Patient Registration Form

Please note that the patient's name as provided here must match the name on the insurance card in order for claims to be successfully submitted to insurance.

Patient last name: _____ First name: _____MI: __

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other

Mailing Address: _____

City: _____ State: _____ Zip: _____

Child's Legal Guardian: ☐Mother ☐Father ☐Other(provide guardianship paperwork)_____

Race (Optional): _____

Emergency contact: _____Emergency contact relationship: _____

Emergency contact phone number: _____

Pharmacy of choice: _____Pharmacy phone number: _____

Please provide Patient's proof of insurance at the front desk

Mother's Name: _____ DOB: _____

Address (If different from above):_____

Father's Name: _____ DOB: _____

Address (If different from above):_____

E-mail address for "**my health online**" access: _____

Home phone:	(_____)_____-_____	☐ Yes ☐ No
Mom's mobile:	(_____)_____-_____	☐ Yes ☐ No
Mom's work phone:	(_____)_____-_____	☐ Yes ☐ No
Dad's mobile:	(_____)_____-_____	☐ Yes ☐ No
Dad's work phone:	(_____)_____-_____	☐ Yes ☐ No

May we leave a detailed message regarding your child's medical treatment at this number?

Acknowledgement: All of the above information is true to the best of my knowledge. I authorize Avala Pediatrics to release my information to insurance carriers concerning my medical condition/treatment, etc. in order to facilitate claims payment. In addition, I assign benefits to be paid to Avala Pediatrics for all services rendered. I understand that I am financially responsible for charges for medical services rendered to the above-named patient regardless of insurance coverage/payment. I understand that all co-payments and or deductible amounts are due and payable at the time of service

Signature: _____ Date: _____

Patient Health History Form

(This medical document is strictly confidential)

Patient Last Name: _____ First Name: _____MI: __

Patient Date of Birth: _____ Patient Birth Place: _____

Your Name: _____ Relationship to Patient: _____

Members of Household: _____

Past Medical History

Any complications as a newborn? ☐Yes ☐No | If Yes, specify: _____

Any Developmental Delays? ☐Yes ☐No | Any Hospitalizations? ☐Yes ☐No

Any History of:

Chicken Pox	☐Yes ☐No	Depression	☐Yes ☐No
Measles	☐Yes ☐No	Anxiety	☐Yes ☐No
Seizures	☐Yes ☐No	Headaches	☐Yes ☐No
Urinary Tract Infections	☐Yes ☐No	AIDS/HIV	☐Yes ☐No
Asthma	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Heart Problems	☐Yes ☐No	Other: _____	

Medications:

Name	Dose	Frequency

Allergies: _____

_____

Family History	Age	Health Problems
Father		
Mother		
Siblings		
Grand Parents		

Any smokers in the household? ☐Yes ☐No Any guns in the home? ☐Yes ☐No

What school does child attend? _____

Are there any concerns of school related problems? _____

Any special concerns? _____

_____

Patient or Representative Signature: _____ Date: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

NO SHOW/MISSED APPOINTMENT POLICY

We, at Avala 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 as soon as possible, with at least a 24-hour notice. **You can cancel appointments by calling the following number: (916)722-4791**

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 one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the Doctor at our office and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-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. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. We will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.

6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Avala Pediatrics No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify doctor's office appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

CHAPERONE MEDICAL CONSENT (FOR A MINOR)

I, _____ the parent or legal guardian of _____,
born on (DOB) _____do hereby consent and allow (name) _____
DOB_____ residing at _____

_____

to bring my child to Avala Pediatrics and receive any type of medical care needed for my child including immunizations, and any other care recommended or deemed as necessary for the welfare of my child. I understand the above-named party is responsible for informing me of all information related to services received.

This authorization is effective from (Date)_____ and expires on (Date)_____

_____	_____	_____
Signature of Parent or Legal Guardian	**Date**	**Print Name**
_____	_____	_____
Signature of Witness	**Date**	**Print Name**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information is optional but will assist in treatment if it can be furnished with the consent but is not required.

Father's Telephone: _____ Mother's Telephone: _____

Allergies to drugs or foods: _____

Special Medications, or Pertinent Information: _____

_____

Insurance: _____ Policy # _____

FINANCIAL RESPONSIBILITY AGREEMENT

Acceptance of Full Financial Personal Responsibility for All Charges

I am the legally responsible parent and/or guardian for the minor child noted below. I understand and agree to pay in full all charges incurred for the provision of health care and health care related services to my minor child at the time the services are provided.

Advanced Beneficiary Notice

I understand that my insurer may not pay or cover services that are recommended or that my child's doctor believes are required. I also understand that Avala Pediatrics practices medicine that is consistent with the highest professional, ethical or community standards. **In such cases, I want the items or services that my insurer does not cover or pay for to be provided to my child, and I agree to be wholly responsible for the payment for these services**. I also understand that my child's physician will discuss the treatment options prior to providing the services to ensure that my child's health outcome may be maximized at minimal cost. Notwithstanding the forgoing, I further understand that this may not be practical in all occasions, either because time does not allow it or because my physician cannot reasonably be expected to prospectively know the terms, conditions and limitations of coverage of my child's health insurance coverage.

I agree to pay all charges that are the patient's responsibility and that are generally described in the insurer's Explanation of Benefits ("EOB") form.

EOB

I understand that the insurer's EOB may provide inaccurate claim reimbursement information that could result in Avala Pediatrics being inadequately compensated for the treatment and care provided by the Avala Pediatrics health care practitioners. If that is the case, the pediatric office will notify the patient of the billing error that is described in the insurer's EOB and charge the patient the correct amount by invoicing the patient for the correct amount.

Third Party Billing Agreement

I understand that when my child receives care from this Office, a claim is submitted to my insurer or a bill is provided to me for payment if I do not elect coverage by a third-party payor (i.e., insurer). If I elect to request that a third-party payor ("insurer") be billed on my behalf, I will agree to pay all reasonable processing fees, late fees and other administrative fees associated with this choice, consistent with California law.

Payment Options: We accept most forms of payment, including **CASH, CREDIT/DEBIT CARDS.**

Agreement

This Agreement, Payment Options constitute the sole and entire understanding of the parties with respect to the subject matter contained herein, and supersedes all prior and concurrent understandings and agreements, both written and oral, with respect to such subject matter. This Agreement will remain in force until revoked by me in writing.

_____ _____

Parent or responsible party signature Date

_____ _____

Patient's Name Date of Birth

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS

Completion of this document allows the disclosure and/or use of individual identified records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient: _____ _____

Last First MI Date of Birth

I, the undersigned, do hereby authorize the use and/or release of protected health Medical Records for the above-named child's **from:**

Doctor's Name/Office: _____

Address: _____

Phone: _____ Fax: _____

To the following:

Doctor's Name/Office: Avala Pediatrics

Address: 5959 Greenback Ln, Suite 210, Citrus Heights, CA 95621

Phone: (916) 722-4791 Fax: (916) 723-3388

The disclosure of health information is required for the following purpose:

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to above mentioned patient, from: _____ [Date] to the date this release is presented for such records, to the persons/entities identified herein.

DURATION: This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care provider listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

_____ _____ _____

Printed Name Signature Date

_____ _____

Relationship to Patient Area Code and Telephone Number

Notice of Privacy Practices Acknowledgement

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 treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure 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 Privacy Practices.

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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	Initials:	Reason: