Sunnie Skiles, MD

PROYOUTH PEDIATRIC HEALTH & WELLNESS
Registration Form

6815 Five Star Blvd
Rocklin, CA 95677

Patient Information (Please Print)
Patient Name: _____ Date: _____
Sex: M F Age: _____ Date of Birth: _____
Mother/Legal Guardian Name: _____
SSN: _____ Date of Birth: _____
Driver's License#: _____ E-Mail: _____
Address: _____
City: _____ Zip Code: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Father/Legal Guardian Name: _____
Address if different than above: _____
SSN: _____ Date of Birth: _____
Driver's License#: _____ E-Mail: _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Siblings Names/Dates of Birth/Sex: _____
_____
Emergency Contact Name (not living with you): _____
Relation to Patient: _____ Phone: _____ Alternate Phone: _____

Race: ☐ Decline to report ☐American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐Black or African American ☐White ☐Hispanic ☐Other Race _____
Language: _____

INSURANCE INFORMATION
Primary Insurance Company: _____ Type of Insurance: ☐HMO ☐PPO ☐POS ☐Other
Primary Insured's Date of Birth: _____ Primary Insured's SSN: _____
Primary Insured's Name: _____ Relationship to Patient: _____
ID# _____ Group# _____ Effective Date: _____

ASSIGNMENT AND RELEASE
I the undersigned certify that I (or my dependent) have insurance coverage as above and assign directly to Pediatric Health & Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

PRIVACY POLICY
At Pediatric Health & Wellness we are committed to ensuring patient privacy and confidentiality. Please sign below to indicate that you and the responsible party have had an opportunity to read and understand our privacy policy.

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

CONSENT TO CALL – AUTHORIZATION TO RECEIVE AUTOMATED PHONE CALLS – We use an automated telephone system for appointment reminders and other information from time to time. Please sign below to authorize us to contact you via our automated phone call system.

I consent to receive automated phone calls from Pediatric Health & Wellness:

_____ _____ _____
Responsible Party Signature | Relationship to Patient | Date

TO OPT OUT, SIGN HERE: I DO NOT WISH TO RECEIVE AUTOMATED PHONE CALLS: _____

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PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient of Pediatric Health and Wellness your child has important rights related to the healthcare he or she receives. Your children are entitled to these rights regarding their sex, culture, economic, educational and religious background. You also have the responsibility to be an informed parent. By understanding your rights and responsibilities your child will receive the maximum benefits of his or her healthcare.

PATIENTS' RIGHTS: You have the right to:

- Participate in decisions about your child's healthcare and treatment plan.
- Be treated with respect and dignity.
- Receive from your medical provider complete information about your child's diagnosis, any proposed procedure or treatment alternatives, including non-treatment, to give informed consent.
- Refuse any procedure or treatment if you so desire, and to the extent permitted by law, be informed as to what effect this may have on your child's health.
- Receive full consideration of privacy and confidentiality regarding all information and records about your child's healthcare and account.
- Be informed of the cost of care and treatment and receive an explanation of your financial obligation when required (co-payments, deductible, co-insurance).
- Receive 24-hour access to your Primary Care Physician or covering physician.
- Receive prompt and reasonable responses to questions and requests.

PATIENTS' RESPONSIBILITIES: You have the responsibility to:

- Know the benefits and exclusions of your health insurance coverage.
- Provide your healthcare provider with complete and accurate health information, including current immunization records.
- Change Primary Care Physicians to our practice by contacting your health care insurance plan's member services.
- Know and provide the cost of your co-pay, deductible or co-insurance at the time of service.
- Provide current and up-to-date insurance information. Provide patient's insurance card at time of service.
- Consent to Treat: as a Primary Care Physician's office, we treat children under the age of 18 years. If a person other than the parent or legal guardian seeks medical treatment for your child, we must have a letter of consent to treat signed by the parent or legal guardian.
- If a patient undergoes a legal name change, provide our office with a copy of the court documentation authorizing the change. This will allow us to consider making a name change on your child's medical chart and/or account.
- Provide our office with any demographic changes. Demographics provided should be for the parents/parent or legal guardian with whom the child primarily resides.

