Dear Parent,

Thank you for choosing Sunset Pediatrics as your child's medical home!

We are proud to follow the principles of being a Patient Centered Primary Care Home. What this means is that we strive to provide easy access to the practice and that our approach to your child's care coordinates many different aspects that contribute to a positive healthcare experience.

Central to the success of this care is that we work together as a team. Please call our office before you decide to go to Urgent Care or Emergency Department for non-life-threatening health issues and notify the office immediately in the event that your child received any care outside the practice. This enables us to follow up with you and make necessary updates to the medical record.

Please note that Sunset Pediatrics is dedicated to the health and safety of all our patients. Our practice believes that all children should receive the recommended vaccines according to the guidelines provided by the American Academy of Pediatrics and the CDC. Vaccines are safe and effective in warding off infections and preventing diseases/health complications in children and young adults.

For your convenience, the office is open on Monday – Thursday from 8:30 to 6:30pm, Friday from 8:30 to 5pm and Saturday from 9 to 12pm. To enable you to get in and out of the office without long delays, please fill out any paperwork necessary before the visit. If you are unable to do so, please arrive at least 15 minutes before your visit to complete your forms in time for your appointment.

Before your first visit, please complete the authorization for Release of Medical Information and submit this to your child's previous doctor or clinic so all previous medical records can be transferred to Sunset.

Please allow 3 business days for the completion of any forms or letters submitted for the doctor's review.

We are glad to have you join us at Sunset Pediatrics!

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Patient Name_____ Male ☐ Female ☐

Date of Birth_____ Parent or Guardian Name_____

ALLERGIES (MEDICATIONS, FOODS OR OTHER) _____

_____

HOSPITALIZATIONS, SURGERIES, INJURIES (ORTHOPEDIC, LACERATIONS, ETC.)

_____

_____

_____

REASON FOR VISIT

Well Child Check/Sports Physical Yes ☐ No ☐

Medical Concern(s) - Please List:

_____

_____

_____

If patient has been treated for any other significant illnesses/medical problems by other providers, please describe the problems and list the physician or medical facility treating him/her.

ILLNESS OR MEDICAL PROBLEM PHYSICIAN/MEDICAL FACILITY

_____

_____

_____

HEALTH HISTORY

Please ✓ the appropriate answer unless otherwise specified. If in doubt about the question, please circle it. Your doctor or nurse will review your answers with you.

___ Parent Completing: Does your child have, or has your child ever had, any of the following?

___ Patient Completing: Do you have, or have you ever had, any of the following?

NEWBORN

Premature ☐ Jaundice requiring treatment ☐ Significant Problems in 1st month ☐

EYES

Vision changes past year? ☐ No ☐ Yes
Wear glasses or contacts lenses? ☐ No ☐ Yes
Eye muscle surgery? ☐ No ☐ Yes

EARS

Repeated infections? ☐ No ☐ Yes
Ear tubes? ☐ No ☐ Yes
Speech problems or delay? ☐ No ☐ Yes
Deafness or decreased hearing? ☐ No ☐ Yes

NOSE AND THROAT

Nose or throat problems? ☐ No ☐ Yes

DIGESTIVE TRACT

Diarrhea? ☐ No ☐ Yes
Constipation? ☐ No ☐ Yes
Recurrent vomiting? ☐ No ☐ Yes
Recurrent abdominal pain? ☐ No ☐ Yes
Bloody bowel movements? ☐ No ☐ Yes

CHEST

Wheezing with exercise? ☐ No ☐ Yes
Asthma/hay fever? ☐ No ☐ Yes
Pneumonia? ☐ No ☐ Yes
Tuberculosis skin test change? ☐ No ☐ Yes

SKIN

Birthmarks or moles? ☐ No ☐ Yes

HEART

Heart murmur? ☐ No ☐ Yes
Chest pain? ☐ No ☐ Yes
High blood pressure? ☐ No ☐ Yes
Congenital heart problem? ☐ No ☐ Yes

BLOOD

Anemia? (Low Iron?) ☐ No ☐ Yes
Bleeding or easy bruising? ☐ No ☐ Yes

URINARY TRACT

Congenital Kidney Disorder/Prob? ☐ No ☐ Yes
Bed wetting problems? ☐ No ☐ Yes
Infection one or more times? ☐ No ☐ Yes

