

South Area Pediatric Medical Group, Inc.

3811 Florin Road #16
Sacramento, CA 95823
TEL 916-394-2580
FAX 916-424-8302

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 _____

South Area Pediatric Medical Group, Inc.

PATIENT INFORMATION

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

Address _____ City _____ State _____ Zip _____
 Phone Number _____

Patient Lives With: Mother Both Other Guardian

Mother / Guardian Name _____ Date of Birth _____
 Mother / Guardian Address _____ City _____ State _____ Zip _____
 Phone _____ Social Security Number _____ Driver's License _____
 Occupation _____ 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 _____
 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 _____
 Other _____ Phone Number _____

I hereby authorize South Area Pediatric Medical Group Inc. to release information and/or receive treatment 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.

South Area Pediatric Medical Group, Inc.

Signature _____

Date _____

South Area Pediatric Medical Group, 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

South Area Pediatric Medical Group, Inc.

3811 Florin Road #16
Sacramento, CA 95823
TEL 916-394-2580
FAX 916-424-8302

Thank you for choosing South Area Pediatric Medical Group, 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

Please be advised of our office policies:

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

South Area Pediatric Medical Group, Inc.

INFANTS, CHILDREN & YOUNG ADULTS



3811 Florin Road #16
Sacramento, CA 95823
TEL 916-394-2580
FAX 916-424-8302

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 health 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 _____

South Area 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 missed a scheduled appointment it:

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

1. Appointment Confirmation South Area 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 do you 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 South area pediatrics Inc. No Show/Missed Appointment policy as described above.

_____ Patients/Guardians Signature _____ Date

*Definition of a "No-Show" Appointment South Area 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 to 10 minutes early
3. Give 24 hours notice to cancel an appointment

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for _____
(Name of patient) to receive the health screening tests and immunizations recommended by the CHDP Program from Rahat Saied, MD FAAP
(Name of provider)

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

<input type="checkbox"/> School	Name _____			
	Address (number, street)	City	State	ZIP code
<input type="checkbox"/> Health care provider	Name South Area Pediatric Medical Group, Inc.			
	Address (number, street)	City	State	ZIP code
	3811 Florin Rd. #16	Sacramento	CA	95823
<input type="checkbox"/> Other	Name _____			
	Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.