Stephen P. Kundell, MD and Laila Niazi, MD
Thousand Oaks Pediatrics

Father's Name________________________ Address____________________________________
Street City State Zip

Father's Home Phone ________________ Work Phone ________________ Cell Phone ________________

Father's DOB________ Employer______________ Occupation______________ SS#______________

Employer Address____________________________________ Father's email__________________

DL#:__________________________ exp__________

Mother's Name ______________________ Address____________________________________
Street City State Zip

Mother's Home Phone ________________ Work Phone ________________ Cell Phone ________________

Mother's DOB________ Employer______________ Occupation______________ SS#______________

Employer Address____ Mother's email________________

DL#:__________________________ exp:__________

Which parent is primary insured: ___________________
Preferred Contact Individual for appointments, lab results, and other communication: ______________________
Preferred contact type: □ email, □ cell phone, □ home phone,

PLEASE BRING YOUR CURRENT INSURANCE CARD OR A LEGIBLE COPY TO THE VISIT

CHILDREN **Please write names,birthdates, and cell phone if applicable**

1____ 4. ___________________________________

2.____ 5. ___________________________________

3.____ 6. ___________________________________

Has any parent or child died? Yes_____ No_____ If yes, what cause? ___________________________

Are any children adopted? Yes_____ No_____ If yes, at what age? ___________________________

Previous or referring physician ____

Person to contact in emergency, if neither parent is available:

Name____ Relationship _________________________

Address ____

Phone______________________________________

I wish to assign insurance payment to Drs. Kundell and Niazi. I understand that my insurance plan may require a review of records prior to reimbursement. I give my permission for said record release.

Signature____ **Date**______________________

THOUSAND OAKS PEDIATRICS
PEDIATRIC HISTORY FORM

Child's Name________________ **BD**______________ **Age**_________ **Today's Date**___________

A. BIRTH HISTORY

(Circle any that apply and give details)

1. *Pregnancy:* Planned, Unplanned, Problems Conceiving, IVF, Drug Use, Alcohol, Tobacco, Medications, Illness, Injury, High Blood Pressure, Diabetes________________________________

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2. *Birthplace:*________________________________
3. *Labor:* Normal, Premature (# weeks) _________ Late, Induced, Spontaneous, C-Section (why):

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Duration of Labor _____________

4. *Birthweight* _____________ *Length*____________
   Apgar Scores ________________________________
5. *Problems after birth*: None, Breathing, Apnea, Infection, Feeding Problems, Jaundice, Seizures, Colic ________________________________

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6. If baby was in NICU, for how long?____________

B. PAST MEDICAL HISTORY

1. How is your child's general health? __________
2. *Hospitalizations & Surgeries* (when, where, why)

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3. *Serious Injuries*________________________________

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4. **Allergic Reactions (to drugs, food, etc)**

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5. *Immunizations* (any routine shots that your child has **not** had)________________________________

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6. *List serious illness, medical diagnosis, or chronic illness:*________________________________

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7. *Current medications*________________________

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8. *Systems Review*: Has your child had any of the following?
(Circle all that apply and give details)
Headaches, frequent ear infections, wears glasses, frequent red eyes, eyes cross, frequent sinus infections, nasal allergies, frequent sore throats, pneumonia, frequent cough, nighttime cough, asthma, frequent croup, chest pain, heart murmur, irregular heart beat, frequent stomach aches, heartburn, diarrhea, constipation, blood in stool, urinary problems, bed wetting, urinary infection, blood in urine, swollen joints, back pain, frequent skin rash, seizures, weakness, anemia, bleeding problems, Sleep problems, nightmares, night terrors, snoring, sleep apnea, anesthesia problems, chicken pox, scarlet fever, roseola,

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C. DEVELOPMENT

1. *Milestones:* Age when your child first:
Sat________Crawled_______Walked___________
Few Words______ Phrases__________________
Toilet Trained- Urine________ -Bowel _________
Any concerns about development?____________