MUSCULO-SKELETAL

Arthritis? ☐ No ☐ Yes
Painful or swollen joints? ☐ No ☐ Yes
Scoliosis/abnormal curve of back? ☐ No ☐ Yes

NEUROLOGICAL

Headaches? ☐ No ☐ Yes
Convulsion, seizure, or fit? ☐ No ☐ Yes

GENERAL

Development or milestone delay? ☐ No ☐ Yes

IS PATIENT PHYSICALLY HANDICAPPED OR LIMITED IN ANY WAY?

☐ No ☐ Yes

If yes, please name or describe:_____

_____

_____

DO YOU HAVE ANY QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR DOCTOR?

☐ No ☐ Yes

Please list:

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT INFORMATION

TODAY'S DATE: _____

Last _____ First _____ Middle _____

Birth Date ____ /____ /____ Sex: M ☐ F ☐ SSN# _____

Race: White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Not Provided ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Provided ☐ Language: _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Patient's Primary Care Physician (PCP) _____

How were you referred to Sunset Pediatrics? _____

SIBLINGS

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

Last _____ First _____ Middle _____ Birth Date ___ /___ /___ Sex M ☐ F ☐

PRIMARY GUARDIAN INFORMATION

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ____ /____ /____ Sex M ☐ F ☐ SSN# _____

Driver's License # _____ Address: Same as Patient Y ☐ N ☐ (if no, please enter below)

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (1) _____

Preferred method of contact to confirm appointments: Phone (home ☐ cell ☐) Text Msg ☐ (Number: _____)

Employer _____ Work Phone _____

SECONDARY GUARDIAN INFORMATION

Last _____ First _____ Middle _____

Relationship to Patient _____ Birth Date ____ /____ /____ Sex M ☐ F ☐ SSN# _____

Driver's License # _____ Address: Same as Patient Y ☐ N ☐ (if no, please enter below)

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail (2) _____

Employer _____ Work Phone _____

EMERGENCY CONTACT (1)

Last _____ First _____ Middle _____

Relationship to Patient _____ **To authorize consent for treatment, please complete attached consent form**

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

EMERGENCY CONTACT (2)

Last _____ First _____ Middle _____

Relationship to Patient _____ **To authorize consent for treatment, please complete attached consent form**

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

PRIMARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ____ /_____ /_____ Relationship to Patient _____ Effective Date ___/___/___

SS # or ID # _____ Group # _____

SECONDARY INSURANCE COMPANY

Name _____ Subscriber _____

Subscriber Birth Date ____ /_____ /_____ Relationship to Patient _____ Effective Date ___/___/___

SS # or ID # _____ Group # _____

PHARMACY INFORMATION:

Name: _____ Phone: _____

Address _____ City _____ State _____ Zip _____

PHARMACY AUTHORIZATION:

By signing this consent form you are agreeing that Sunset Pediatrics can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment and payment purposes. Understanding all of the above, I hereby provide informed consent to Sunset Pediatrics to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature _____ Date _____

AUTHORIZATION AND CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY

I hereby authorize Sunset Pediatrics to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign Sunset Pediatrics all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of visit will result in additional charges. I have received a copy of the current Notice of Privacy Practices.

Signature _____ Date _____

AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD (BY OTHER THAN GUARDIAN)

I, the undersigned parent or legal guardian of _____ _____/_____/_____

Patient's name Patient's DOB

authorize the following individuals to accompany my child, make decisions for treatment necessary by a physician and sign any necessary waivers at Sunset Pediatrics in my absence:

_____

(Name) (Relationship to patient) (Phone#)

_____

(Name) (Relationship to patient) (Phone#)

I understand that this consent authorization is given in advance of any specific diagnosis, treatment or hospital care being required in order to provide authority for a licensed physician to render any and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child. I understand that I am responsible for settling any costs arising from this care provided in my absence.

This consent will remain in effect indefinitely unless otherwise noted here: _____(Date to end consent)

_____

Parent or Legal Guardian Signature Date Print Name

FINANCIAL POLICY

Sunset Pediatrics participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what your particular benefits may be. Thus, it is important for you to contact your insurance company if you have any questions regarding your benefits, and for you to know what your payment obligations will be at the time of service.

