larchmont pediatrics
pediatric and adolescent medicine

Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined

Race: Asian / Black / Hawaiian / White / Other/ Declined

Child's parents are: Married___ Divorced___ Never Married ___

Separated___ Widow(er)___ other____

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined

Race: Asian / Black / Hawaiian / White / Other / Declined

Child's parents are: Married___ Divorced___ Never Married ___

Separated___ Widow(er)___ other____

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined

Race: Asian / Black / Hawaiian / White / Other/ Declined

Child's parents are: Married___ Divorced___ Never Married ___

Separated___ Widow(er)___ other____

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phone (323) 960-8500 fax (323) 960-8585

Child 4: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined

Race: Asian / Black / Hawaiian / White/ Other / Declined

Child's parents are: Married___ Divorced___ Never Married ___

Separated___ Widow(er)___ other____

Child 5: *Last Name:* _____ *First Name:* _____ *MI:* _____

DOB: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

If child is 13yrs or older, child's cell phone number: (____) _____ - _____

Ethnicity: Hispanic / Non-Hispanic / Unknown / Declined

Race: Asian / Black / Hawaiian / White/ Other / Declined

Child's parents are: Married___ Divorced___ Never Married ___

Separated___ Widow(er)___ other____

Home Address:
(Medical Information, Records, Notices Pertaining to Medical Care)

_____

(Street) *(City)* *(State & Zip)*

Billing Address:
(Patient Statements/Bills)

_____

(Street) *(City)* *(State & Zip)*

Primary MD (Please Circle One)

Dr. Neville Anderson Dr. Nneamaka Priest Dr. Courtney Mannino No Preference

How did you hear about us? _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

*Relationship to patient:*_____ *Effective Date:*_____

Insurance Carrier: _____

ID# _____ *Group #* _____

Phone Number on back of card for Providers, claims or benefits_____

Address for claims on back of card _____

We require a copy of the front and the back of your insurance card, please attach.

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

*Relationship to patient:*_____ *Effective Date:*_____

Insurance Carrier: _____

ID# _____ *Group #* _____

Phone Number on back of card for Providers, claims or benefits_____

Address for claims on back of card _____

We ask that you contact your insurance company prior to scheduling an appointment with our office to *verify that we are an in network provider for your specific plan.*

Self Pay: Y / N

If you are Self Pay, payment is due in full on the date of the visit, we do not bill.

Guarantor: _____ **Relationship to Patient:**_____
(who is financially responsible to pay billed charges)

*If not married, separated or divorced, we do not bill multiple guarantors. One parent/guardian is responsible for payment and any division of financial responsibility is to be handled by the guarantor.

Parent/Legal Guardian 1: (Primary contact person)

Name: _____

Relation to Patient:_____

Lives with patient? Yes / *No*

If you do not live with the patient, please provide your address:

_____

(Street) *(City)* *(State & Zip)*

Date of Birth: ____ / ____ / ____ *Social Security #:* _____ - _____ - _____

Home Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Work Phone: (____) _____ - _____ *Email:* _____

Employer: _____ *Occupation:*_____

How would you ideally prefer to be contacted? Please circle one:

Home Phone Work Phone Cell Phone

Larchmont Pediatrics may leave messages on all my phone contacts listed above.

Circle one: Yes / No Initials_____

If "no" what number should we contact you at? _____

Relation to Child 1 *Parent* *Step Parent* *Guardian* *Other:* _____

Relation to Child 2 *Parent* *Step Parent* *Guardian* *Other:* _____

Relation to Child 3 *Parent* *Step Parent* *Guardian* *Other:* _____

Relation to Child 4 *Parent* *Step Parent* *Guardian* *Other:* _____

Relation to Child 5 *Parent* *Step Parent* *Guardian* *Other:* _____

Parent/Legal Guardian 2

Name: _____

Relation to Patient: _____ *Lives with patient?* Yes / No

If you do not live with the patient, please provide your address:

_____

(Street) *(City)* *(State & Zip)*

Date of Birth: ____ / ____ / ____ *Social Security #:* _____- _____ - _____

Home Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Work Phone: (____) _____ - _____ *Email:* _____

Employer: _____

Occupation: _____

How would you ideally prefer to be contacted? Please circle one:

Home Phone Work Phone Cell Phone

Larchmont Pediatrics may leave messages on all my phone contacts listed above.

