SALINAS PEDIATRIC MEDICAL GROUP, INC.

PATIENT INFORMATION

Last Name:	First Name:	Middle:
Social Security #	Birth date:	Gender:
Home Phone:	E-Mail:	
Street Address:	City:	Zip Code:
Primary Language:	Race:	Ethnicity:
How did you hear about our office?		

Father / Guardian

Name of Father/Guardian:		Date of Birth:
Street Address:		City:
Social Security #:		Zip Code:
Relationship to Patient:		
Home Phone:	Cell Phone:	Work Phone:

Mother / Guardian

Name of Mother/Guardian:		Date of Birth:
Street Address:		City:
Social Security #:		Zip Code:
Relationship to Patient:		
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured:	Date of Birth:
Relationship to Insured:	Social Security #:
Insurance Carrier:	Employer:
Insurance Address:	City:

State: Zip Code:	Policy / Group #:

SECONDARY INSURANCE

Name of Insured:	Date of Birth:
Relationship to Insured:	Social Security #:
Insurance Carrier:	
Insurance Address:	City:
State: Zip Code:	Policy / Group #:

ADDITIONAL CONTACT INFORMATION

Alternate Persons Approved to Bring Patient in for Exams:

Name	**Relationship**
*	
*	
*	

***Anyone listed here has full authority to authorize procedures and vaccinations in lieu of parent/guardian being present at appointment.**

Person to Notify in Case of Emergency

Name:	Address:
City: Zip Code:	Home Phone:
Cell Phone:	Relationship to Patient:

Name:	Address:
City: Zip Code:	Home Phone:
Cell Phone:	Relationship to Patient:

Signature:_____

Date:_____

Salinas Pediatric Medical Group, Inc.

Financial Policy **Patient Name: _____**

To Our Valued Patients: **Account # _____**

Thank you for choosing Salinas Pediatric Medical Group, Inc. We are committed to providing you with the best medical care possible. Please review the following Financial Policy. Your signature constitutes an agreement to the procedures and policies of our practice.

Payment at Time of Service

As a courtesy, we will bill your insurance for all office visits. We ask that you pay any portion not covered by your insurance due to deductibles or co-payments, or any outstanding balances due, on the day of service.

Submission of Claims

We will submit your insurance claims. It is important to remember that your insurance is a contract between you and your insurer. We file insurance claims as a courtesy to you - you are still responsible for payment of services regardless of the amount your insurance pays. You will receive your statement within 30 days of your office visit. If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. If your insurance company requests additional information from you, you have 30 days to provide that information. After 30 days we have the right to bill you directly for any balance due. Please notify us immediately of any changes in your insurance or coverage.

Balances Due after Insurance Pays

If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. We urge you to keep your account current. All account balances past due over 120 days will be sent to an outside agency for collections and a $30 transfer fee will be added to the total balance. At that point, the account is out of our hands. Should the account be referred to an attorney for collections, the undersigned shall pay actual attorney's fees and collection expenses.

Self- Pay _____ (initial here to indicate if you are Self-Pay – not using insurance)

I understand that if I do not disclose the availability of insurance coverage for medical care at this time, I cannot use that insurance coverage to apply to medical care obtained while this agreement is in effect. This includes Medi-Cal and Central California Alliance for Health that may be granted retroactively to include some of the time period covered.

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I know that verification is not a guarantee of payment and that I am responsible for any unpaid balances left after my insurance.

I have read the above policies and agree to them. I authorize SPMG to furnish any information to my insurance company concerning my treatment. I understand that I am financially responsible for payment of all services rendered.

_____ _____

Signature of Patient or Guarantor **Date**

HIPAA NOTICE OF PRIVACY PRACTICES:

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

Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's health care history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. SPMG receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited. We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for SPMG in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for SPMG in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers' compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Disclosures SPMG Makes With Your Authorization

SPMG will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by SPMG or by a person requesting your PHI from SPMG. Your PHI can be disclosed without your authorization for any other uses required by law.

Health Information Exchanges / Patient Portals

We may use and share your health information with your doctors/providers involved in your care through the Central Coast Health Connect, a Health Information Exchange (HIE) and the SVMHS Patient Portal using a secure internet connection. An HIE is a way of sharing health information with other participating health care providers or entities for treatment, payment and health care operation purposes. This allows your participating health care provider to have your most recent information available from

other participating health care providers when making decisions about your care. You may opt-out and prevent your medical information from being available through the Central Coast Health Connect, or prevent the sharing of your health information by contacting SVMHS Health Information Management Department at 831-759-1957.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the SPMG office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. SPMG may charge a reasonable fee for providing you copies of your PHI. SPMG will only maintain that PHI that we obtain or utilize in providing your health care benefits.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you.

You have the right to get this notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that SPMG has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (831)422-9066.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____ _____

Print Name Signature Date

SALINAS PEDIATRIC MEDICAL GROUP, INC.

MEMBER RIGHTS AND RESPONSIBILITIES

All patients in the care of the physicians of Salinas Pediatric Medical Group, Inc., are entitled to full medical care within the scope of a pediatric office, ages 0-18 years of age, according to the standards set by the State of California and the American Academy of Pediatrics and the American Medical Association or through the legal system for the United States of America. It is the responsibility of the doctors in charge of the care for each patient to follow those recommendations of the above-mentioned bodies in prescribing medications and in performing procedures during the course of the treatment period. It is also the responsibility of the doctors to refer the patient to another medical facility which can supply the corrective treatment for a patient's condition, should the care offered through this facility be found to be inadequate or in need of supplement for more severe conditions.

It is the responsibility of the responsible party to follow the directions given the caregiver of a patient by the doctor who is in charge of the care on a specific date of service and to report back to the doctor regarding any concerns that have or may develop in regard to the medical health of the patient in questions.

SALINAS PEDIATRIC MEDICAL GROUP, INC.

Dear Patient / Parent / Guardian,

Salinas Pediatric Medical Group utilizes TeleVox technology to deliver automated messages to phones of patients (such as appointment reminders).

By signing this form you provide express consent for us to contact you via our automated calling program to your home, cell number, or via text messaging.

_____ _____

Parent / Guardian **Date**