Bakersfield Pediatrics

IF children have different addresses, different parents, or a different person carries insurance, please complete a separate form for each.

CHILD 1	CHILD 2	CHILD 3
Last Name:_____	Last Name:_____	Last Name:_____
Middle Initial:_____	Middle Initial:_____	Middle Initial:_____
First Name: _____	First Name: _____	First Name: _____
Date of Birth: _____	Date of Birth: _____	Date of Birth: _____
Sex: M / F / _____	Sex: M / F / _____	Sex: M / F / _____
Language: _____	Language: _____	Language: _____
Ethnicity: Hispanic Non-Hispanic Other	Ethnicity: Hispanic Non-Hispanic Other	Ethnicity: Hispanic Non-Hispanic Other
Race: _____	Race: _____	Race: _____
Primary Physician: _____	Primary Physician: _____	Primary Physician: _____
Mobile # (>14yrs): _____	**Mobile # (>14yrs): _____**	**Mobile # (>14yrs): _____**

Primary Address: _____ Apt: _____ Primary Phone: (_____)_____

City: _____ State: _____ Zip Code: _____

Patient is living with: (circle one) Both Parents Father Mother Parent and Step Parent Other _____

Are Parents: (circle one) Married Single Divorced Separated Widowed

Who carries insurance? Name: _____ Relationship: _____

DOB: _____ Social Security #:_____

Parent 1- please circle M / F	**Parent 2- please circle M / F**
Name: _____	Name: _____
SS# _____-_____-_____DOB _____	SS#_____ _____DOB _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Mobile Phone: (____) _____	Mobile Phone: (____) _____
Work Phone: (____) _____	Work Phone: (____) _____
Home Phone: (____) _____	Home Phone: (____) _____
Email: _____	Email: _____
IF DIFFERENT FROM PATIENT	***IF DIFFERENT FROM PATIENT***
Address: _____Apt. _____	Address: _____Apt. _____
City: _____State: _____Zip: _____	City: _____State: _____Zip: _____

Appointment Reminders: (please circle one) Parent 1 or Parent 2

☐ Primary Phone:(_____)_____ ☐ Email: _____ ☐Text: (_____)_____

Preferred Pharmacy Name and location:_____

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

I hereby authorize the following people to bring my child(ren) to appointments without a parent or guardian present.
I authorize them to consent to any and all examinations, tests, procedures and treatments deemed necessary by the provider.

The providers may discuss diagnosis or treatments with the authorized person(s) listed below. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice.

Full Name	Relationship to Patient	Phone Number(s)
		Cell:
		Cell:
		Cell:
Emergency Contact	**Relationship to Patient**	**Phone Number(s)**
		Cell: Home: Work:

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Bakersfield Pediatrics. will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Bakersfield Pediatrics within this time frame, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS, RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS

- I authorize Bakersfield Pediatrics to file insurance claims for services and supplies rendered to and for my/our child(ren).
- I authorize Bakersfield Pediatrics to release information, including my/our child(ren) medical and billing information, to referring or consulting physician and to patient's insurance company. The transmission of all information may be done electronically.
- I authorize that payment of all third-party benefits otherwise payable to me be made directly to Bakersfield Pediatrics.
- I assign to Bakersfield Pediatrics all payments for medical services and supplies provided to my dependent child(ren).

I understand that I am financially responsible to Bakersfield Pediatrics for the above-named patient(s). If my insurance company fails to fully compensate Bakersfield Pediatrics any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third-party payer within 45 days from date of service. If I fail to pay within 30 days, from statement date, Bakersfield Pediatrics has the right to charge my payment card that I have on file with them. In the event Bakersfield Pediatrics refers my account to an attorney to collect any monies owed to Bakersfield Pediatrics. Bakersfield Pediatrics shall be entitled to recover reasonable attorney's fees and costs of litigation.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

I understand that Bakersfield Pediatrics cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

******I acknowledge that I have received or reviewed a copy of the following:***

1) Notice of Privacy Practices and 2) BP Office Policies ***Please initial.*** _____

_____ _____

Parent/Guardian Signature **Date**

_____

Patient name

Acct#:

Bakersfield Pediatrics Patient History Form

Pregnancy and Birth History

Problems during pregnancy	no	yes
Medications	no	yes
Smoking/Alcohol/Drugs	no	yes
Diabetes	no	yes
Illness during pregnancy	no	yes
Other		

Delivery: Vaginal Cesarean Section
Reason for C/S
Full Term Premature # weeks:
Birth Weight Birth Length

Problems immediately after birth:

Infection	no	yes
Breathing Difficulty	no	yes
Jaundice	no	yes
Home with mother	no	yes
Other	no	yes

