Patient Registration

Child's Last Name: ______________________ First Name: ____________________ MI: _____
Sex ______ Date of birth: ________________ Social Security #______________________
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (*Circle all that apply*)

Child's Last Name: ______________________ First Name: ____________________ MI: _____
Sex ______ Date of birth: ________________ Social Security #______________________
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (*Circle all that apply*)

Child's Last Name: ______________________ First Name: ____________________ MI: _____
Sex ______ Date of birth: ________________ Social Security #______________________
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (*Circle all that apply*)

Primary Language spoken in the home? ____
Secondary Language spoken in the home? ____

Phone numbers/email:

Parent 1:Name: ________________________________ Date of birth: _____________
Address: ______________________________ City: _______________ State:_____ Zip_____
Social Security #: ______________________________
Work phone ___________________________ Cell: ________________________________
Parent's email: ___________________________ work email: _________________________
Employer: ______________________________ Occupation: __________________________
Lives with patient (circle one)? Yes No Biological Relation to Patient: ____________
Should billing statements be sent to this Parent? Yes or No (*Please circle one*)

Parent 2: Name: ________________________________ Date of birth: _____________
Address: ______________________________ City: ______________ State:______ Zip_____
Social Security #: ______________________________
Work phone ___________________________ Cell: ________________________________
Parent's email: ___________________________ work email: _________________________
Employer: ______________________________ Occupation: __________________________
Lives with patient (circle one)? Yes No Biological Relation to Patient: ___________
Should billing statements be sent to this Parent? Yes or No (*Please circle one*)

HARVEST
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From small acorns MIGHTY OAKS GROW

Emergency Contacts, other than parents: Name & Relationship
1: _____ ph#: _____
2: _____ ph#: _____

Insurance:
Primary Insurance: _____
Policy Holder's Last Name: _____ First Name: _____
Policy Holder's Birth Date: _____ Social Security Number: _____
ID# _____

Secondary Insurance: _____
Policy Holder's Last Name: _____ First Name: _____
Policy Holder's Birth Date: _____ Social Security Number: _____
ID#: _____ Group #: _____

Billing statements sent to (If different from above):
Name _____
Relationship to patient _____
Address: _____
Phone: _____

Privacy Constraints (Check One):
____ No restrictions. Okay to leave message / send mail.
____ Restrictions – Person to person with patient / guardian only.
____ Restrictions: _____

How would you ideally prefer to be contacted regarding (circle one):
Medical issues: Home Phone / Work Phone / Cell Phone / Home e-mail
Appointment Reminders: Home Phone/Cell Phone/Home e-mail/Work e-mail
***Recall*:** Home Address / Home Phone / Work Phone / Cell Phone / Home e-mail
Billing Statements: Home Address / Home e-mail / Work e-mail
General Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home e-mail
Patient Portal: Cell Phone/Home e-mail/Work e-mail

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.
_____
_____

_____ _____
Parent or Legal Guardian Signature **Date**

Financial Agreement

Thank you for choosing Harvest Pediatrics to care for your child/children. We are honored to be your child's primary care provider and take our responsibility very seriously. The economics in health care have changed dramatically. Insurers have narrowed their reimbursement to only that face to face time between patient and provider. However, there are hours of additional professional time demanded of us for forms and paperwork. This has placed a substantial burden on the office that can no longer be funded through office visit charges. Regrettably, we find it necessary to charge for additional services. Please read this carefully and ask any questions you may have. We greatly value our relationship with you and want to serve your child/children to the best of our ability. To ensure the highest quality of service and care to our patients, we have established the following financial agreement.

"Physical Exams" are preventive services, and insurers only reimburse for those aspects of a visit billed with these codes. This includes updating the medical history, performing an exam and ordering routine preventative tests. It does not include **addressing specific medical problems**. If you wish to have additional medical problems addressed, please let the staff know at the time the appointment is scheduled. More time can be allotted, but there **will be additional charges**, and this may generate additional copayments or contribution of deductibles.

Immunization Records: Please bring your child's immunization card with you to every scheduled well exam.

Prescription Refills: Please allow 48 hours for all prescription refills.

Changes: You are responsible for letting us know about any change to your child's name, address, phone number or insurance company. We'll ask you about changes each time you come in.

Copayments: Copayments are required at the time of your visit. We accept cash, checks, Visa and Master Card.

Non-Covered Services: As a courtesy to you, we will bill your insurance company. We do not know what is or is not covered by your insurance company. Consider checking your policy before your visit if you are not sure about what is covered. You are responsible for payment of whatever part of the bill your insurance does not cover.

Self-Pay Patients (no insurance): You are required to pay your bill at the time of service. The front desk staff will not be able to quote exact prices in advance. The cost will be determined by the doctor based on the treatment rendered.

Late Policy: In order for your physician to be able to provide the best care possible, it is important to be on time for your appointments. Therefore, if you are more than 10 minutes late for an appointment, please be prepared to reschedule.

Cancellations/No Shows: When possible, each patient will receive a reminder call prior to his or her appointment. We require a 24-hour notice to cancel or reschedule your child's appointment. You will be charged a fee of $25.00 - $50.00 if you do not let us know more than 24 hours before your child's appointment. Three (3) no-shows will be subject to the entire family dismissal from our practice.

School/ Camp/Sports Forms, Letters and Prior Authorizations: Whenever we have to complete a form, write a letter get prior authorization the fee ranges from $10.00 - $50.00.

Printing of reports, including labs, x-rays, chart notes, etc: $5.00 min to $25.00 for complete records.

Delinquent Account: After 90 days, if we do not receive full payment for your portion of the bill, we may send your account to a collection agency. As a result, the patient-physician relationship will end and your children will have to find a new doctor within 30 days.

Hardships: If you are having financial problems and have trouble paying your bill, please call our billing office to ask for help. We want to help you, but we can't help you if we do not hear from you. Call: 707-252-1076.

ACKNOWLEDGEMENT:

By signing this form, you accept the office financial agreement and have been given a copy for your records.

We thank you for choosing Harvest Pediatrics, Inc. for your children's medical needs.

_____ _____ _____

Patient Name Parent Signature Date

PATIENT PRIVACY NOTICE

OUR PLEDGE TO YOU

We understand that medical information about you is private and personal. We are committed to protecting it. Doctors and other staff make a record each time you visit our office. This notice applies to the records of your care at Harvest Pediatrics, whether created by your doctor or other staff.

We are required by law to:

* Keep medical information about you private.
* Give you this notice describing our legal duties and privacy practices for medical information about you.
* Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND SHARE YOUR MEDICAL INFORMATION

This section of our notice tells how we may use medical information about you. In all cases not covered by this notice, we will obtain a separate written permission from you before we use or share your medical information. You can later cancel your permission by notifying us in writing. We will protect medical information as much as we can under the law. Sometimes State law gives more protection to medical information than Federal law. Sometimes Federal law gives more protection than State law. In each case, we will apply the laws that protect your medical information the most.

Treatment: We will use and share medical information about you for purposes of treatment.

Payment: We will use and share medical information about you so we can be paid for treating you.

Healthcare Operations: We will use and share medical information about you for the purpose of improving our healthcare operations.

Appointment Reminders: We may contact you with appointment reminders.

Treatment Options and Health-related Benefits and Services: We may contact you regarding possible treatment options, health-related benefits or services that you might want.

Public Health: We will report certain medication information for public health purposes.

Required by Law: We are sometimes required by law to report certain information.

Public Safety: We may, and sometimes have to, share medical information about you in order to prevent or lessen a serious threat to the health or safety of a particular person or the general public.

Coroners, Medical Examiners and Funeral Directors: We may share medical information about deceased patients with coroners, medical examiners or funeral directors.

Organ and Tissue Donation: We may use or share medical information with organizations that handle organ, eye or tissue donation or transplantation.

Military, Veteran, National Security and Other Government Purposes: We may use or share medical information about you for national security purposes.

Judicial Proceedings: We may share medical information about you in response to court orders or subpoenas only when we have followed procedures required by law.

Law Enforcement: We may share medical information about you with police without your written permission.

Family Members and Others Involved in Your Care: Unless you tell us otherwise, we may share medical information about you with family members or others you have named who help with your medical care.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

Requesting Information About You: You can look at, or get a copy of medical information about yourself.

Correcting Information About You: If you believe that information about you is wrong or missing, you can ask us in writing to amend the records. We do have the right to deny this request.

Restricting How We Use or Share Information About You: You can ask that medical information be given to you in a confidential manner. You must tell us in writing of the exact way or place for us to communicate with you.

DO YOU HAVE CONCERNS OR COMPLAINTS?

