San Fernando Pediatrics & Urgent Care

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

WELCOME!

We would love to welcome you to **San Fernando Pediatrics & Urgent Care**. Thank you for choosing us to be your medical home. We strive to provide you and your family, the best possible care under one roof.

At this clinic we provide primary care for children and adolescents as well as urgent care and home visits for all ages; from newborn to parents and grandparents.

We compiled this packet to gain sufficient information for the proper care of our new patients. Please read this packet and our policies carefully, then sign and date all appropriate places. Ask us any questions you may have.

Office Hours and Appointments

Monday to Friday 9 am to 6 pm

1. We offer same day appointments and walk-ins, when available.
2. We take our last patient before 5:30 pm to allow ample time to care for you.
3. We require at least a 24-hour cancelation notice to avoid cancelation fees.
4. Late arrivals of over 15 minutes, may be asked to reschedule.

Medical Protocols

1. We practice evidence based medicine and guidelines according to scientific studies.
2. Medical questions, will be addressed during your office visits only.
3. We can not offer medical advice over the phone.
4. If you or your child is sick, they must be seen by our medical provider in order to be diagnosed and treated properly.
5. There will be a maximum of two concerns addressed at each sick visit.

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Initial History Questionnaire

Patient's Name: _____ DOB: _____ Age: _____

Form completed by: _____ Relationship to patient _____ Date: _____

Household Information:

Name	Relationship to child	Birthdate	Health Problems

Are there siblings not listed? If so, give names and where they live. If one or both parents are not living in the home, how often does he/she see that parent? _____
_____
_____

Birth History

Birth weight _____Vaginal or Caesarean Section? (please circle) If Caesarean, why? _____
_____

Was your baby born term or early? If early, why? _____

Any illness or problems in the pregnancy? _____

During pregnancy did mother smoke, drink alcohol, or use illicit drugs? _____

Was mother on any medications during pregnancy? _____

Did your baby have any problems right after birth? _____ If so, what were they? _____
_____

Was initial feeding Breastfeeding or Formula? _____

Did your baby go home with mother from the hospital? _____

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General History

Do you consider your child to be in good health? **YES / NO**; Explain: _____

Does your child have any illness or medical condition? **YES / NO**; Explain: _____

Has your child had any serious injuries or accidents? **YES / NO**; Explain: _____

Has your child had any surgeries? **YES / NO**; Explain: _____

Has your child ever been hospitalized? **YES / NO**; Explain: _____

Is your child allergic to any medications: **YES / NO**; Explain: _____

Is your child allergic to any foods? **YES / NO**; Explain: _____

Is your child on any chronic medications? **YES / NO**; Explain: _____

Developmental History

Are you concerned about your child's physical development? **NO / YES**; Explain: _____

Are you concerned about your child's mental or emotional development? **NO / YES**; Explain: _____

If your child is in school, How is his/her behavior in school? _____

Has he/she repeated or failed a grade in school? **NO / YES;** Explain: _____

How is his/her academic performance? _____

Is he/she in a special/resource class? **NO / YES**; Explain: _____

Please provide us with all medical records and vaccine records

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Authorization for Release of Medical Information

Patient Name: _____ DOB: _____/_____/_____

I, _____ hereby authorize the release of

medical information TO:

San Fernando Pediatrics & Urgent Care
107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888)799-8585

FROM:

Doctor/Clinic/Hospital:_____
Address: _____
Telephone: _____ Fax: _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___Other (specify): _____

___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I also consent to the specific release of the following records:

Drugs/Alcohol/Substance abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Tests for antibodies to HIV _____ (initial)
HIV diagnosis and treatment _____ (initial)
Genetic information _____ (initial)

Purpose of disclosure:

___ Treatment/ Ongoing medical care
___ Coordination of care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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Consent to treat for minors in the absence of parents

Patient Name: _____ DOB: ____/____/_____

Please sign **ONE** of the options below.