Please sign and date indicating that you understand your Rights and Responsibilities.

Patient's name: _____ Signature: _____

Date Signed: _____ Relationship to Patient: _____

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FINANCIAL POLICY

1. WHO BRINGS PAYMENT: Payment is due regardless of who brings the child in for the service. Grandparents, babysitter, aunts, etc., will be expected to bring in payment for your copay, co-insurance or deductible. If you are reachable by phone, we can take your credit card information over the phone and send the receipt home with your child's caregiver. For separated or divorced parents, financial responsibility still belongs to the parent bringing that child in for treatment. We will not bill another parent; it is your responsibility to bring what you will owe when you arrive. YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU DO NOT PAY YOUR CO-PAY.

2. FINANCIAL RESPONSIBILTY: Payment is determined from benefits we receive from your insurance company. You are ultimately responsible for any deductibles, co-insurances, or copays that are not paid by your insurance company. This includes services they do not think are medically necessary, or do not cover, but that our providers deem necessary, appropriate and/or a standard of care for pediatrics.
   - Responsible Party Initials_____ Date_____

3. INSURANCE CARD: Our billing system requires that an insurance card be scanned in to each record. We ask that you bring your insurance card with you to EVERY office visit. If you are unable to present an insurance card at the time of service, we require that you pay for the service or reschedule your appointment.

4. For newborns, most commercial insurance companies allow only 30 days to add your newborn to your plan. Please do so as soon as possible. All newborn bills will be billed to the parents until it can be verified that the newborn has coverage. By 2 months of age, all babies without proof of insurance will be expected to pay in full for their 2 month well visit and all visits since birth.

5. WELL VISITS: Your insurance company may cover well visits differently, and it is very important that you familiarize yourself with the details of your insurance coverage. No one likes being surprised with a bill! While some insurance companies may pay for well visits 100% (where there is no cost to you), benefits may include a copay, co-insurance, and/or deductible. If during a well visit your child is sick or has an issue that is not related to the normal growth and development of your child, and he/she needs treatment and/or medical attention for your concerns, you will be asked to reschedule the well visit. Not everything is covered by your insurance during the well visit. We do not charge a co-pay, however, some preventive screenings, such as behavior screenings, urine samples, hemoglobin, hearing, and vision tests may not be covered, and you will be responsible for the remaining balance.

INSURANCE

HOW DO YOU KNOW WHAT IS COVERED?

We have enrolled in numerous insurance programs in order to accommodate the needs and requests of our patients. While we are pleased to be able to provide this service to you, unfortunately we are unable to track all the individual benefits of the plans. Each one has different stipulations regarding how often services may be rendered and what they will cover. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated or which policy you have chosen to enroll in.

Please keep in mind, while we do have contracts with most of the major carriers; we are NOT providers for many of the Affordable Healthcare Act Policies they offer. The ultimate responsibility in finding out if we are an in-network provider rests with you. Plans change annually and so can their networks or our affiliation with certain networks.

As a courtesy, we verify eligibility; however the information we receive is very basic and only a quote of benefits. For detailed information regarding your insurance benefits, please contact your insurance company directly.

Secondary Insurance: Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. We do not bill secondary insurance.

INSURANCE TERMS THAT MEAN YOU HAVE FINANCIAL RESPONSIBILITIES

1. CO-INSURANCE- This is a fee you pay based on a percentage of the reimbursement the office will receive for providing your services. If for example, the insurance pays $100, and you have a 30% co-insurance, you will be required to pay $30 at the time of service.
2. CO-PAY- A flat fee that you have to pay at every visit. This is a fee that your insurance company requires you to pay. Contracts between insurance companies and medical offices often stipulate that a patient must pay their copay in order to be seen. This implies you can be turned away if you do not have the copay.
3. DEDUCTIBLE- The amount you have to pay before the insurance will pay for anything. A deductible can be $500 or $5000. It is very important to know how much your deductible is and if it has been met. The insurance company allows a certain charge for each service we provide. That charge is called the allowable. You will be required to pay the allowable amount for the services you receive at the time of your visit. We will still send a claim to your insurance company so that they know to apply your charges towards your deductible.
4. MAXIMUM BENEFIT- This is a dollar limit on how much your insurance company will pay for a particular type of service. They may only pay, for example, a maximum of $500 for a well visit and immunizations. After this $500 has been reached, you would be paying for the service in full, as if you had no insurance. Some insurance companies limit the number of visits, instead of putting a dollar limit on a service.