Circle one: Yes / No Initials_____

If "no" what number should we contact you at? _____

Relation to Child 1	*Parent*	*Step Parent*	*Guardian*	*Other*
Relation to Child 2	*Parent*	*Step Parent*	*Guardian*	*Other*
Relation to Child 3	*Parent*	*Step Parent*	*Guardian*	*Other*
Relation to Child 4	*Parent*	*Step Parent*	*Guardian*	*Other*
Relation to Child 5	*Parent*	*Step Parent*	*Guardian*	*Other*

*****If there is only one parent/legal guardian please initial here*** _____

If parents are divorced or separated, please fill out this section:

Who has legal custody?

_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

If patient is adopted, please fill out this section:

Date of adoption _____

Please provide a copy of the *legal paperwork* stating parental rights.

Additional Contact Questions:

May all contacts have access to the patient's records? Yes / No

If no, please detail who may have access:

_____

_____

_____

Emergency Contacts, *(other than parents)*:

1: Name_____ *Phone*: (_____) _____ - _____

Relationship to patient _____

2: Name_____ *Phone*: (_____) _____ - _____

Relationship to patient _____

Pharmacy Information:

Name of Pharmacy that you would like us to send your prescriptions to:

_____

Address of pharmacy:

_____

Phone number of pharmacy:

_____

Consent to Treat:

I hereby give consent to Larchmont Pediatrics to perform any x-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where the treatment is provided. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Larchmont Pediatrics recommends.

I voluntarily authorize and consent to the exchange of medical data including medications, consults, vaccinations, diagnostic tests, and hospital records with other providers who have provided care or may provide care in the future.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed:_____

Dated:_____

Print Name:_____

Please specify relationship to minor:

( ) parent with legal custody

( ) guardian with legal custody

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TRANSFER AND CORRESPONDENCE OF YOUR CHILD'S
HEALTH CARE INFORMATION VIA EMAIL

We are happy to respond to your request, but in order for us to do so via email you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your request. Please note the physician is unavailable via email and no medical advice will be given over email.

REQUEST CONSENT FORM

I, _____, authorize Larchmont Pediatrics and any of its employees to send information that I request to my email address provided below. I am aware the physician is unavailable via email and no medical advice will be given over email. This consent form will be effective until I notify Larchmont Pediatrics to revoke it in writing.

Your name: _____ Relationship to child: _____

Child's name: _____ Child's name: _____
Child's name: _____ Child's name: _____
Child's name: _____ Child's name: _____

Email address:_____

Signature:_____ Date: _____

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Administrative Family Plan for Non-Covered Services

At Larchmont Pediatrics, we are committed to providing the best possible care to our patients. Many changes have taken place in the health insurance industry in recent years. Services once covered in full are now partially covered with lower reimbursements, covered only under certain circumstances, or in some cases not covered at all.

We want to provide high quality medical care that is based on our families' needs but unfortunately this means providing services that are not covered by insurance companies. We have decided to charge an annual administrative fee to all our families in order that we may provide comprehensive, exceptional care. This fee includes non-covered and non-reimbursable administrative services such as:

- Completing forms for child care centers, schools, sports and camps within 3 business days at no charge.
- Writing notes for missed school or work, P.E. excuses, return to activities.
- Sending copies of medical records to specialists and/or other providers at no additional charge upon your written request.
- Preparing letters and reports.
- Coordination of care with specialists at no charge.
- Access to CHADIS, the website where you will fill out the developmental questionnaires online prior to your visit. Not having this access will require arriving to all well visits 20 minutes prior to your appointment time to complete them in the office. *There are questionnaires required prior to all well visits.

