

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

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Parent/Guardian Name \_\_\_\_\_ Address \_\_\_\_\_  
Street City State Zip  
Parent Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Parent DOB \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_  
Employer Address \_\_\_\_\_ Parent email \_\_\_\_\_  
DL#: \_\_\_\_\_ exp \_\_\_\_\_

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Parent/Guardian Name \_\_\_\_\_ Address \_\_\_\_\_  
Street City State Zip  
Parent Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Parent DOB \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_  
Employer Address \_\_\_\_\_ Parent email \_\_\_\_\_  
DL#: \_\_\_\_\_ exp \_\_\_\_\_

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Which parent is primary insured: \_\_\_\_\_  
Preferred Contact Individual for appointments, lab results, and other communication: \_\_\_\_\_  
Preferred contact type:  email,  cell phone,  home phone, Is it ok to leave a message? \_\_\_yes or no \_\_\_\_\_

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**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 \_\_\_\_\_

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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 \_\_\_\_\_  
\_\_\_\_\_
2. Birthplace: \_\_\_\_\_
3. Labor: Normal, Premature (# weeks) \_\_\_\_\_  
Late, Induced, Spontaneous, C-Section (why):  
\_\_\_\_\_  
Duration of Labor \_\_\_\_\_
4. Birthweight \_\_\_\_\_ Length \_\_\_\_\_  
Apgar Scores \_\_\_\_\_
5. Problems after birth: None, Breathing, Apnea, Infection, Feeding Problems, Jaundice, Seizures, Colic \_\_\_\_\_  
\_\_\_\_\_
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)  
\_\_\_\_\_  
\_\_\_\_\_
3. Serious Injuries \_\_\_\_\_  
\_\_\_\_\_
4. **Allergic Reactions (to drugs, food, etc)**  
\_\_\_\_\_  
\_\_\_\_\_
5. Immunizations (any routine shots that your child has **not** had)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. List serious illness, medical diagnosis, or chronic illness:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Current medications  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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,  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. DEVELOPMENT**

1. Milestones: Age when your child first:  
Sat \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_  
Few Words \_\_\_\_\_ Phrases \_\_\_\_\_  
Toilet Trained- Urine \_\_\_\_\_ -Bowel \_\_\_\_\_  
Any concerns about development? \_\_\_\_\_  
\_\_\_\_\_
2. School: Grade Level \_\_\_\_\_  
Avg. Grades \_\_\_\_\_  
Special Education? \_\_\_\_\_  
Special services like OT, PT, Speech? \_\_\_\_\_  
\_\_\_\_\_
3. Any behavior problems?  
\_\_\_\_\_  
\_\_\_\_\_
4. Routines:  
Feeding Problems \_\_\_\_\_  
Special Diet \_\_\_\_\_  
Vitamins, Fluoride \_\_\_\_\_  
Nutritional supplements \_\_\_\_\_  
Habits \_\_\_\_\_  
Sports \_\_\_\_\_  
Hobbies \_\_\_\_\_

**THOUSAND OAKS PEDIATRICS**

**Stephen P. Kundell, MD and Laila Niazi, MD**

**PRIVACY POLICIES**

With my consent, Stephen P. Kundell, MD and Laila Niazi, MD may use and disclose protected health information (PHI) about me or my dependent children to carry out treatment, payment and healthcare operations (TPHO). Please refer to Thousand Oaks Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Thousand Oaks Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susan Kundell, Privacy Officer, at 1000 Newbury Road, Suite 200, Newbury Park, CA 91320.

With my consent, Doctors and staff of Thousand Oaks Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any call pertaining to clinical care, including laboratory results among others.

With my consent, Doctors and staff of Thousand Oaks Pediatrics may send by mail, fax, or email to my home or other designated location any items that assist the practice in carrying out TPHO such as appointment reminder cards and patient statements and laboratory results.

I have the right to request that Thousand Oaks Pediatrics restrict how it uses or discloses my PHI to carry out TPHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Thousand Oaks Pediatrics use and disclosure of my PHI to carry out TPHO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Stephen P. Kundell, MD and Laila Niazi, MD may decline to provide treatment to me

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Signature of Patient or Legal Guardian Date

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Print Name of Patient or Legal Guardian

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Patient's Name (LIST ALL DEPENDENT CHILDREN)

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

FINANCIAL POLICY  
EFFECTIVE May 1, 2022

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 60 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.**

**Premier Medical Billing (805) 229-7538**

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 \_\_\_\_\_

updated 05/01/22