Medical History

Current Medication
Medication Allergies
Food Allergies
Hospitalizations

Previous infections/problems:

Anemia	no	yes
Asthma	no	yes
Bedwetting	no	yes
Behavior problems	no	yes
Bladder or kidney infection	no	yes
Chicken pox	no	yes
Constipation	no	yes
Convulsions or seizures	no	yes
Ear infection	no	yes
Eczema	no	yes
Hay fever	no	yes
Hearing problems	no	yes
Learning problems	no	yes
Pneumonia	no	yes
Sleep problems	no	yes
Speech	no	yes
Transfusion	no	yes
Vision problems	no	yes
Weight problems	no	yes

Other

Developmental History

Child was able to do the following at what age:
Smile
Roll over
Sit alone
Crawl
Walk alone
First words
Toilet trained

Family History

Alcohol or drug problems	no	yes
Allergies	no	yes
Asthma	no	yes
Birth defects	no	yes
Blood diseases	no	yes
Blindness	no	yes
Cancer	no	yes
Convulsions	no	yes
Elevated cholesterol/trig	no	yes
Deafness	no	yes
Death in childhood (incl. SIDS)	no	yes
Diabetes	no	yes
Headaches/migraines	no	yes
Heart defects (incl. congenital)	no	yes
Heart attacks	no	yes
At what age?		
Hip dislocation	no	yes
Hypertension	no	yes
Immune deficiency (incl. AIDS)	no	yes
Learning problems	no	yes
Liver disease	no	yes
Lung disease	no	yes
Mental retardation	no	yes
Psychiatric disorders	no	yes
Thyroid disease	no	yes
TB test—positive results	no	yes
Conditions that run in the family		

Social History

Exposure to passive smoke	no	yes
Smoker in the household	no	yes

Household Parent/Caretaker:

Name	Age	Employer

Married Divorced Separated Widowed Other

Others in the home:

Name	Age	Relation to patient

Others important in childs life:

Name	Age	Relation to patient

Completed by:

Date:

This information has been reviewed with the parent(s)

Provider Signature:

Date:

Patient Name_____Date _____ Account #_____

Bakersfield Pediatrics Office Policies

Please check mark or initial all policies and sign and date at the bottom of the next page to indicate you understand each individual policy. If you have any questions, please ask a member of our staff.

☐ **DEDUCTIBLES, CO-PAYMENTS AND COINSURANCE**- All applicable copays, coinsurance and deductible amounts are due and expected at the time of service. If a deductible is applicable, Bakersfield Pediatrics will collect $100 as an estimated amount for the office visit. Any remaining balance will be billed to the guarantor. If your plan has a coinsurance amount for Preventative visits, an estimated patient responsibility amount will be due at the time of service.

☐ **COVERAGE TERMS**- Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing the terms and conditions of your policy. It is not the responsibility of Bakersfield Pediatrics to know your policy details. As a courtesy Bakersfield Pediatrics will attempt to verify eligibility and benefits, however, we are unable to obtain the exact details of payment until the claim is processed.

☐ **OUTSTANDING BALANCES**- Outstanding balances for all family members are due prior to the physicians visit. Bakersfield Pediatrics has the right to refuse service for non-urgent medical services if balances are not paid in full before the scheduled visit.

☐ **INSURANCE UPDATES-** You are a responsible for providing us any updates to your insurance. If any charges are denied due to not providing current insurance information, the guarantor will be responsible for any unpaid balances.

☐ **BILLING POLICY-** As a courtesy, Bakersfield Pediatrics will bill your insurance for all procedures performed at the time of service. When the Explanation of Benefits and insurance payment is received, your account will be credited. Any remaining patient responsibility will be expected when you receive a statement or at the time of your next appointment (whichever comes first).

☐ **INSURANCE COMPANY DISPUTES**-It is the plan holders' responsibility to negotiate payments with his/her insurance company. Remember, Bakersfield Pediatrics bills your insurance company as a courtesy to you.

☐ **PPO's and HMO's-** We are in network with most PPO plans. We will do our best to verify your plan is in network with Bakersfield Pediatrics, but it is ultimately the plan subscriber's responsibility to confirm their benefits and in network providers. If you have an HMO plan, you will need to select one of Bakersfield Pediatrics physicians as your primary care provider (PCP) before your first scheduled appointment.

☐ **COLLECTION POLICY-** If payment is not made at the time the billing statement is received, you may be responsible for interest and penalties. Bakersfield Pediatrics utilizes an outside collection agency for any unpaid debt. If your account goes to collections you will be responsible for attorney fees, interest and penalties. Bakersfield Pediatrics cannot remove an account from of collections after it has been sent. If any member of the family is sent to collections, the entire family will be discharged from the practice.

