TLC PEDIATRIC MEDICAL GROUP PATIENT REGISTRATION FORM

Last Name: _____
First Name: _____
Address: _____
City, State, Zip: _____
Gender: [ ] M [ ] F
Primary Language: [ ] English [ ] Spanish
Interpreter: [ ] Yes [ ] No

Date of Birth: _____
Social Security: _____
Primary Phone: _____
Secondary Phone: _____
E-Mail: _____
Pharmacy Name: _____ Phone #: _____
Address (If available): _____
City, State, Zip: _____

Siblings Name	Gender	
_____	[ ] M [ ] F	Sibling DOB: _____
_____	[ ] M [ ] F	Sibling DOB: _____
_____	[ ] M [ ] F	Sibling DOB: _____

RESPONSIBLE PARTY

Mother/Legal Guardian Information

Name: _____
Home # _____ Cell # _____
Address: _____
City, State, Zip: _____
Date of Birth _____
Social Security _____
Driver's License # _____
Employer _____
Address _____
Telephone # _____

Father/Legal Guardian Information

Name: _____
Home # _____ Cell # _____
Address: _____
City, State, Zip: _____
Date of Birth _____
Social Security _____
Driver's License # _____
Employer _____
Address _____
Telephone # _____

INSURANCE INFORMATION

Policy Holder: _____
Primary Insurance: _____
Co pay: _____

What is the child's living situation if not with both biological parents? ☐Adoptive Parents ☐joint custody ☐Foster Parents ☐single custody (who)?

TLC Pediatric Medical Group and all affiliated providers are licensed and board certified, see certificate in back hallway.

EMERGENCY CONTACT INFORMATION

Who can be contacted besides Responsible Party/Parents?
Name: _____
Relation to Patient: _____

Home Phone _____
Cell Phone _____
Work Phone _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I Authorize TLC Pediatric Medical Group's physicians to provide care for my child(ren), and hereby authorize TLC Pediatrics Medical Group to release any medical information necessary to process insurance claims.

Signature _____ Date _____

Any Co pay or Deductible is payable at the timeof service by the person who brings the patient to our office, regardless of relationship status.

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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Financial Policy

Thank you for choosing our practice. We are committed to the success of your child or children's medical treatment and care. Please understand that payment for our services is part of our treatment.

We accept payment by cash, check, Visa, MasterCard, Amex, Discover and Debit card. We also accept payment by phone. Our Front Desk Coordinators will print a receipt for you as proof of payment. Co-Pay for sick visits is non-negotiable. Co-Pay is payable at time of service. All returned checks will be assessed an additional charge of $20.00. This charge is not covered by insurance.

If you are unable to keep an appointment, we ask you to call to reschedule or cancel no later than 24 hours prior to your appointment as a courtesy to other patients.

Please bring your insurance card to each visit. For security reasons you may be asked to produce your driver's license. Deductible, Co-Insurance and Co-Pays are a contractual obligation between you and your insurance. All claims are processed electronically. Once the claim is forwarded to the appropriate insurance carrier, you will receive a statement. Your insurance may forward an explanation of benefits to you. You may be asked to sign a waiver form during your office visit to accept financial responsibility for non-covered services. Balance due is expected within 30 days of statement date.

If one of our physicians refers your child to a specialist, our Referral Coordinator will help you coordinate all necessary steps and provide you with the information and referral documentation.

A parent, legal guardian or authorized adult must accompany minor patients. The accompanying adult is responsible for payment of co-pay at the time of service regardless of relationship status. If you choose to send your adolescent child to our office without an authorized adult present, our office must have written permission on file in order to treat the patient. **For any billing questions, feel free to call our billing department.**

I have read and understand and agree to the above financial policy. I understand that in the event that my insurance company denies payment of a claim either in whole or in part I am responsible for payment in full. I hereby authorize payment of insurance benefits directly to the physician for medical services provided. I hereby authorize the release of medical information necessary to process the claim.

Signature: _____ Date : _____

TLC MEDICAL GROUP, INC.

