INSTRUCTIONS

Welcome and thank you for choosing Northwest Pediatric Medical Group to meet your child's health care needs. We look forward to meeting your family.

This is a list of the paperwork included in the New Patient packet necessary for the registration process.

Please complete the forms and bring them to your first office visit.

1. **Registration Form** will give us the basic information about your family and insurance.

2. **Medical History Form** will tell us about your child's medical history.

3. **Notice of Privacy Practice Consent Form (also known as the HIPPA Form)** will let us know that you have read about our privacy practices (these can be found on the new patient page of our website northwestpediatricmedicalgroup.com/new patient).

4. **Appointment Reminder Consent Form** will allow us to text or leave messages to remind you of upcoming appointments.

5. **24 Hour Cancellation & "No Show" Fee Policy** explains our policy for appointment cancellations and appointment "no shows".

6. **Telehealth Informed Consent** allows us to conduct telehealth sick visits as needed to accommodate your child.

7. **Authorization to Use & Disclose Medical Information** will allow NW Pediatrics to disclose information regarding the minor's medical care to those non-guardian adult(s) listed on the form. **This is optional and is typically for grandparents or other family members to bring child to appts when you are unable to.**

8. **Authorization for Release of Confidential Information** is used to request medical information/records from your previous pediatrician. Only complete the highlighted items that may apply to you.

The Initial Visit

If you're preparing for your child's first visit, please bring the following items:

- Insurance card(s)
- Parent's photo ID
- Co-pay
- Complete immunization records
- List all of your child's medications and dosage (or take pictures of the labels)
- Medical records from your previous pediatrician (If you do not have them, we can request them after you have signed a release of records form)

7355 N. PALM AVENUE #100 ● FRESNO, CA 93711 ● 559.271.6300 ● FAX 559.271.6326

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PATIENT REGISTRATION FORM

Date:____________________ Patient/MRN:__________
Primary Care Physician:____________________

PATIENT INFORMATION

Patient:__________ SSN:__________ DOB:__________
Marital Status:__________ Employer/School:__________ Sex:__________
Address:__________ City/State:__________ Zip:__________
Phone- Home:__________ Cell:__________ Work:__________

RESPONSIBLE PARTY (only if patient is a Dependent)

Parent/Legal Guardian:__________ SSN:__________ DOB:__________
Relation to Patient:__________ Employer:__________ Sex:__________
Address:__________ City/State:__________ Zip:__________
Phone- Home:__________ Cell:__________ Work:__________

EMERGENCY CONTACT/GUARDIAN

Name:__________ Relation to Patient:__________ Phone:__________
Address:__________ City/State:__________ Zip:__________

INSURANCE INFORMATION-PRIMARY

Company:__________ Employer:__________
Group:__________ ID:__________ Copay:__________
Subscriber:__________ SSN:__________ DOB:__________
Relation to Patient:__________ Phone:__________ Sex:__________
Address:__________ City/State:__________ Zip:__________

INSURANCE INFORMATION-SECONDARY

Company:__________ Employer:__________
Group:__________ ID:__________ Copay:__________
Subscriber:__________ SSN:__________ DOB:__________
Relation to Patient:__________ Phone:__________ Sex:__________
Address:__________ City/State:__________ Zip:__________

This office will bill all HMO and PPO contracted payers- copayments and/or deductibles must be paid at the time of visit.
I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30 day period for all charges whether or not paid by said insurances. I hereby authorize said insurances to release information necessary to secure payment.

Signature:____________________ Date:__________

HISTORY

Date:______________________________ History given by:______________________________

History recorded by:______________________________

FAMILY MEMBERS	BIRTHDATE	HT	WT	HEALTH CONDITIONS
MOTHER				
FATHER				
SIBLINGS	BIRTHDATE	SEX		

Referred by:__________________________

FAMILY HISTORY OF CHILD

Allergies:______________________________

Diabetes:______________________________

Heart Disease:______________________________

Hypertension:______________________________

Kidney Disease:______________________________

Cancer:______________________________

Cystic Fibrosis:______________________________

Hip Dysplasia:______________________________

Scoliosis:______________________________

Thyroid:______________________________

Sickle Cell:______________________________

Hemophilia:______________________________

Mental Retardation:______________________________

Seizure Disorder:______________________________

T.B. Contact:______________________________

Eye Condition:______________________________

Hearing Loss:______________________________

Other:______________________________

PAST HISTORY OF CHILD

Pregnancy: Full-Term/Premature Delivery: Vaginal/Caesarian

Birth Weight:________________ Length:____________

Breast/Formula Drugs/Tobacco/Alcohol

Illnesses:______________________________

Hospitalizations:______________________________

Operations:______________________________

Drug Reaction:______________________________

Food Reaction:______________________________

Pollen Allergy:______________________________

SYSTEMS REVIEW

HEENT:______________________________

____

C.R.:______________________________

____

G.U.:______________________________

____

N.M.:______________________________

____

Other:______________________________

Current Regular Medications:______________________________

DEVELOPMENTAL MILESTONES

SMILES	SITS	STANDS	TRANSFERS OBJECTS	WALKS	FINE PINCHER	WORDS
PHRASES	KNOWS COLORS	PEDALS TRIKE	TOILET TRAINED DAY	TR NIGHT	RIDES BIKE	TIES SHOES

Place label here

MRN:________________

NOTICE OF PRIVACY PRACTICES
CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Community Medical Providers.