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2. *School:* Grade Level____________________
Avg. Grades______________________________
Special Education? ________________________
Special services like OT, PT, Speech?___________

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3. *Any behavior problems?*

____

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4. *Routines:*
   Feeding Problems__________________________
   Special Diet______________________________
   Vitamins, Fluoride _________________________
   Nutritional supplements ____________________
   Habits __________________________________
   Sports __________________________________
   Hobbies _________________________________

THOUSAND OAKS PEDIATRICS

HIPPA PRIVACY ADMINISTRATOR: Stephen P. Kundell, MD (805.480.3730)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ____________________ Date: ____________________

Print Name: ____________________ Telephone: ____________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ______________________________

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Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

≤Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

____

Firmado: ____________________ Fecha: ____________________

Imprimir Nombre: ____________________ Teléfono: ____________________

Si no está firmada por el paciente, por favor indique la relación:

≤ El padre o tutor del paciente menor de edad

≤ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: ______________________________

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THOUSAND OAKS PEDIATRICS
Stephen P. Kundell, MD and Laila Niazi, MD

FINANCIAL POLICY
EFFECTIVE October 1, 2014

Please review our financial policies that follow and sign below.

- ***Returned checks.*** All returned checks will be charged a $12.00 fee in addition to the balance owed.
- ***Well and sick visits at the same time.*** Your insurance company may cover well and sick visits differently,

and it is very important that you familiarize yourself with the details of your insurance coverage. No one likes being surprised with a bill! While some insurance companies may pay for well visits 100% (where there is no cost to you), sick benefits may include a copay, co-insurance, and/or deductible. If during a well visit your child is sick or has an issue that is not related to the normal growth and development of your child, and he/she needs treatment and/or medical attention for your concerns, *your provider may bill the insurance company for both services*. Regardless of whether there is no charge for the well visit, you will be responsible for any charges passed on to you for the sick visit portion.

- *Proof of Insurance.* Proof of insurance must be shown at any time there has been a change. Without proof of insurance, you will be charged for the visit in full. **For newborns**, proof of application will be expected by the 30-day mark for those still not added to the insurance. Most commercial insurance companies allow THE FIRST 30 days since birth to add your newborn to your plan. Please do so as soon as possible. All newborn bills will be held and sent to the insurance company once it can be verified that the newborn has coverage. By 2-months of age, all babies without proof of insurance will be expected to pay in full for their 2-month well visit and all visits since birth.
- ***Financial responsibility.*** **Payment is determined from benefits we receive from your insurance company. Regardless of what is quoted or misquoted by them, you are ultimately responsible for any deductibles, co-insurances, or copays that are not paid by your insurance company. All balances are due per the terms regardless of claims status. This includes services they do not think are medically necessary, or do not cover, but that our providers deem necessary, appropriate and/or a standard of care for pediatrics. I understand that any amount due and owing over 30 days may accrue interest and finance charges of 1.5% per month, not to exceed 18% per annum.**
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* The ABN serves as warning that your medical insurance may not pay for the care your provider recommends. However, it is still possible that your medical insurance will approve coverage. To get an official decision from your medical insurance, you must first receive the care and sign the ABN form, agreeing to pay for it yourself if your medical insurance rejects coverage. When you receive your Explanation of benefits (EOB) and shows that coverage has been denied for a service or item, you should file an appeal. Receiving an ABN does not prevent you from filing an appeal. Signing below means that you have received and understand this notice.

Please call our billing office if you have any questions. Conejo Valley Practice Management - (805) 375-0874

continued on next page....