If you believe your privacy rights may have been violated, you may contact our Chief Privacy Officer, below:

Linda Simas
Office Manager, Harvest Pediatrics
1100 Trancas St., Suite 270, Napa, CA 94558
707-252-1076

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I have received a copy of Harvest Pediatric's Notice of Privacy Practices.
I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practices on the following date,

_____ but acknowledgement could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (explain):

_____
_____
_____
_____
_____

- ☐ Other (specify):

_____
_____
_____
_____
_____

HIPAA AUTHORIZATION FORM

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Harvest Pediatrics to use and/or disclose certain protected health information about me to insurance carriers, other physicians, or agencies to whom a referral for care may be made.

This Authorization permits Harvest Pediatrics to use and/or disclose the following individually identifiable health information about me, including but not limited to, dates of services, types of services and diagnosis rendered.

I acknowledge that by signing I authorize Harvest Pediatrics to receive payment from a third party (insurance) in exchange for using or disclosing the Protected Health Information.

I do not have to sign this Authorization in order to receive treatment from Harvest Pediatrics. I have the right to refuse to sign this Authorization. When my information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this Authorization. My written revocation must be submitted to the Privacy Officer at Harvest Pediatrics.

I also acknowledge that by signing, I authorize Harvest Pediatrics to leave Protected Health Information on a secured voicemail, i.e., lab results and appointment confirmation calls.

_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient
_____	_____
Please Print Patient's Name	Date

BAY AREA IMMUNIZATION REGISTRY CONSENT

This office will enter demographic information, immunizations and the tuberculosis skin testing information into a computerized tracking system called CAIR which will allow us to access the record for future visits should you lose your immunization record or need the information transferred to a doctor or school. All information entered is confidential but may be accessed by the State and local health care providers, including pediatricians, schools, and emergency rooms to obtain immunization histories and/or Tuberculin Skin Test (TST) results. The Immunization Registry, BARR/CAIR has been disclosed to me. Please Initial:

_____I consent to share immunization history _____ I decline to share immunization history

_____ I consent to share TST results _____ I decline to share TST results (Initials)

X_____ Date: _____

Relationship to Patient: _____ Account # _____

Patient Name: _____Patient Date of Birth: _____

****

El Condado de Napa de Salud y Servicios Humanos entrara la informacion dada arriba en un sistema llamado CAIR que nos permitira el acceso a su registro para futuras visitas si usted perdiera la tarjeta de vacunacion o se necesite trasferir dicha informacion a un doctor o a la escuela. Toda la informacion entrada en este sistema es confidencial pero puede ser accessible por el Estado y proveedores de salud locales, incluyendo pediatras, escuelas y salas de emergencia de hospitales para obtener historial de vacunacion y el resultado de la Prueba de Tuberculina (TST). El registro de vacunas, BARR/CAIR se me ha sido revelado. Por favor de marcar con sus iniciales:

_____ Yo doy permiso para compartir el historial de vacunas

_____ Yo me niego a compartir el historial de vacunas

_____ Yo doy permiso para compartir los resultados de TST

_____ Yo me niego a compartir los resultados de TST (Iniciales)

X_____Fecha:_____

Relacion a paciente: _____ Numero De Cuenta:_____

Nombre del paciente:_____

Fecha de Nacimiento:_____

Harvest Pediatrics is closed to Medical

Date: _____

My child_____ has been accepted as a new patient at **Harvest Pediatrics** with _____ Insurance Company as my primary carrier. Since **Harvest Pediatrics** is closed to new **Medi-Cal** patients, I understand that I would not be able to use **Medi-Cal** benefits with **Harvest Pediatrics**. I will be responsible for all copayments, co-insurance, deductibles and any other amount that my primary insurance carrier states is my responsibility.

Signature: _____ **Date:** _____

Harvest Pediatrics Account Number: _____

Fecha: _____

Mi niño/niña _____ ha sido aceptado como paciente nuevo de **Harvest Pediatrics** con la aseguranza _____.

Como **Harvest Pediatrics** esta cerrado a pacientes nuevos con **Medi-Cal**, yo entiendo que no podre usar mis beneficios de **Medi-Cal** en **Harvest Pediatrics**. Yo sere responsible por cualquier co-pago, deductible, etc. por la cantidad que mi aseguranza diga que es mi responsabilidad.