____
Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative

____
Authorized Representative's Relation to Patient

____
Date

NORTHWEST
MEDICAL GROUP
A member of Community Foundation Medical Group and Community Medical Providers

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FRESNO, CA. 93711
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APPOINTMENT REMINDER
CONSENT FORM

Patient Name:_____________________________ **DOB:**___________________________________

_______ Reminders via **VOICEMAIL** should be directed to (*choose one*)

HOME phone (___)________________ *or,* **CELL** phone (___)__________________

_______ Reminders via **TEXT** should be sent to **CELL** phone (___)_____________________

Who does this number belong to? (*full name*) ____

Relationship

- o Self (*if age 18 or older*)
- o Spouse
- o Mother
- o Father
- o Step Mother
- o Step Father
- o Legal Guardian

I consent to receive calls and/or texts from Northwest Medical Group/Sante Health/Community Medical Foundation Medical Group for appointment reminders at the phone number(s) above, including my wireless number provided. Normal text messaging rates may apply.

Patient (*if age 18 or older*)/**Authorized Signature:** ____

Please print your name (*if different from patient*): ____

Authorized Representative's Relation to Patient: ____

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, CMP-Northwest Pediatric Medical Group, aka Community Foundation Medical Group, will charge a fee of $35.00 for all missed appointments ("no shows") and appointments which, are not cancelled with a 24-hour advance notice.
"No Show" fees will be billed to the patient and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in dismissal from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

______________________________	______________________________
Patient Printed Name	Date
______________________________	______________________________
Parent/Guardian Signature	Printed Parent/Guardian Name and Relation to Patient

PT NAME: ____________________
DOB: ________________________

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

PATIENT INITIALS

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of California at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medi-Cal, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

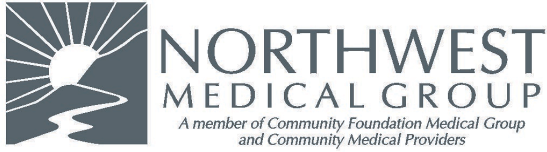
_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Community Medical Providers, staff and ______________________________.
(Patient's name)

______________________________	______________________________
Patient or Legal Representative Signature	**Relationship to Patient**
______________________________	______________________________
Print Patient or Legal Representative Name	**Witness Signature/Date/Time**



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AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

(   ) I authorize Northwest Medical Group to use and disclose medical information regarding my medical care.

Name of Patient: ________________________________ DOB:_____________________________

Consisting of **ANY AND ALL MEDICAL INFORMATION**

Name of Recipient(s):____________________________ Relation to Patient:_____________________

Recipient(s) Phone Number:_______________________

Name of Recipient(s):____________________________ Relation to Patient:_____________________

Recipient(s) Phone Number:_______________________

Name of Recipient(s):____________________________ Relation to Patient:_____________________

Recipient(s) Phone Number:_______________________

Name of Recipient(s):____________________________ Relation to Patient:_____________________

Recipient(s) Phone Number:_______________________

If we are requesting this authorization form from you for our own use and disclosure, or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services/treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of this signed authorization
  You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

By: ______________________________________ **Date:**______________________________
(Patient)

Or By: __________________________________ **Relation to Patient:** __________________________
(Patient's Legal Representative)

Please print your name (*if different from patient*):____

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

HIPAA RELEASE FORM

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

SECTION I
I,________________________________ give my permission for ____________________________to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

SECTION II – HEALTH INFORMATION

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

☐ Disclose my complete health record except for the following information:

☐ Mental health records

☐ Communicable diseases including, but not limited to, HIV and AIDS

☐ Alcohol/drug abuse treatment records

☐ Genetic information

☒ Other (Specify) PROBLEM LIST, SHOT RECORD, GROWTH CHART & ANY RECORDS DEEMABLY NECESSARY FOR THEIR CARE
____

Form of Disclosure:

☒ Electronic copy or access via a web-based portal

☒ Hard copy

SECTION III – REASON FOR DISCLOSURE

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

TRANSFERRING CARE / NEW PCP
____
____
____

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

SECTION IV – WHO CAN RECEIVE MY HEALTH INFORMATION

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

NAME: MEDICAL RECORDS DEPT

ORGANIZATION: NORTHWEST PEDIATRIC MEDICAL GROUP

ADDRESS: 7355 N PALM AVE, FRESNO, CA 93711

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION V – DURATION OF AUTHORIZATION

This authorization to share my health information is valid:

☐ From ________________________ to ________________________.

☒ All past, present, and future periods

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

NAME: ____

ORGANIZATION: ____

ADDRESS: ____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

FOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
MEDICAL RECORDS RELEASE REQUEST

SECTION VI – SIGNATURE & IDENTIFICATION

Signature: ______________________________ Date: ______________________________

Print your name: ____

Date of birth: ______________________________ Phone Number: ______________________

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: ______________________________________

Signature of person completing this form: __________________________________

Describe below how this person has legal authority to sign this form:

____

____

____

____