OPTION 1

I authorize San Fernando Pediatrics & Urgent Care' providers to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, **I authorize that my child may be treated in my absence**. I understand that I am responsible for settling any costs arising from this care provided in my absence. The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

OPTION 2

I authorize San Fernando Pediatrics & Urgent Care' providers to provide medical care for my child. However, in the event that my child is brought to the clinic by anyone other than a legal guardian or me, **I do not authorize that my child be treated in my absence**. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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Vaccine Policy Statement

As healthcare providers dedicated to the health and well being of your child, we firmly believe that vaccinating children and young adults may be the single most important intervention we perform as your child's physician. As a parent or caregiver, it is also one of the most direct ways you can proactively improve your child's health. The recommended vaccines and their schedule given are the results of many years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians. Prevention of death and disability from vaccine preventable diseases is the cornerstone of Pediatrics.

- We firmly believe in the safety of vaccines.
- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We agree with and strictly follow all the recommended vaccines according to the schedule published by the **Centers for Disease Control** and the **American Academy of Pediatrics**.
- Based on all available literature, evidence and current studies, we know that vaccines do not cause autism or other disabilities.
- We vaccinate ourselves and our children.

Please feel free to discuss any questions or concerns you may have about vaccines with any one of us in advance to your visit. If you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider that shares your views.

Acknowledgement of receipt of San Fernando Pediatrics & Urgent Care Vaccine Policy

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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Patient and Family Information

Child 1: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

Child 2: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

Child 3: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

Child 4: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

Child 5: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

Child 6: Last Name: _____ First Name: _____

DOB: ___/___/_____ Sex: M / F / ___ Preferred Language:_____

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Pharmacy Name: _____ Pharmacy Tel: _____

Children's parent are: ___Married ___Never Married ___Divorced ___Separated ___Widow ___Other_____

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

Who has 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.

Emergency Contacts, other than parents.

Name & Relationship: _____ Phone Number: _____

Name & Relationship: _____ Phone Number: _____

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Custodial Parent (Patient lives with this parent):

Name: _____Relationship to the patient: _____

DOB: ___/___/_____ Home phone: _____ Cell phone:_____

Email:_____Employer: _____

Work Phone:_____

Home address: _____
(Street) (City/State/Zip)

Guarantor (Bill this parent):

Name: _____Relationship to the patient: _____

DOB: ___/___/_____ Home phone: _____ Cell phone:_____

Email:_____Employer: _____

Work Phone:_____

Home address: _____
(Street) (City/State/Zip)

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Financial Policy

San Fernando Pediatrics & Urgent Care participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what are your particular benefits may be. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits so that you know what your payment obligations will be at the time of service.

Primary insurance information

Insurance name: _____ Subscriber ID: _____ Group: _____

Secondary insurance information (if applicable)

Insurance name: _____ Subscriber ID: _____ Group: _____

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, or by credit or debit card. We also accept Health Savings Account (HSA) cards for payment. Please note that your co-payment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid or met your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so. Please ensure that if you are unable to bring your child in by yourself, whomever brings the child, is prepared to make all payments.

Credit Card on File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, it is our policy to have a valid credit card secured on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt may be sent to you by email or text to your mobile phone.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

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No-Show & Same-Day Cancelation Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of $50 per individual patient appointment. Repeated no-shows will result in the family being advised to transfer care out of the practice.

Authorization to Treat and Bill

I have read, understood and agree with the above financial policies. I consent to be treat by San Fernando Pediatrics & Urgent Care and any provider at this clinic. If I am not the patient, I am authorized to consent to treatment and billing for the patient identified below. I authorize Ali Anari MD, inc DBA: San Fernando Pediatrics & Urgent Care, to bill my medical insurance for the care I receive and to release any information the insurance carrier requires to process this bill.

