NEW FAMILY REGISTRATION FORM

Child's Name: _____ DOB:_____ Sex:_____

Child's Name: _____ DOB:_____ Sex:_____

Child's Name: _____ DOB:_____ Sex:_____

Home Address: _____ City:_____ State:_____ ZIP:_____

Billing Address: _____ City:_____ State:_____ ZIP:_____

Email address:_____ Permission to contact you via email? YES NO

How did you hear about our practice?_____

Preferred Pharmacy: _____Pharmacy Phone:_____

Emergency contact:_____ Phone:_____

PARENT #1 Name: _____ DOB_____

Employer:_____ Occupation:_____ Work Phone:_____

Cell:_____ Home phone:_____

PARENT #2 Name: _____ DOB_____

Employer:_____ Occupation:_____ Work Phone:_____

Cell:_____ Home phone: _____

INSURANCE INFORMATION:

Subscriber Name: _____ Insurance Company_____

ID#_____ Group #_____ Phone#_____

Financial Agreement: By signing below, I hereby certify the correctness of the above information and authorize the release of information to my insurance company. I assign benefits to Andrew M. Matthew, MD, Jessica M. Hochman, MD, and/or Dr. Tenenblatt, MD. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. I also understand that I am ultimately responsible for my bill regardless of my insurance coverage. Also note at Oak Park Pediatrics, there is a **$50 fee for walk-in appointments, missed appointments, or appointments canceled less than 24 hours.**

I give permission to Andrew M. Matthew, M.D, Jessica Hochman, M.D. and Dr. Karen Tenenblatt, MD to render treatment for my minor children.

Signature: _____ Relationship : _____ Date:_____

CHILD HEALTH QUESTIONNAIRE

CHILD'S NAME: _____ Date of Birth: _____ Date:_____

BIRTH HISTORY:

Any problems or health concerns during pregnancy? YES NO

If yes, please explain:_____

Any issues as a newborn or with delivery? YES NO

If yes, please explain:_____

Please fill out below, **if not relevant please leave blank:**

EARLY DEVELOPMENT:

Any developmental concerns about your child? (e.g. speech delay, motor delays, or social concerns?)

If Yes, please describe:

_____

MEDICAL PROBLEMS:

Does your child have any medical problems for which you want the doctor to be aware? YES NO

If Yes, please describe:

_____

ALLERGIES: Does your child have any known reactions to medications, vaccinations or food?

If Yes, please describe:

_____

HOSPITALIZATION/SURGERY: Has your child ever been hospitalized?

If yes, why?_____

FAMILY HISTORY: Any pertinent family history (first-degree relatives)? Such as heart disease, diabetes, thyroid disease, cancer, asthma, scoliosis, allergies, eczema, migraine, substance abuse or anxiety/depression?

If so, please describe:

_____

_____

ADDITIONAL: Any other health information you would like the doctor to be aware of?

_____

FAMILY FINANCIAL RESPONSIBILITY

Dear Parent,

We understand that insurance policies are complicated and constantly changing. At Oak Park Pediatrics, our office will bill your insurance policy. However, our office does not verify insurance benefits, and thus it is the patient's responsibility to ensure our participation in your health insurance network. If, for whatever reason, your insurance company does not pay, you, the parent, ultimately will bear the financial responsibility for your child's medical bill.

Furthermore, co-pays must be paid at the time of service. This is a contractual agreement that you have with your insurance company. After your claim has been reconciled with your insurance, you will receive a billing statement from our office. The amount on this statement will reflect your balance, and that balance is due upon receipt. Any balance remaining on your account for services not covered by your insurance company is your responsibility.

Your signature below will confirm that you understand your financial responsibility.

SIGNATURE: _____ DATE:_____

AUTHORIZATION FOR

SOMEONE OTHER THAN PARENT TO BRING CHILD TO OAK PARK PEDIATRICS

I authorize _____

_____

_____

to bring my child/children,

Child's Name _____ DOB_____

Child's Name _____ DOB_____

Child's Name _____ DOB_____

Child's Name _____ DOB_____

to the office of Oak Park Pediatrics, to be seen and treated by Andrew M. Matthew, M.D., Jessica M. Hochman, M.D., or Karen Tenenblatt M.D.

Parent name: _____

Parent signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR OAK PARK PEDIATRICS

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment, and Health Care Operations.

• **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
• **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also use and disclose medical information for the following purposes: for Appointment Reminders and Communication with your Family, and for specific situations regarding Public Health, and Public Safety. As warranted and often required by law, your medical information may be used in Judicial and Administrative Proceedings and shared with Health Oversight Agencies, Law Enforcement Agencies, the Medical Examiner's office and Specialized Government Programs. We may also contact you regarding treatment alternatives or other health related benefits and services that may be of interest to you. We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.
• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

• The right to inspect and copy your protected health information. • The right to amend your protected health information.
• The right to receive an accounting of the disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The privacy act took effect on April 14, 2003 and will remain in effect until further notice, during which time we are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. If you file a complaint, we will not hold it against you.

For More Information about HIPAA or to file a complaint Contact:
The US Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W. Washington, D.C. 20201
(877) 696-6775 (Toll-Free)

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Oak Park Pediatrics Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian Date

_____
Patient Name

358 N Kanan Road, Oak Park, CA 91377
www.oakparkpediatrics.com
info@oakparkpediatrics.com
P (818) 707-0046

Oak Park PEDIATRICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____

Signature of Parent/Guardian Date

_____

Patient Name

****

SIGNATURE ON FILE

- ☐ I authorize use of this form on **all** of my insurance submissions
- ☐ I authorize release of information to all my **Insurance Companies**
- ☐ I understand that **I am responsible** for my bill
- ☐ I authorize my doctor to act as **my** agent in helping me obtain payment from my insurance Companies
- ☐ I authorize payment direct to my doctor
- ☐ I permit a copy of this authorization to be used in place of the original

Name_____

Signature_____ Date_____

Oak Park Pediatrics
358 N, Kanan Rd,
Oak Park, CA 91377

Dear Oak Park Pediatrics Families,

Thank you for being part of our practice! We take pride in the exemplary care we provide to your family. In order to continue our current level of service, and to maintain the most excellent staff that we can, we ask our families to provide an annual non-contractual administrative fee for specific services we provide that are not covered by insurance companies. This annual fee request will renew every January 1st, and this year, it will take effect on January 1st, 2023. The fee is in lieu of individual charges for the services listed below:

- Access to after hours on-call emergency service
- Same day appointments for urgent visits
- In-office laboratory services
- Coordinated care with other pediatric specialists and therapists
- Electronic prescriptions
- Pharmacy requests for prescriptions, both new and refills
- Letters to schools, airlines etc for your child's needs
- Appeal letters of medical necessity and pre-authorization referrals to insurance companies to advocate for the needs of your child
- Copies of medical records and reports sent to specialists
- Completed health forms for school/camp/sports in a timely manner
- Insurance claims submitted on behalf of in network patients

The Oak Park Pediatrics annual family administration fee is:

- $150.00 per year for families with a single child
- $200.00 per year for families with two children
- $250.00 per year for families with three or more children

Thank you,

Drs. Hochman, Matthew & Tenenblatt

FAMILY ADMINISTRATIVE FEE

I, the undersigned, agree to the Oak Park Pediatric annual family administration fee. I understand that this fee will be paid and renewed annually in order to continue to receive specific benefits not covered or not reimbursed by my insurance plan.

I agree to pay the additional multiple child cost within 15 days after a second child is added to the practice. All administrative fees are due within 15 days of the new calendar year (by January 15th) or upon joining our practice.

The annual family administration fee for Oak Park Pediatrics is:

- $150.00 per year for families with a single child
- $200.00 per year for families with two children
- $250.00 per year for families with three or more children

I have read and understand the administration fee information and agree to the terms of Oak Park Pediatrics annual administrative fee policy. **Please complete the form and email to info@oakparkpediatrics.com.** Thank you in advance!

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Name:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Amount Enclosed $ _____

CREDIT CARD AUTHORIZATION

Card Holder's name: _____
Signature of Card Holder: _____ Date:_____

Credit Card Number:_____ Expiration date (MM/YY):_____
Card type: [ ] Visa [ ] Master Card [ ] AMEX
CVV CODE: _____ Zip Code: _____

358 N Kanan Road, Oak Park, CA 91377
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P (818) 707-0046