BALANCES

While no one likes to discuss paying bills, it's a necessary evil we must all face. In order to improve our office efficiency, reduce our overhead expenses, and ensure that we can financially sustain ourselves in order to continue providing our patients the services they are accustomed to, the following are our policies regarding outstanding balances. All outstanding balances not paid within 90 days may be turned over to a collection agency, and a discharge notice terminating patient care will be sent to you. All costs incurred in collecting a delinquent account will also be added to your charges. During this 30 day period, discharged patients will need to transfer medical care to another physician's office; however, we will continue to provide emergency medical care to you during this time period. If the balance is not paid within that 30 days, patient care will be officially terminated. Depending on the amount of the balance, payment plans for no more than a 3 to 6 month time frame may be granted on an individual basis. Any payment plan obligations not met, will be immediately turned over to collections and patient care terminated as described above.

TRANSFER OF RECORDS AND OTHER FEES

Records when a paper copy is requested	$15.00
Forms for school, child care, etc.	$5.00
Complex forms	$25.00
Returned checks and denied credit cards	$45.00
Missed appointment charge	$25.00

Please sign below that you understand our policies.

Responsible Party Signature_____ Relationship to Patient_____

Date_____ Patient Name_____

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PHOTOGRAPHY CONSENT FORM

Pediatric Health & Wellness recognizes the need to ensure the welfare and safety of all individuals taking part associated with our practice.

We will not permit photographs, video or other images of children to be taken without the consent of the parents/guardians.

The images will be placed in the patient's chart, and will only be used for treatment of your child.

Pediatric Health & Wellness will take all steps to ensure these images are used solely for the purposes they are intended.

Patient Name: _____DOB: _____

(Please initial) _____ I authorize my child's photograph to be used only for my medical record and insurance purposes. I understand these photos will not be used on the office website or in any publications.

(Please initial) _____ I **DO NOT** authorize my child's photograph to be taken.

Parent Name: _____

Parent Signature: _____Date:_____

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We pride ourselves on providing only the highest quality care for your child and do this by following the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced-based clinical outcome information. However, insurers rarely keep pace with guidelines, and do not want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time.

For example, your child's hearing and vision screening may have been covered at your last visit, but that is no guarantee that your insurer will cover the same screening at this visit. Frustrating, isn't it? And often we only find out that a plan is no longer paying for something when they send us a payment denial for a bill.

It's unfortunate for both of us, as we waste time and effort having to find out why payment was denied and then have the expense of billing you for it, while you, in addition to your copay / coinsurance / deductible cost sharing, may now have a 'non-covered service' to pay for too.

Your insurer may already have a policy in place whereby it does not cover things like in-office strep testing and urinalysis, to name a few. You can verify with your insurer which services it covers and which it does not. Performing tests in-office is a quick and more efficient than sending tests out to labs, and performing screenings such as hearing and vision tests avoids incurring the inconvenience and expense on your part to refer you to a specialist for these things.

As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign below that you understand that some of screenings and tests may not be covered by your insurance.

Below is a list of the most frequently provided services you can use to determine coverage with your insurer.

Vision Screening	Hemoglobin Test
Hearing Screening	Throat Culture
Behavioral Screenings	Urinalysis

If you do not wish for your child to have any of these tests or screening exams, please inform the staff at the beginning of your visit. Please realize that in doing so it may be necessary to send a test to an outside lab, refer you to a drawing station, or schedule a visit with a specialist in order to obtain the necessary information. This may significantly delay diagnosis and treatment, return to school or activities, or the provision of requested forms.

I acknowledge that I have been informed in advance of receiving these services, that these services may not be covered by my insurance plan. I understand that I will be financially responsible for the amount not covered by my insurance.

Patient Name:_____

Parent Signature:_____**Date:**_____

Parent Name:_____

Decline or Start Sharing/Information Request

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Street Address:
Patient Date of Birth:	Patient's City/Zip Code:
Patient ID (optional):	Patient County:
Patient Phone:	

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/ tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).***

** Note: The immunization record/TB Tests may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization/TB test records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in CAIR.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.

☐ I REQUEST to review or correct my/my child's CAIR immunization/TB test record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

Fax or email this form to the CAIR Help Desk at
1-888-436-8320, CAIRHelpDesk@cdph.ca.gov

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HEALTH FORM POLICIES

It is our goal to accommodate as many requests as possible, bearing in mind the following:

1. Blank forms will not be accepted. Forms will only be accepted for completion if the patient information has been completed, and signed by the parent.

2. **Turnaround time for form completion is usually fewer than 5 business days.** While every effort will be made to complete forms as quickly as possible, parents should realize that at certain times of the year we may receive dozens of health forms in one week, and remember that each of these has to be carefully reviewed by a physician before it is released. **Parents are strongly advised not to wait until the last moment to look at the paperwork they have received from the program their child is scheduled to attend.** _____
Initial here

3. **Forms will be held here for parents to pick up.** Due to HIPAA regulations, forms will be released to **parents only**. Federal law prohibits doctors' offices from faxing or mailing medical information to nonmedical facilities. We cannot be responsible for delays or losses in the mail.

_____
Initial here

4. **Many forms require the information to be based on an examination completed within 12 months of the date the form is completed.** Additionally, no form will be completed for any patient who has not had a comprehensive well child checkup in our office in more than 12 months.

5. **Forms are completed on the basis of examinations conducted by physicians in this medical group.** Examinations performed by "checkup centers" will not be co-signed by your physician, nor will she complete any forms based in whole or in part on any information provided by such centers. Forms are completed based on information obtained by staff from your child's chart. All forms are reviewed by a physician for completeness and accuracy. In some cases, forms mandate that only the physician may complete them.

Please sign below that you understand our policies.

Responsible Party Signature_____ Relationship to Patient_____

Date_____ Patient Name_____

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DISCHARGE POLICY

We reserve our right to discharge a patient from our clinic for any of the following:

- Non-payment of an account balance
- Abusive language or behavior directed toward staff, use of profanity
- Disruptive behavior that upsets other patients in the clinic
- Destructive behavior that damages clinic property or stealing clinic property
- Missing 2 or more appointments without 24 hours notification
- Blatant disregard of an advised plan of care
- Misuse or the suspicion of misuse of prescription medications
- Request to commit insurance fraud, forging clinic documents
- Habitual verbalization of dissatisfaction with our policies

Facts about HIPAA

The Health Information Portability & Accountability Act (HIPAA) is a group of FEDERAL regulations that all physician offices, hospitals, providers, etc. are required to meet after April 14, 2003. HIPAA requires us to provide copies of our Notice of Privacy Practices to each person/family seen at our office after April 14, 2003. Please refer to the Notice of Privacy Practices for detailed information about requirements and your rights to privacy.

HIPAA requires the completion of certain paperwork, including your signature that you have received a copy of the Notice of Privacy Practices.

HIPAA restricts the use and release of your medical information without a signed authorization.

HIPAA requires that authorization forms are completed & signed before any information can be released to third parties (schools, daycares, etc.) Therefore, we cannot fax or send school excuses, school/daycare forms or medication instructions to schools or daycares without a signed authorization form.

We may fax or mail information to the parent/guardian home or work. The parent/guardian would then be responsible for forwarding the information to the appropriate school or daycare.

HIPAA requires that any use or release of medical information only contain the minimum amount of information necessary for the required function.

HIPAA requires that we restrict access to patient areas of our office. Therefore, we request that you remain in the exam rooms, and that you check with our front office staff before entering any patient area. Photography and video recording is not permitted while in our office.