I authorize payment of medical benefits to San Fernando Pediatrics & Urgent Care. I understand that I am responsible for all charges for the treatment I receive. I understand that if I do not provide accurate and complete insurance information, San Fernando Pediatrics and Urgent Care may not receive payment from my carrier and I will be entirely responsible for my bill. Even after my medical insurance pays San Fernando Pediatrics & Urgent Care, I may owe payment for services not covered by my insurance and I agree to pay these promptly. I understand that San Fernando Pediatrics & Urgent Care may send lab specimens to an outside laboratory (QuestDiagnostics or LabCorp). I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that San Fernando Pediatrics & Urgent Care is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, San Fernando Pediatrics & Urgent Care may choose not to bill insurance and may decline to accept credit/debit cards or checks as a form of payment. I understand that if I fail to pay San Fernando Pediatrics & Urgent Care for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 35% in addition to the amount owed for services/treatment rendered. I understand that I may contact San Fernando Pediatrics & Urgent Care to work out payment arrangements that may prevent this additional cost.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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Administrative Fee Form

Patient Name: _____ DOB: ____/____/_____

Please select **ONE**

☐ Please charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family).

☐ Please do NOT charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family). I prefer to pay a-la-carte for services covered by the fee and understand that a $50 fee will need to be charged for each request, including any school entry, annual school physical, sports and camp physical forms and prescription refill requests made when the patient is not in the office.

I understand that I may switch my preference to the annual fee prior to incurring the first charge.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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Non-Covered Services Waiver

We pride ourselves on providing only the **highest quality care** for you and your children. We do this by following many of the American Academy of Pediatrics and other trusted sources for evidenced-based clinical outcome information. However, insurers rarely keep pace with guidelines, or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary. The following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Vision Screening Test ($10.00)

Snellen vision screening is a simple test performed with the use of a Snellen eye chart used to measure visual acuity on older children and adults. As we consider this to be an important test for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount for you to $10.00 per test.

Audiometry Hearing Screening Test ($45.00)

Hearing screen is an important test that is done each year, starting at the age of 4. It is also required for most preschools, public and private schools, and for sports physicals. If your insurance does not cover the charge, we will significantly discount the amount for you to $45.00 for both ears.

Ear Piercing ($99.00)

We offer medical grade ear piercing offered to adults and pediatrics using only sterile medically safe materials that is only available through a medical professional. which is not a covered service by your insurance company. This service is not covered by insurance and costs a one-time charge of $99.00, which includes: A pair of sterile earrings with back, Topical anesthetic, Piercing procedure, Aftercare instructions, and piercing aftercare kit.

In-office lab tests

Often, patients want to know as soon as possible if their child has the flu, strep, etc. We can effectively and efficiently determine that by performing in-office testing. Many insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests out to external labs results in waiting days for results that we can provide to you much more quickly (in some cases, within minutes or overnight). We believe it is important to treat your child as quickly as possible, and therefore offer these services in-office.

In-office Test	Fees
RSV Test	$35.00
Rapid Flu	$25.00
Rapid Strep	$25.00
Mono test	$25.00
H. Pylori	$25.00

In-office Test	Fees
UA & Pregnancy Test	$25.00
Urinalysis (UA)	$25.00
Glucose check	$25.00
PPD (TB) test	$35.00
COVID-19 Test	$85.00

In-office Test	Fees
Eye exam	$35.00
GI cocktail	$10.00
B12 injection	$35.00
Benadryl injection	$25.00
Ace bandage	$5.00

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Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does pay for these services.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and San Fernando Pediatrics & Urgent Care is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to San Fernando Pediatrics & Urgent Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize San Fernando Pediatrics & Urgent Care to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from San Fernando Pediatrics & Urgent Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____

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San Fernando Pediatrics & Urgent Care

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the law of the state of jurisdiction, and not by a lawsuit or resort to court process except as the law of the state of jurisdiction provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration. **Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses. **Article 4: Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well. **Article 5: Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient. **Article 6: Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with the law of the state of jurisdiction. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ 04/01/2020
Physician's or Duly (Date)
Authorized Representative Signature

By: _____
Patient's Signature (Date)

By: Ali Anari MD, inc
Print or Stamp Name of Physician,
Medical Group or Association Name

By: _____
Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (if applicable) (Date)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient