurance | Member ID # | |
| **EMERGENCY CONTACT - *Contact cannot be residing at the same address as parents** | | |
| Name | Relation | Phone |
| Address Apt # | City | ZIP code |
| **PREVIOUS DOCTOR (if applicable)** | | |
| Name | Phone | |
| Address | | |

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

1) I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

*2)* I have read, understand and agree with the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice *of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

3) I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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(Parent's/Legal Guardian's Initials)

## OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and **present your current insurance card at every visit.** IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card.
3. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **Co-payments are due at time of service.**
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. If Family Choice Pediatrics does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
8. A **$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. <u>It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.</u>
10. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

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(Parent's/Legal Guardian's Initials)

## NO SHOW/MISSED APPOINTMENT POLICY

We, at Family Choice Pediatrics, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. **If you are unable to keep your appointment, please call us at least TWENTY-FOUR hours prior to your appointment time.** You can cancel appointments by calling: **(562) 431-6548.**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted the day prior to your scheduled appointment. However, **it is the responsibility of the parent/legal guardian/patient to arrive for their appointment on time.**

YOU UNDERSTAND AND AGREE TO THE FOLLOWING POLICY**:**

1) Please cancel your appointment at least TWENTY-FOUR hours prior to your appointment time.
2) If less than a twenty-four-hour cancellation is given this will be documented as a "No-Show" appointment.
3) If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4) You will receive a phone call after the first and second "No-show/Missed" appointment. If you have three "No-Show/Missed" appointments, dismissal from the practice will be considered. **You will be notified by letter if the dismissal has been approved.**
5) We may need to reschedule your appointment if you arrive fifteen or more minutes late.
6) We do not take "Walk Ins". All visits are by appointment only.

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(Parent's/Legal Guardian's Initials)

## VACCINATION POLICY

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives, and we firmly believe in the safety of our vaccines. All children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

Vaccinating children and young adults may be the single most important health-promoting intervention that we perform as health providers and that you can perform as parents/caregivers. The recommended vaccines and the schedule of their administration are the results of years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

It is for these reasons that Family Choice Pediatrics requires all parents to vaccinate their children according to the recommended schedule. While we are happy to answer questions and discuss the safety and efficacy of the vaccines, if parents chose to deviate from the accepted schedule and to delay beginning routine vaccination, they will be discharged from our practice and be expected to find a different primary care source.

We encourage any parent who wants to learn more to visit the following websites with reliable, scientific information to explain all aspects of vaccines – from manufacturing, to how they work to protect children, to data regarding safety and efficacy.

_____

(Parent's/Legal Guardian's Initials)

## INSURANCE POLICY

I hereby authorize Family Choice Pediatrics, Inc. to disclose, when requested by the above named insurance carrier or its representatives any and all information with respect to any illness(s) or injury (ies), medical history or treatment, and copies of all medical records. 2) I authorize payment directly to Family Choice Pediatrics, Inc. for medical benefits. I understand that I am financially responsible for any charges not covered by my insurance company.

_____

(Parent's/Legal Guardian's Initials)

I have read, understand and agree to all of the above. I hereby authorize Family Choice Pediatrics, Inc. to provide medical care, treat, perform examinations, and administer treatment as may be necessary in the diagnosis, management and overall health care of this patient.

Patient's Name _____Patient's Date of Birth _____

Patient's Name _____Patient's Date of Birth _____

Patient's Name _____Patient's Date of Birth _____

Patient's Name _____Patient's Date of Birth _____

Parent's/Guardian's Name Printed _____

Parent's/Guardian's Signature if Patient is a Minor: _____ Date: _____

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

I request and authorize to release healthcare information of the patient named above to:

**Family Choice Pediatrics, Inc.**
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This request and authorization apply to:

☐ Complete Medical Records

☐ Laboratory, diagnostic, and imaging studies

☐ Vaccine Records

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

Parent's/Legal Guardian's Name: _____

(Print)

Signature of Parent/Legal Guardian: _____

Date: _____

# Pediatric Health Questionnaire

| **Child's Name** (Last, First, M.I.): | **Date of Birth**: |
|---|---|
| **Allergies to medication** | **Allergies to food:** |

**Birth History**

| Place of birth: | □ Full term > 37 weeks<br>□ Pre-term < 37 weeks | □ Vaginal delivery<br>□ C-section<br>□ Vacuum assisted |
|---|---|---|
| Birth Weight: | Birth Length: | Medical Problems in the Newborn period:<br>(i.e. Prematurity, jaundice, respiratory distress, sepsis) |

Feeding: □ Breast □ Formula (please specify)

**Medical History**

**Please check (X) if your child has had any of the following:**

| | | |
|---|---|---|
| □ ADD/ADHD<br>□ Abdominal Pain<br>□ Acne<br>□ Allergic Rhinitis<br>□ Allergies<br>□ Anemia<br>□ Asthma<br>□ Bronchitis/Bronchiolitis | □ Chicken Pox<br>□ Concussion<br>□ Constipation<br>□ Diabetes<br>□ Eczema<br>□ Gastritis/GERD<br>□ Heart Disease<br>(Please Specify) | □ Headaches<br>□ Hearing Problems<br>□ Pneumonia<br>□ Recurrent Ear Infections<br>□ Turner's<br>□ UTI<br>□ Other<br>(Please Specify) |

**Surgical History**

**Please check (X) if your child has had any of the following:**

| | **Year** | | **Year** |
|---|---|---|---|
| □ Appendectomy<br>□ Circumcision<br>□ Hernia Repair<br>□ Tonsillectomy | | □ Adenoidectomy<br>□ Other | |

**Medications**

**Please list all medications (if any) that your child is taking including name, dose, and frequency:**

| Family History | | |
|---|---|---|
| | **Age** | **Significant Health History** |
| **Father** | | |
| **Mother** | | |
| **Children** □ M □ F | | |
| □ M □ F | | |
| **Maternal Grandfather** | | |
| **Maternal Grandmother** | | |
| **Paternal Grandfather** | | |
| **Paternal Grandmother** | | |

FAMILY CHOICE PEDIATRICS

Thank you for being a part of our pediatric family!