Please note you will receive a separate bill for laboratory, anesthesiology, radiology and hospital services.

IDENTIFICATION

Please bring a valid driver's license or state ID card, insurance cards and any necessary forms to all appointments so your insurance can be billed in a timely and accurate manner.

DIVORCED OR SEPARATED PARENTS/GUARDIANS

Please see attached policy regarding custody and responsible party concerns.

COPAYMENTS AND DEDUCTIBLES

Depending on your insurance policy, a copayment/deductible may be required at the time of service. These payments are expected to be made at the time of your appointment. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment. If you fail to make a copay at the time of service, a $15 billing fee will be added to your account.

Please note that the copayment 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 and have not yet paid your deductible in full, it is likely that any non-preventative 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 yourself, that whoever brings the child in is prepared to make all payments.

COMING SOON 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, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determine to be patient responsibility as spelled out in your Explanation of Benefits. Once your card is charged, a receipt will be sent to you by email.

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

NON-SUFFICIENT FUNDS

When checks are returned to Sunset Pediatrics for non-sufficient funds a $35 charge will be added to your account and you will be asked to pay with cash or credit card for future visits.

NO PROOF OF INSURANCE

If you do not provide proof of valid insurance coverage, you will be required to sign a financial policy waiver at the time of service. Full payment will be due at time of service with a 20% discount eligibility.

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 of 20% will be applied to the bill if paid at the time of service. New patients must pay total amount for services at the time of their appointment. For established patients a $100 deposit may be made and remaining payment will be billed to the guarantor on the account.

COLLECTIONS

Accounts are due and payable in full within 30 days of statement date. Accounts with balances exceeding 90 days will incur a late fee of $50. Accounts with balances exceeding 120 days will be released to a collections agency. In the unfortunate event that we need to assign an account to a collection agency an additional fee of $150 will be added to the delinquent balance on the account. Families with any account sent to collections will automatically be dismissed from the practice.

CANCELLATION/NO SHOW 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 24 hours' notice to reschedule or cancel any appointment. Failure to notify the clinic at least 24 hours prior to the appointment will result in a no show fee of $75. Three or more no show appointments within a family (among all siblings) may result in dismissal from the practice. New patients that do not provide notice and miss their first appointment will be advised to seek care at another pediatric clinic.

As legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of Sunset Pediatrics as stated above.

Signature_____ Date _____

Print Name_____Relationship to Patient_____

Divorced or Separated Parent/Guardian Policy

OUR FOCUS IS THE CARE AND WELLBEING OF YOUR CHILD(REN). WE ARE UNABLE TO MEDIATE BETWEEN ANY PERSONAL ISSUES CONCERNING THE CHILD'S PARENTS OR GUARDIANS.

- Please make decisions regarding vaccinating your child(ren), circumcision, reproductive education, etc. prior to visiting our practice.

- Either parent or legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the child's medical record. Any restrictions on parental involvement in the child's care must be clearly presented via a court issued document, a copy of which should be sent to Sunset. Unless such a court order exists in the child's record, we cannot limit the other parent's involvement in your child's care.

- Payment (co-pays, deductibles, etc.) is due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. We will collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

- Both parents/legal guardians can sign a "Consent to Treat" form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice, and can consent for treatment during that visit. We will not be involved in any disputes regarding named individuals on your child(ren)'s consent to treat form. Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with requests to eliminate names on the other's form, unless instructed by the Court. Please refer these requests to your attorney.

- Additionally, Sunset providers and staff cannot:
    - Call the non-attending parent for consent prior to treatment or inform the other parent whenever visits are scheduled.
    - Call the non-attending parent after a child's visit to communicate care information.
    - Tolerate appointment scheduling/cancelling patterns of behavior between parents.

PLEASE NOTE: SHOULD THE ISSUES THAT COME BETWEEN PARENTS BECOME DISRUPTIVE TO OUR PRACTICE OR IMPEDE THE CARE OF CHILDREN, WE RESERVE THE RIGHT TO DISCHARGE YOUR FAMILY FROM FURTHER TREATMENT.