Coastal Kids

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, Coastal Kids. 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 Coastal Kids within this time frame, any unpaid balance becomes your sole responsibility.

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

- I authorize Coastal Kids to file insurance claims for services and supplies rendered to and for my/our child(ren).
- I authorize Coastal Kids 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 Coastal Kids.
- I assign to Coastal Kids all payments for medical services and supplies provided to my dependent child(ren).

I understand that I am financially responsible to Coastal Kids for the above-named patient(s). If my insurance company fails to fully compensate Coastal Kids 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, Coastal Kids has the right to charge my payment card that I have on file with them. In the event Coastal Kids refers my account to an attorney to collect any monies owed to Coastal Kids. Coastal Kids 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 Coastal Kids 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) CK Office Policies ***Please initial. __________***

____ _______________________________

Parent/Guardian Signature **Date**

____

Printed Name

Acct#:

Coastal Kids 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 ____________________
Psychiatric disorders no yes ____________________
Thyroid disease no yes ____________________
TB test—positive results no yes ____________________
Conditions that run in the family no yes ____________________

____

____

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 #___________

Coastal Kids 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, Coastal Kids 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 Coastal Kids to know your policy details. As a courtesy Coastal Kids 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. Coastal Kids 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, Coastal Kids 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, Coastal Kids 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 Coastal Kids, 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 Coastal Kids 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. Coastal Kids 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. Coastal Kids 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, Coastal kids 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-**Coastal Kids 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.

Coastal Kids 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 Coastal Kids receives a returned check, checks will no longer be an acceptable form of payment, only cash or 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. Coastal Kids 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 Coastal Kids 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 –** Coastal Kids 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 Coastal Kids.

SIGNATURE____ **DATE:** __________________________

Patient Name:____

Pt Acct #:

Coastal Kids
Payment on file Agreement

Acct #: ____________

Coastal Kids

Payment Card on File Agreement

Dear Parent or Guardian,

In order to streamline our collection process, you will be asked to provide a payment card to be held securely on file. A payment card is considered one of the following cards: debit, credit, FSA, HSA or HRA. Please be assured your payment card information is stored by an encrypted merchant service and Coastal Kids only has access to the last 4 digits of your card.

You will have ample time to review and/or question your insurance companies' determination of benefits.

If you decline a request for a payment card on file and your account becomes delinquent, a payment card on file will become a requirement.

I authorize Coastal Kids to charge the payment card on file for outstanding patient portion balances for the following patients:

Patient Name:____D.O.B.______________________

Patient Name:____D.O.B.______________________

Patient Name:____D.OB._______________________

Last 4 digits of payment card:

Authorized Signature:____________________________________ Date:___________________________

Printed Name:____

Coastal Kids   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, Coastal Kids 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 Coastal Kids regarding your lab or test results, please do not hesitate to contact our office.

I, (parent/guardian)______________________________, give Coastal Kids 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