ABC Children's Clinic Inc.

MARJAN MONFARED, M.D.
ALEX VAN DER HAM, PA-C

26750 TOWNE CENTRE DR. STE. A
FOOTHILL RANCH, CA 92610
P) 949.380.1234 F) 949.305.2230

DEMOGRAPHICS

PATIENT

Patient's Full Name: _____ Date of Birth: _____ Sex: □ Male □ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Primary E-Mail: _____

REQUIRED BY THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American □ Hawaiian Native or Pacific Islander □ White □ Declined to specify

Ethnicity: □ Unknown □ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify

PARENT/GUARDIAN

Father/Guardian: _____ Date of Birth: _____ □ Married □ Single □ Divorced □ Separated

SSN: _____ Driver's License: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Mother/Guardian; _____ Date of Birth: _____ □ Married □ Single □ Divorced □ Separated

SSN: _____ Driver's License: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Responsible Party Of Whom The Child Resides: _____

OTHER CHILDREN

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

EMERGENCY CONTACT

In case of emergency, whom should we contact? (Other than parent)

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE

When using private health coverage and Medi-Cal simultaneously, the private health coverage is billed first. After the private health carrier pays or denies a claim, Medi-Cal is then billed and will pay for services it covers.

Subscriber: _____

Primary: _____ □ PPO □ HMO □ MEDICAL If HMO or Medical, which group: _____

Secondary: _____ □ PPO □ HMO □ MEDICAL If HMO or Medical, which group: _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I authorize ABC Children's Clinic Inc. to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school and camp forms. I authorize payment directly to ABC Children's Clinic Inc. for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance**. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits**. I also understand that I am responsible for advising ABC Children's Clinic Inc. of any all changes to my insurance. Payment of co-pays are due on date of service. **PLEASE SEE FINANCIAL POLICY.**

Signature: _____ Relationship: _____ Date: _____

A photocopy or scan or this authorization shall be considered as effective and valid as the original.

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PAST MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

BIRTH HISTORY

Birth weight _____

Birth length _____

Location of delivery _____

Pregnancy was:
- ☐ Uncomplicated
- ☐ Complicated by: _____
- ☐ Gestational Diabetes
- ☐ Hypertension
- ☐ Pre-eclampsia

There was:
- ☐ Premature Rupture of Membranes
- ☐ Premature Delivery
- ☐ Prolonged Labor _____ Hours
- ☐ Normal Vaginal
- ☐ C/Section for _____

DURING THE PREGNANCY, DID MOTHER:

Smoke	☐ NO	☐ YES
Drink alcohol	☐ NO	☐ YES
Use drugs or medications	☐ NO	☐ YES

What? _____ When? _____

BABY WENT HOME FROM HOSPITAL AFTER:

_____ DAYS

PAST HISTORY

Any existing medical problems?	☐ NO	☐ YES	_____
Is your child on any current medications?	☐ NO	☐ YES	_____
Allergies (seasonal, environmental, food or medication)	☐ NO	☐ YES	_____
Any previous hospitalizations?	☐ NO	☐ YES	_____
Any previous surgeries?	☐ NO	☐ YES	_____
Asthma, Bronchitis, Bronchiotis or pneumonia	☐ NO	☐ YES	_____
Chicken Pox	☐ NO	☐ YES	_____
Chronic Skin Problem (acne, eczema)	☐ NO	☐ YES	_____
Diabetes	☐ NO	☐ YES	_____
Frequent Ear Infections	☐ NO	☐ YES	_____
Heart Problem or Heart Murmur	☐ NO	☐ YES	_____
Use of drugs or alcohol	☐ NO	☐ YES	_____

FAMILY HISTORY

PLEASE LIST WHICH RELATIVE (MATERNAL OR PATERNAL):

Diabetes	☐ NO	☐ YES	_____
High Blood Pressure	☐ NO	☐ YES	_____
Heart Disease	☐ NO	☐ YES	_____
Asthma	☐ NO	☐ YES	_____
Allergies	☐ NO	☐ YES	_____
Cancer	☐ NO	☐ YES	_____
Alcohol or Drug Abuse	☐ NO	☐ YES	_____

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TUBERCULOSIS ▪ LEAD ▪ TOBACCO QUESTIONAIRE

Name: _____ DOB: _____ Date: _____

TUBERCULOSIS RISK ASSESMENT

1.	Was your child born in Africa, Latin America, Caribbean, or Eastern Europe?	☐ NO	☐ YES
2.	Has your child traveled to or lived Africa, Asia, Latin America, Caribbean or Eastern Europe for more than one week?	☐ NO	☐ YES
3.	Has your child been exposed to anyone with TB disease?	☐ NO	☐ YES
4.	Does your child have close contact or live with anyone who was positive for TB skin test?	☐ NO	☐ YES
5.	Has your child spent time with anyone who has been in jail, uses illegal drugs or has HIV?	☐ NO	☐ YES
6.	Has your child ever tested HIV positive?	☐ NO	☐ YES
7.	Does your child live with someone who was born outside of the United States?	☐ NO	☐ YES
8.	Does your child live with someone who has traveled outside of the United States?	☐ NO	☐ YES

LEAD POISONING RISK ASSESMENT

1. Does your child live in or regularly visit a house/preschool/child care center built before 1960?	☐ NO	☐ YES
2. Does your child live in or regularly visit a house, child care center or other building that is being remodeled or having paint removed?	☐ NO	☐ YES
3. Does your child live with or regularly visit another child that has lead poisoning?	☐ NO	☐ YES
4. Does your child chew on or eat non-food items like paint chips or dirt?	☐ NO	☐ YES
5. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?	☐ NO	☐ YES
6. Do you give your child home remedies that may contain lead?	☐ NO	☐ YES

TOBACCO RISK ASSSEMENT

1. Does anyone in the house smoke?	☐ NO	☐ YES
2. Does anyone smoke at your child's daycare?	☐ NO	☐ YES
3. Does anyone smoke at the place where your child frequently visits?	☐ NO	☐ YES

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FINANCIAL POLICY

ABC Children's Clinic believes providing and maintaining a positive and communicative physician-patient relationship with our families is important. We want to make sure you understand all ABC Children's Clinic financial policies relating to your responsibility as well as the responsibility of your insurance company. We will be happy to provide further clarification if needed. After your review, please sign the Financial Policy. If you have any questions, please do not hesitate to ask a member of our staff.

DEMOGRAPHICS

All demographic information will be updated annually. It is the patient's or legal guardian's responsibility to inform us of address and telephone number changes. We will need these in written form, therefore, please arrive 15 minutes early for your appointment when needing to update any information.

IDENTITY THEFT PROTECTION

A copy of all parents' drivers' licenses and insurance cards must be kept on file for your protection in compliance with HIPAA and Red-Flag.

NEWBORNS

Newborns are usually covered by the mother's insurance and medical group for the first 30 days of life. The baby must be added to the insurance policy as soon as possible within the first 30 days of life for coverage to continue for your child. If this is not done, your insurance may not cover your child and you will be responsible to ABC Children's Clinic and other health care providers for the cost of all care provided, including the hospital stay. Insurance carriers limit the amount of time we can retroactively bill. You must provide us with a current insurance card at your 2 month visit.

UNINSURED

If you have no insurance or if you have insurance with which we are not contracted, payment in full is due at the time of each visit. Payments for services that are not covered by your insurance carrier are due in full at the time of each visit. We have found that some insurance plans do not cover Well Care and circumcisions. Please contact your carrier regarding coverage for these services.

HMO – CALOPTIMA POLICY

If you have an HMO or Cal Optima policy, please make sure that Dr.Marjan Monfared is selected as your primary care provider (PCP) and you are assigned to one of the following IPA's (health group). If your insurance company has not been informed that we are the PCP as of the date of your visit, you will be responsible for the full cost of the visit.

COMMERICIAL HMO	**CAL OPTIMA - MEDICAL**
Prospect	**CHOC Health Alliance**
Regal	**Cal Optima Direct**
Arta Western	

COPAY

Co-payments specified by your insurance are due at each visit by the accompanying adult.

INSURANCE

On arrival, please present you current insurance card at every visit. After billing your insurance company, the remaining balance is your responsibility. You will receive a statement if your insurance carrier has responded and a payment is due from you. Insurance carriers limit the amount of time we can retroactively bill. You must provide us with a current insurance card within 30 days of the visit.

Should your insurance company deny payment for services performed, it is the insured's responsibility to pursue the issue. Billed services not covered by insurance are the insured's responsibility, including vaccine charge.

FINANCIAL AGREEMENT

I, the undersigned, assign all medical or surgical benefits form the insurance carriers directly to ABC Children's Clinic and/or their associates for services rendered to me (or my dependents). I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that if my insurance has been paid within 90 days of claims submittal, I will become financially responsible for the charges. I hereby authorize this office to release information required by the insurance carriers to secure the payment of benefits. I have read and understand that office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name _____ Date Of Birth _____

Responsible Party Name _____ Relationship To Patient _____

Signature _____ Date _____

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PRIVACY NOTICE ACKNOWLEGEMENT

Name: _____ DOB: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I hereby acknowledge that I received a copy of this Medical Practice's Notice of Privacy. I further acknowledge that a copy of the current notice will be available at each appointment.

Parent/Legal Guardian Name: _____

Signature: _____ Relationship to patient: _____

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PATIENT PORTAL CONSENT

Name: _____ DOB: _____ Date: _____

Email Address: _____
(Please provide email address to which you have consistent access)

ABC Children's Clinic's "Patient Portal" is a secure confidential easy to use website, administered and maintained by Office Practicum on behalf of ABC Children's Clinic. The portal uses encryption and gives 24 hour access to your medical record. Secure messages and information can only be viewed by someone entering the correct username and password to log into the Patient Portal site. We will assign you this login information upon completion of this form.

From this portal you can:

- Request appointments, view and print immunization records
- Request and print completed school, camp, and sports physical forms
- Request prescription refills (controlled medications do not apply)
- View your child's health records and send messages to clinical staff
- Update contacts, address, and other demographic information
- View and request specialty referrals

Once you have reviewed, signed and returned this form to ABC Children's Clinic, we will give you a username and email a password to set up your portal account.

PARENT/LEGAL GUARDIAN ACKNOWLEGMENT AND CONSENT

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between my physician and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered to my satisfaction.

Parent/Legal Guardian Name: _____

Signature: _____ Relationship to patient: _____

ACCESS PATIENT PORTAL

https://patientportal.intelichart.com