HIPAA Privacy Rule

It is the policy of this medical practice that our employees comply with our Notice of Privacy Practices, which is consistent with HIPAA and California law.

Our Notice of Privacy Practices is provided to all our patients at the first patient encounter if possible. Copies are available at our reception desk.

A. How this Medical Practice May Use or Disclose Health Information.

At TLC Pediatrics we collect medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files and on a computer. This information is considered "protected health information" under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patients written authorization.

1.Treatment: We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. We may also disclose medical information to members of the patients' families or others who can help them when they are sick or injured.

2. Payment: We use and disclose medical information to obtain payment for the services we provide. We may also assist other health care providers in obtaining payment for services they have provided to our patients.

3. Appointment Reminders: We may use and disclose medical information to contact and remind our patients about appointments.

4. Sign-in sheet: We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

5. Notification and communication with family: We may disclose our patients' health information to notify or assist in notifying family members, personal representatives or other persons responsible for their care about their location, general condition or in the event of death. If our patient or guardian is able and available to agree or object, we will give the patient or guardian the opportunity to object prior to making these disclosers, although we may disclose this information in a disaster even over the patient's or guardian's objection if we believe it is

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necessary to respond to the emergency circumstances. If our patient or guardian is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

6. Required by law: As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law.

7. Public health: We may, and are sometimes required by law, to disclose our patient's health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Judicial and administrative proceedings: We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them.

9. Law enforcement: We may, and are sometimes required by law, to disclose our patients' health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

B. Our Patients' Health Information Rights.

1. Right to request special privacy protections: Our patients have the right to request restrictions on certain uses and disclosures of their health information, by a written request specifying what information they want to limit and what limitations on our use or disclosure of that information they wish to have imposed. We reserve the right to accept or reject these requests, and will notify each patient of our decision.

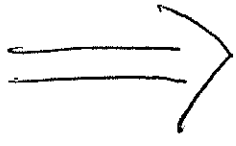
2. Right to request confidential communications: Our patients have the right to request that they receive their health information in a specific way or location. We will comply with all reasonable requests submitted in writing which specify how or where they wish to receive these communications.

3. Right to inspect and copy: Our patients have the right to inspect and copy their medical information, with limited exceptions. To access their medical information, they must submit a written request detailing what information they want access to

and whether they want to inspect it or get a copy of it. We will respond to every written request within the time required by California and federal law. We will charge a reasonable fee, as allowed by California and federal law. We may deny their request under limited circumstances. If we deny a guardians' request for their Childs records because we believe allowing access would be reasonably likely to cause substantial harm to the patient, they have the right to appeal our decision.

4. Right to amend or supplement: Our patients have a right to request that we amend their health information that they believe is incorrect or incomplete. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change their health information, and if we refuse, we will provide them with information about TLC's denial and how they can disagree with the denial.

5. Right to an accounting of disclosures: Our patients have the right to receive an accounting of disclosures of their health information made by TLC, except that TLC does not have to account for disclosures provided to them or pursuant to their written authorization or disclosures for purposes of research or public health.



TLC MEDICAL GROUP, INC.

Acknowledgement of receipt of Notice of Privacy Practices

Notice: All physicians at TLC Pediatrics are licensed and Board Certified. All Certificates are displayed in the hallway by the laboratory. If interested in viewing credentials, please ask our staff to direct you to them.

HIPAA ACCEPTANCE:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy. I further acknowledge that a copy of the current notice is posted in the reception area. I had the opportunity to read the poster at the time of my arrival. TLC will offer a copy of any amended Notice of Privacy as they occur. I authorize TLC Pediatric to email me the notice as needed.

I give TLC Pediatrics my permission to release medical information concerning my child or children using the HIPAA guidelines.

Please sign this notice for your child's record.

Patient Name: _____

Responsible party name: _____

Signature: _____ Date: _____

Relation to patient: _____

If over 18, Please sign and specify who can access your records

Patient Name: _____

Patient Signature: _____ Date: _____

Person(s) allowed to access records and relation to patient:

_____

_____

_____

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