Families with one child: $150 per year
Families with two children: $200 per year
Families with three or more children: $250

Please feel free to contact our office at (323) 960-8500 with any questions or concerns. We are aware that health insurance is expensive. By charging a single annual fee and not charging you for individual services (ie completion of forms, access to the portal, etc) your out of pocket expenses will actually be lower. However, if you are experiencing financial hardship, we will work with you so that you can remain in our practice.

Our goal is to provide comprehensive, high quality medical care to your family. We are honored to be your family's medical home!

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Larchmont Pediatrics Administrative Family Plan Agreement

I agree to Larchmont Pediatrics family plan administrative fee. I understand that this fee is for items and services not covered and not reimbursed by my insurance plan.
The cost of the annual administrative fee is:

- Families with one child: $150 per year
- Families with two children: $200 per year
- Families with three or more children: $250 per year

This fee will be paid in full at or prior to your first visit and thereafter annually.

Please list your child/children below.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Childs's Name: _____ Date of Birth: _____

Childs's Name: _____ Date of Birth: _____

Enclosed is my payment of $_____

Print Name: _____

Signature: _____ Date: _____

Please return entire form with your payment.

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Office Policies

We would like to thank you for choosing Larchmont Pediatrics. Our goal is to provide and maintain a good physician-patient relationship. To achieve this, we would like to keep you informed of our current office and financial policies as outlined below. Your clear understanding of these policies is important to our professional relationship.

Financial Policies

You must confirm with your insurance company that we are in network with your particular plan. We will bill your insurance company after each visit. We bill your insurance for you as a courtesy; it is your responsibility to provide us with current insurance information. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co pays must be paid at the time of service. After your visit charges have been reconciled with your insurance, you will receive a billing statement from our office. Any balance remaining on your account, for services not covered by your insurance company is your responsibility. If you have no insurance, payment for an office visit is required to be paid in full at the time of service. The amount on your statement will reflect your balance, and that balance is payable on receipt. A $30 fee will be charge for any return checks. A $25 late fee will be automatically added to your bill for every 30 days your payment is late. Any balance outstanding longer than 45 days will be forwarded to a collection agency and you will be discharged from our practice. It is your responsibility to understand your insurance policy and what benefits are covered and not covered including for well check-ups. As a courtesy we will bill your insurance for you. However, all charges not covered by your insurance company are your responsibility. Please be sure to notify us of any changes in insurance, address or phone numbers. **Remember, newborns must be added to your insurance plan immediately after birth.**

Larchmont Pediatrics Annual Administrative Family Fee will be due each year. For detailed information please see our Administrative Family Plan Agreement or visit our website at www.larchmontpediatric.com. You can reach our billing department M-F from 9:00am-5:00pm at (323) 970-8390 or at billing@larchmontpediactric.com.

Appointments

In order to see our patients on time, we encourage our patients to arrive 15 minutes prior to their scheduled appointment time. Patients who arrive more than 10 minutes late will be rescheduled. In order to receive your preferred date and time for your well-child visits, we ask that you schedule your next appointment when you check-in for your current appointment. All appointments must be scheduled including sick visits, we do not accept walk ins but are usually able to accommodate same day sick visits. If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow us time to provide that time slot to another patient. Failure to keep an appointment or canceling less than 24 hours prior to a scheduled appointment will result in a $25-$150 charge, fee is based on the type of appointment made and the time allotted for it.

Forms and Prescription Refills

If you need a school or camp form filled out please give us a minimum of 3 days to complete and return them. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Vaccine Policy

We feel very strongly that vaccinating children on a schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If you should refuse to vaccinate your child despite all our

efforts, we will respect your decision but we will ask you to find another health care provider who shares your views. Please feel free to discuss any concerns you may have about vaccines with us. We welcome having the conversation with you. You may see our philosophy on vaccines on our website www.larchmontpediatric.com.

A few Additional things

- Your child must have regularly scheduled well child exams, we feel it plays a crucial role in preventing illness, promoting your child's well-being, and keeping you informed about your child's development.
- We ask that you keep your scheduled appointments (or reschedule if you must) but repeated failure to show up for scheduled appointments will result in dismissal from our practice.
- Please pay your statement balance when you receive your bill. When we bill your insurance, we are in a sense, extending you credit for services we performed while waiting to be paid. We are often not paid by the insurance company until 45 – 60 days after we see your child. When we have to make multiple attempts to collect balances from you, it takes time away from other important functions of the office and increases our costs.
- Please be polite and courteous to our staff. We are here to help and look forwarding to seeing you.