QUESTIONS TO ASK YOUR INSURANCE

1. What are my vaccine benefits? Does a deductible apply? How much? Do I have a co-insurance? How much? Will copay apply if I only need to get vaccines and do not see my doctor? Is there a maximum benefit or cap on my vaccine benefits? What is that limit?
2. What are my sick benefits? Is there a deductible? Co-insurance? Copay? How much in each case?
3. What are my child's well benefits? Does a deductible, co-insurance or copay apply? How much? Is there a maximum benefit or cap on these services? What is the limit? Is there a limit on the number of well visits I can have in a year? If so, what? Do well benefits end at a certain age?
4. What is my benefit year? Does it start over on Jan. 1? Can my (older) child get one well visit per calendar year or benefit year?
5. For any of these services, do I have a copay *and* co-insurance? To which services does this apply?
6. Is this information all spelled out clearly in my benefit handbook? If not, can I get this in writing? Is this information available online to me?

I, the undersigned, hereby agree to the office policy as stated above, and I agree that in the event of default in the payment of any amount due, if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Parent/Guardian Signature ______________________________________ Date: ____________

Print Name of Parent/Guardian ____

LIST ALL DEPENDENTS ________________________________ Date of Birth ____________

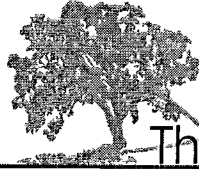
Patient Name (PRINTED) ______________________________ Date of Birth ____________

Patient Name (PRINTED) ______________________________ Date of Birth ____________

Patient Name (PRINTED) ______________________________ Date of Birth ____________

Patient Name (PRINTED) ______________________________ Date of Birth ____________

updated 8/25/19



Pediatrics, Adolescent Medicine, Developmental Pediatrics, Special Needs

Laila Niazi, M.D. Stephen Kundell, M.D..

Consent to Receive Email and/or Text Messages from Thousand Oak Pediatrics

By signing below, I authorize THOUSAND OAKS PEDIATRICS through its vendor TEXTING SERVICE to contact me by SMS text or via email message to serve me better. THOUSAND OAKS PEDIATRICS will send me messages through the THOUSAND OAKS PEDIATRICS member outreach program to help me or my child stay healthy, including:

- Timely reminders about needed doctor visits
- Timely reminders about upcoming appointments

I understand that message/data rates may apply to messages sent through THOUSAND OAKS PEDIATRICS to my cell phone. The reminders will notify you about 3 days before, 1 day before and day off the appointment.

I know that I am under no obligation to authorize THOUSAND OAKS PEDIATRICS to send me text messages or emails as part of this program.

I may opt-out of receiving these communications from THOUSAND OAKS PEDIATRICS at any time by calling THOUSAND OAKS PEDIATRICS @ (805) 480-3730.

Preferred Method of Reminder, please circle one:

a. Text Message to phone
b. Email
c. Or Both

Please list the email or phone number for THOUSAND OAKS PEDIATRICS to send you messages as per the selection made above:

Email ________________________

Phone ________________________

SMS **texting** and/or **email messaging** shall be used as a communication platform from THOUSANDS OAKS PEDIATRICS to the patient, this service **shall not be used** to communicate any protected health **information** of **patients**.

Name: ____

Patient Name: ____

Signature: ____

Date: ____/____/____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: ____________________

I AUTHORIZE THE RELEASE OF MEDICAL RECORDS ON:

PATIENT'S NAME: ______________________________________

BIRTHDATE: ______________________________________

ADDRESS: ______________________________________

CITY, STATE, ZIP: ______________________________________

FROM: ____

____

____

TO:

__ **STEPHEN KUNDELL, M.D.**
__ **LAILA NIAZI, M.D.,**
THOUSAND OAKS PEDIATRICS
1000 Newbury Road, Suite 200
Newbury Park, CA 91362
PHONE: 805-480-3730
FAX: 805-480-1951

INCLUDE:

__ **ALL MEDICAL RECORDS**

__ **MENTAL HEALTH RECORDS**

__ **SUBSTANCE ABUSE RECORDS**

__ **HIV/ STD TESTING RESULTS**

I understand that this may include information relating to mental or emotional diagnoses.

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SIGNATURE (PARENT OR GUARDIAN, OR PATIENT IF OVER 18 YRS)

NAME / RELATIONSHIP: ____