Firma: _____ **Fecha:** _____

 # de cuenta de Harvest Pediatrics: _____

Harvest Pediatrics Vaccination Policy

The health care providers of Harvest Pediatrics recognize that immunizing children against infectious disease is one of the most powerful and effective benefits that we can offer our patients and our community. As pediatricians, we spend a great deal of effort to keep abreast of the latest developments in infectious disease and vaccine science, in addition to accumulating years of experience providing vaccines to children. Also, we value the knowledge of the thousands of experts that make these fields their life work.

Regrettably, over the last several years we have seen the return of some dangerous diseases because some families have failed to follow the recommended vaccine schedule due to unfounded fears and misinformation about vaccine safety. Extensive testing has reassured us that immunizations are safe and effective. The recommended schedule of receiving vaccines is based on careful science, thorough testing and years of experience. There are no "alternative" schedules that have been tested and found to be either safe or effective.

As of March 1, 2015, Harvest Pediatrics clarified our vaccine policy in order to provide optimum preventative health for our patients and a healthy office environment for our most vulnerable patients. Our policy is that each of our patients must receive the recommended vaccinations on the schedule published by the American Academy of Pediatrics and its affiliated agencies. Exceptions to this schedule are rarely appropriate, but may be deemed necessary by your provider.

I hereby acknowledge that I have read, understand and agree to abide by the Harvest Pediatrics Vaccination Policy. In doing so I will keep my child's vaccinations up to date by following the **AAP** an **ACIP** vaccine schedule recommendations.

Patient Name_____ **Parent Signature** _____

Date _____ **Account #** _____

Are you concerned about your child's mental or emotional development? Explain: _____ No Yes

If your child is in school:

How is his/her behavior in school? _____

- Has he/she repeated or failed a grade in school? Explain: _____ No Yes
- How is his/her academic performance? _____
- Is he/she in a special/resource class? Explain: _____ No Yes

NEW PATIENT FAMILY HISTORY			
HAVE ANY FAMILY MEMBERS HAD ANY OF THE FOLLOWING?	NO	YES	WHO?
Deafness			
Nasal Allergies			
Asthma			
Tuberculosis			
Heart Disease (before 50 years old)			
High Blood Pressure (before 50 years old)			
High Cholesterol			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Diabetes (before 50 years old)			
Bed Wetting (after age 10)			
Epilepsy/Convulsions			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Mental Retardation			
Immune Problems, HIV Aids			
Additional Family History			
NEW PATIENT PAST HISTORY- HAS YOUR CHILD EVER HAD:			
Chicken Pox			
Frequent Ear Infections			
Nasal Allergies			
Problems with Eyes/Vision			
Asthma, Bronchiolitis			
Pneumonia			
Any Heart Problem/Heart Murmur			
Anemia or Bleeding Problem			
Blood Transfusion			
Frequent Abdominal Pain			
Constipation Requiring Doctor Visit			
Bladder/ Kidney Infection			
Bed Wetting (after age 5)			
Has she started menstrual periods?			
Chronic or Recurrent Skin Problems			
Frequent Headaches			
Seizures or Neurological Problems			
Diabetes/ Thyroid Problems			
Use of Alcohol or Drugs			

NEW PATIENT INITIAL HISTORY QUESTIONNAIRE

NAME:

Date of Birth: _____ Age: _____

Form completed by: _____ Date: _____

Household Information

Name	Relationship	Birth Date	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? If Caesarean, why? _____

Was your baby born at term? _____ If early, why? _____	Yes	No
Any illness or problems in the pregnancy? How many weeks gestation? _____	No	Yes
During pregnancy did mother smoke, drink alcohol or use recreational drugs? _____	No	Yes
Was mother on any medications during pregnancy? _____	No	Yes
Did your baby have any problems right after birth> If so, what were they? _____	No	Yes
Was initial feeding BREAST or FORMULA? _____		
Did your baby go home with mother from the hospital? _____	Yes	No
Did your baby pass the hearing test at the hospital? _____		

General

Do you consider your child to be in good health? Explain: _____	Yes	No
Does your child have any illness or medical condition? Explain: _____	No	Yes
Has your child had any serious injuries or accidents? Explain: _____	No	Yes
Has your child had any surgeries? Explain: _____	No	Yes
Has your child ever been hospitalized? Explain: _____	No	Yes
Is your child allergic to any medications? Explain: _____	No	Yes
Is your child allergic to any foods? Explain: _____	No	Yes
Is your child on any chronic medications? Explain: _____	No	Yes

Development

Are you concerned about your child's physical development? Explain: _____	No	Yes