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Notice of Privacy Practices

Effective Date: April 2, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your child(ren)'s medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to your child(ren) as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your child(ren)'s medical information. It also describes your rights and our legal obligations with respect to your child(ren)'s medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this notice.

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

This medical practice collects health information about you and stores it in your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about your child(ren) to provide their medical care. We disclose medical information to our employees and others who are involved in providing the care your child(ren) need. For example, we may share your child(ren)'s medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to your child(ren), or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help your child when he/she is sick or injured.

Payment: We use and disclose medical information about your child(ren) to obtain payment for the services we provide. For example, we give your child(ren)'s health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to your child(ren).

Health Care Operations: We may use and disclose medical information about your child(ren) to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this

information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your child(ren)'s medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you or your child(ren), when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services**.** A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your child(ren)'s appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet: We may use and disclose medical information about your child(ren) by having you sign in when you arrive at our office. We may also call out your child(ren)'s name when we are ready to see you.

Notification and communication with family: We may disclose your child(ren)'s health information to notify or assist in notifying a family member, your child(ren)'s personal representative or another person responsible for their care about your child's location, his/her general condition or in the event of your child's death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your child(ren)'s care or helps pay for their care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing: We may contact you to give you information about products or services related to your child(ren)'s treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to your child(ren), or to provide your child(ren) with small gifts. We may also encourage you to purchase a product or service when we see you. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.

Required by law: As required by law, we will use and disclose your child(ren)'s health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health: We may, and are sometimes required by law to disclose your child(ren)'s health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult 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.

Health oversight activities: We may, and are sometimes required by law to disclose your child(ren)'s health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and administrative proceedings: We may, and are sometimes required by law, to disclose your child(ren)'s 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 your child(ren) in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

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

Coroners: We may, and are often required by law, to disclose your child(ren)'s health information to coroners in connection with their investigations of deaths.

Organ or tissue donation: We may disclose your child(ren)'s health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public safety: We may, and are sometimes required by law, to disclose your child(ren)'s health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions: We may disclose your child(ren)'s health information for military or national security purposes or to correctional institutions or law enforcement officers that have your child in their lawful custody.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your child(ren)'s health information/record will become the property of the new owner, although you will maintain the right to request that copies of your child(ren)'s health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Larchmont Pediatrics, Inc. will not use or disclose health information which identifies your child(ren) without your written authorization. If you do authorize this medical practice to use or disclose your child(ren)'s health information for another purpose, you may revoke your authorization in writing at any time.

C. Patient Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your child(ren)'s health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your child(ren)'s health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your child(ren)'s health information, with limited exceptions. To access your child(ren)'s medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We may charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to Amend or Supplement: You have a right to request that we amend your child(ren)'s health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your child(ren)'s health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your child(ren)'s health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

Right to Alternative Communication: You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at end of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website at www.larchmontpediatric.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how Larchmont Pediatrics, Inc. handles your health information should be directed to our Privacy Officer listed at the end of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Privacy Officer: Diane Hall
Telephone: (323) 960-8500 Fax: (323) 960-8585
E-mail: dianehall@larchmontpediatric.com
Address: Larchmont Pediatrics, Inc. 321 N Larchmont Blvd, Suite 1020, Los Angeles, CA 90004

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Acknowledgement and Assignment of Benefits

INSURANCE

I hereby acknowledge that I have contacted my medical insurance provider and confirmed that Larchmont Pediatrics is in network with my particular plan.
I understand that I am responsible for ALL services not covered by my insurance.

Initials_____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the Notice of Privacy Practices which describes how medical information about my child (ren) may be used and disclosed, and how I can get access to this information. To remain environmentally friendly, I understand that this information is available online at www.larchmontpediatric.com and a printed copy will be provided at my request.