☐ **FINANCIAL HARDSHIP-** If you encounter financial hardship, Bakersfield Pediatrics will consider a payment arrangement. Payment arrangements can be set up through our internal billing department. You may contact a member of the billing department for assistance at 949-599-2434.

☐ **WALK-INS-**Bakersfield Pediatrics discourages walk-in appointments as we are better prepared to serve you with advanced notice. If a patient comes in without an appointment scheduled, we will triage the situation and determine whether the patient needs to be seen urgently. We would then do our best to work the patient into our schedule. We do charge a $50.00 walk-in fee, which will be billed to your insurance. This fee is your responsibility should the insurance not cover the charges in full. If it is determined that the patient does not need to be seen urgently and our schedule does not allow for additions at that time, a later appointment time will be offered.

Bakersfield Pediatrics Office Policies - continued

☐ **CHECK AS FORM OF PAYMENT AND RETURNED CHECKS-** Checks will not be accepted as up-front payment for visits that include vaccines, only cash or credit card will be an acceptable form of currency. There will be a $35.00 returned check fee applied to your bill for any returned check to cover the charge incurred from our bank. If Bakersfield Pediatrics receives a returned check, checks will no longer be an acceptable form of payment, only credit will be accepted.

NORMAL OFFICE HOURS- (Last visit is scheduled 15 minutes prior to close)
Monday- Friday: 8:00am to 5:00pm

AFTER HOUR AND WEEKEND HOURS - (Last visit is scheduled 15 minutes prior to close)
Monday- Thursday: 5:00pm-5:45pm

Saturday: 9:00am to 1:00pm

Sunday: 9:00am to 12:00am

A $60.00 after hour/weekend fee will be billed to your insurance as a courtesy, coverage varies by insurance. This fee is your responsibility should the insurance not cover the charges in full. If your insurance carrier is St Joseph/Hoag affiliated, you will be referred to an authorized Urgent Care facility for after hour and weekend care as it is not within our contract agreement with this plan.

☐ **NO SHOWS AND CANCELLATIONS-** If an appointment is missed or is not cancelled 24 hours in advance a $50 fee will be applied to the patient's account. This fee is not covered by insurance and therefore will not be billed to insurance.

☐ **COPY OF MEDICAL RECORDS-** A written request must be received prior to the release of each medical record. Bakersfield Pediatrics charges a reasonable clerical fee of $20.00 for each patient's medical records. We have 14 days from time of written request and payment in full to provide the records.

☐ **FILE REVIEW CHARGES/ LETTER WRITTEN-**There will be an additional charge for all requests for review of records or letters written on the patient's behalf. This charge will be billed to your insurance company and any remainder balances will be your responsibility.

☐ **VACCINE POLICY** – The pediatricians at Bakersfield Pediatrics have all witnessed tragedies and heartbreaks caused by vaccine-preventable diseases. Because of this we are strong advocates for vaccinating children to prevent illnesses we so frequently encountered in the past. We are also aware of the presence of misinformation, not validated by scientific studies, on the value and side effects of vaccines. Not vaccinating children not only puts that child at risk but also other patients of ours, including children too young to vaccinate and children with immune deficiencies. For the safety of all our patients, we will only be accepting children that are vaccinated. If it is your intention not to vaccinate your child, we advise that you find another pediatric group that will better fit your needs.

☐**AUTHORIZATION TO TREAT A MINOR –** Bakersfield Pediatrics will be unable to treat any minor (under the age of 18) without a parent or legal guardian present. A minor may be treated in the presence of an adult other than the parent or legal guardian with proper written consent.

Patient Name:_____ D.O.B._____

Patient Name:_____ D.O.B._____

Patient Name:_____ D.O.B._____

By my signature below, I state that I have read and understand the policies of Bakersfield Pediatrics.

SIGNATURE_____ **DATE:** _____

Patient Name:_____

Bakersfield Pediatrics Acct:_____

Authorization to Release Test Results For Patients Under 18 Years of Age

In order to efficiently convey lab results, test results and/or other communication, Bakersfield Pediatrics is requesting that you provide secure telephone number(s), for our staff to call and leave messages regarding test results. This will help prevent the delay of pertinent information relating to your child. If you have not heard from Bakersfield Pediatrics regarding your lab or test results, please do not hesitate to contact our office.

I, (parent/guardian)_____, give Bakersfield Pediatrics permission to leave messages regarding my child's (patient)_____results, on the numbers listed below.

Primary contact Name: _____Phone: (____)_____

Secondary Contact Name:_____Phone: (____)_____

_____ _____

Signature Date