****IMPORTANT NOTICE****

In order to assure that our practice is in compliance with HIPAA Privacy Regulations, Pediatric Health & Wellness does not transmit patient information via email or text message. Texting is not considered a secure method of transmitting private health information. Some carriers may store the text messages for a time, meaning they could be read by someone else. Not everyone protects their phone in the event of loss or theft, leaving private health information potentially unprotected.

Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent. Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients. We apologize for any inconvenience you may feel this causes.

Please sign below that you understand our policies.

Responsible Party Signature_____ Relationship to Patient_____

Date_____ Patient Name_____

Revised 04/2018

AUTHORIZATION FOR RELEASE OF INFORMATION
To Schools & Daycares

Must be completed for all authorizations
I hereby authorize the use or disclosure of my health information as described below. By signing this authorization, I authorize Pediatric Health and Wellness to use and/or disclose certain protected health information about me to the entity listed below.

Patient Name:_____ DOB:_____/_____/_____

Organization/Persons receiving the information: (Please list name and address)

School Name:_____ Daycare Name:_____

Other:_____

This authorization permits Pediatric Health and Wellness to use and/or disclose the following individually identifiable health information about my child (circle one or more of the following and/or specifically describe the information to be used or disclosed):

Immunization Records School Excuses School Forms Medication Instructions Medication Authorizations

For the following purpose (please circle one) As requested by: School Daycare Parent

- o I do not authorize the release of health information to schools or daycares.

_____ _____ _____
Signature of Patient or Legal Guardian Print name Date

_____
Patient Name

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CONSENT FOR PERSONS OTHER THAN PARENTS OR LEGAL GUARDIAN TO OBTAIN MEDICAL CARE

THIS PERTAINS ONLY TO PERSONS OTHER THAN MY CHILD'S PARENT/LEGAL GUARDIAN

Patient's Name: _____ **Date of Birth**: _____

As the parent/ legal guardian, I hereby give my permission for the following people to obtain medical care for my child.

Authorized Persons	Relationship to Patient	Phone Number

OR:

☐ I do not authorize anyone **OTHER THAN MY CHILD'S PARENT/LEGAL GUARDIAN** including family members, relatives or close personal friends, to obtain medical care for my child, or to have access to any information regarding my child's medical condition/s.

Signature: _____ *Date:* _____

Print Name: _____

Rev 04/2018

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME/OTHER NAMES USED:_____ **DATE OF BIRTH**:_____

PATIENT ADDRESS:_____

PLEASE PROVIDE PREVIOUS DOCTOR'S INFORMATION BELOW

I AUTHORIZE: NAME:_____

ADDRESS:_____PHONE:_____FAX:_____

TO DISCLOSE TO: **SUNNIE SKILES, M.D. PEDIATRIC HEALTH & WELLNESS**
6815 FIVE STAR BLVD. #100 ROCKLIN, CA 95677
PHONE: 916-626-3060 FAX: 916-626-3063

The following information contained in the records specified below (check box and initial applicable lines below):
___Mental health or developmental disability treatment records (excludes "Psychotherapy notes")
___Substance abuse treatment records
___HIV test results (This authorizes disclosure of laboratory test results only. **NOTE that your records may include information concerning your HIV status EVEN if you do not initial this line.**)
___The following records, please be specific with the types of health information, or records for the date(s) of treatment as specified:

VACCINE RECORDS
COMPLETE MEDICAL RECORD

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

____At the request of the patient or personal representative; OR ____Other:_____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:_____

MY RIGHTS: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may revoke this authorization at any time, but I must do so in writing and submit it to the following: **Attn: Privacy Official 6815 Five Star Blvd #100, Rocklin, CA 95677**. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality las (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R part 2.

SIGNATURE:_____ **DATE**:_____

PRINT NAME OF PERSONAL REPRESENTATIVE:_____

RELATIONSHIP TO PATIENT:_____ **Patient/Representative Address and phone**:_____

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:
The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.