Initials_____

FINANCIAL & OFFICE POLICIES

I hereby acknowledge that I have read and I understand Larchmont Pediatrics, Inc's financial, credit card on file and office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Initials_____

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance benefits to be paid directly to Larchmont Pediatrics, Inc. for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g. deductibles, co-insurance, and co-pays). I am also responsible for charges not covered by insurance including but not limited to the annual administrative fee, charges for missed appointments or finance fees accrued on late balances. I authorize Larchmont Pediatrics, Inc. to release information to my insurance company when requested by the insurance company.

Initials_____

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to Larchmont Pediatrics, Inc.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Please Print Name Relationship to Patient

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phone (323) 960-8500 fax (323) 960-8585

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Good health care for newborns, infants, children, and adolescents begins with the well-child visit (checkup) and other services that help keep children healthy. These are *preventive* services. Our doctors and staff provide these services based on a plan called Bright Futures. The American Academy of Pediatrics (AAP) made this plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests, and advise about staying healthy and safe. This plan can be altered to suit each child as needed. We also follow the AAP vaccine schedule for newborns, infants, children, and adolescents.

Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care reform law) includes a rule that all preventive care screenings and services included in the Bright Futures plan and vaccine schedule must be covered by ***most*** health plans. This is not always true, though, as some older plans, called grandfathered plans, do not have to pay in full for preventive services.

There may also be times when a child needs a service that is not considered preventive on the same day as a well-child visit. If a child is not well or a problem is found or needs to be addressed during the checkup, the physician may need to provide an additional office visit service (called a *sick visit)* to care for the child. This is a different service and is billed to your health plan in addition to the preventive services provided on that day. If you have a co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.

We value your time and want to make the most of each appointment for the child. This is why we will address any problem that needs a doctor's care during well-child visits so that only one trip is needed. Some services that may be provided and billed in addition to preventive services include

The doctor's work to address more than a minor problem, which will be billed as an office visit (eg, if the doctor gives a prescription, orders tests, or changes care for a known problem)

Medical treatments (eg, breathing treatments)

Any surgery (eg, removing splinters or something the child put in his or her nose or ear)

Tests performed in the office that are not included in the Bright Futures plan

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health plan on the day of your visit. It is our pleasure to help.

Deductible: Amount the policyholder needs to pay for covered health services before a health plan will begin to pay benefits. Usually a new deductible must be met each calendar year.
Co-payment: A fixed amount that you pay for certain health services before the health plan pays.
Coinsurance: The portion of the charge that is NOT paid by the health plan (usually a fixed percentage of each amount paid by the plan).

321 north larchmont blvd, suite 1020, los angeles, ca 90004
phone (323) 960-8500 fax (323) 960-8585

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Credit Card on File Policy

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. We ask that if you choose to leave your credit card on file that you adhere to our practice's credit card on file policy. By signing below, you are agreeing to its terms.

1. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
2. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.
3. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be digitally stored and held by an external vendor, who is the payment agent (WayStar), in order to help maintain the security of my payment information.
4. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, forms, annual administrative family plan for non-covered services, including amounts agreed as part of a payment plan, copayments, coinsurance (after application of insurance proceeds), amounts not covered by insurance and/or fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
    - In the case of charging your card for a statement balance, your insurance will notify us of the amount that is your responsibility (they will also send you this information via an EOB) At that time, we will review the amount you have authorized us to charge, run the payment and email you the receipt. This will in NO WAY compromise your ability to dispute a charge or question your insurance company's determination of payment.
5. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I will receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible late fees on the balance.
6. I will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by me. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
7. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____

Cardholder Name as it Appears on Card Cardholder Email Address

_____

Cardholder Billing Address City State Zip Code

_____

Phone Number

CARDHOLDER SIGNATURE _____ DATE _____

How will I know how much you are going to charge me?

You will receive a letter in the mail (or e-mail) from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB.) This letter tells you exactly, according to your health insurance coverage, how much your health care bill is your responsibility and how much is the responsibility of your insurance carrier.

What happens next?

We receive the same EOB that you do, most insurance companies send it out about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined is your responsibility. This is the same way we normally determine how much to send you a statement for.

