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_____________________

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____________________

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____

In the event that Dr. Kundell and/or Dr. Niazi are unavailable, I authorize my children as listed above to receive any and all medical care by a covering physician or consultant of Drs. Kundell and Niazi's choice. I further authorize Dr. Kundell and/or Dr. Niazi to render medical care to my children as listed above in the event of my absence. I will assume full financial responsibility for this care.

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*______________________

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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?_______________

____

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

____

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 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. 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.
- *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

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?

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____________