The best way to avoid confusion is to keep your credit card on file. Once we receive the insurance EOB for your visit we will charge the cre4dit card on file the exact amount as per the EOB that is stated patient responsibility.

But wait! I'm nervous about leaving you my credit card.

We do not store your sensitive credit card information in our office. We store it on a encrypted gateway. The company we use is called WayStar. We will swipe your credit card with an encrypted reader that will securely upload your credit card information to WayStar or you may give us the number by phone or email and we can securely enter it manually as well. Under HIPAA guidelines, we follow strict rules in terms of protecting your privacy and your credit card is considered protected health information. Because of HIPAA rules, our medical office is far more secure than most retail establishments in relation to identity theft. With a credit card on file, you won't have to bring or swipe your card at every visit thus limiting your data exposure.

This is very much like what a hotel or rental car company does at each check in. And all credit card contracts give card holders the right to challenge any charge against their account.

Deductible: Amount the policyholder needs to pay for covered health services before a health plan will begin to pay benefits. Usually a new deductible must be met each calendar year.

EOB (Explanation of Benefits): A detailed explanation from the insurance company that identifies the amount due for services provided. This includes any payments made by the insurance company and any listed copayment, coinsurance or deductible due from the policyholder.

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Credit Card on File Authorization Form

By signing this form, you give us permission to securely store your credit card account information on file. Use of your credit card is strictly limited to our Credit Card on File Policy. By signing below I acknowledge that I have read and agreed to the terms of Larchmont Pediatrics Credit Card on File Policy. _____ (Initial)

I understand I can revoke my authorization in writing at any time.

Please complete the information below:

I _____ authorize Larchmont Pediatrics, Inc. to charge my
(full name)
credit card account (indicated below) as per the terms of the Credit Card on File Policy.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Credit Card Number _____

Expiration Date _____ Security Code _____

$_____ Is the maximum amount I authorize Larchmont Pediatrics to charge to my card without advanced notice .

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined in the policy provided to me. This payment authorization is for services provided by Larchmont Pediatrics, Inc. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in the Credit Card on File Policy.

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AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I am the parent, guardian, or person having legal custody of (*name, date of birth of minor)*

_____, a minor.

I hereby authorize (*name of adult 21 years or older into whose care the minor has been entrusted*) _____ to act as my agent to consent to any x-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where the treatment is provided. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed physician recommends.

This authorization is given pursuant to the provisions of Family Code § 6910.

Signed:_____ Dated:_____

Print Name: _____

Please specify relationship to minor:

( ) parent with legal custody ( ) guardian with legal custody

Does minor live with you? Y / N If NO, please provide minors address:

_____

This authorization will remain in effect until _____
(expiration date of this authorization)

Relationship of authorized agent to minor: _____

Address of authorized agent: _____

Phone number of authorized agent: _____

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Medical Records Request/Release & Disclosure Authorization

All Sections MUST be completed for all authorizations.

I hereby authorize the disclosure of mine or my child's health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that a photocopy or fax of this authorization is a valid as the original.

Patient Name: _____Date of Birth_____

Address : _____

_____

Phone Number: _____

Persons/organizations authorized to disclose information

_____

_____

Persons/organizations authorized to receive information

Larchmont Pediatrics
321 N. Larchmont Blvd. Suite 1020
Los Angeles, CA 90004

Information that may be used/disclosed:

Entire Medical Record_____

Records of specific visits____	Discharge Summary____	EKG Reports_____	History/Physical_____
Immunization Records____	Consultation Reports____	Problem list____	Medication Records ____
Laboratory Reports_____	X-Ray,MRI, CT Reports ____	Operative Reports_____	Hepatitis Information____
Echo, Stress Test, Holters_____	Mental Health_____	AIDS/HIV Information_____	
Alcohol/Drug Abuse Treatment_____		Other_____	

1. I understand that I may revoke this authorization at any time by notifying Larchmont Pediatrics in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and would no longer be protected.

Signature of Patient or Representative

_____ Date _____/_____/_____

Printed Name of Patient or Patient's Representative

_____ Relationship to Patient_____