Harbor Pediatric Medical Group, APC

601 Dover Drive, Suite 7, Newport Beach, CA 92663

Patient Demographic Information

Please list all your children's Legal Names:

Last	First	MI	Date of Birth	M	F
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Street Address _____ City/State/Zip _____ Phone Number _____

Patient(s) Reside(s) with: ☐Both parents ☐Mother ☐Father ☐Other _____
(Please describe, i.e. joint custody, grandparent/legal guardian)

Responsible Parent/Legal Guardian Information (indicate who is financially responsible for the patient's medical care):
Check this box if both parents share financial responsibility ☐ Please note, we may require copies of legal guardianship papers.

Last _____ First _____ Relationship to patient _____

Street Address, if different than patient _____ City/State/Zip _____ Date of Birth _____

Occupation _____ Employer _____ Email _____ Driver's License _____

Home Phone _____ Work Phone _____ Cell Phone _____

Additional Parent/Legal Guardian Information:

Last _____ First _____ Relationship to patient _____

Street Address, if different than patient _____ City/State/Zip _____ Date of Birth _____

Occupation _____ Employer _____ Email _____ Driver's License _____

Home Phone _____ Work Phone _____ Cell Phone _____

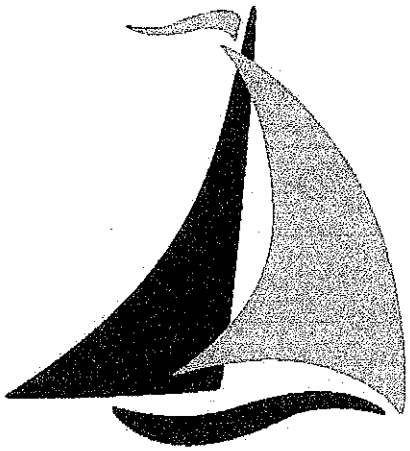
Please list nearest relative and emergency contact:

Name of Nearest Relative _____ Phone _____ Relationship to patient _____

Name of other emergency contact _____ Phone _____ Relationship to patient _____

I certify that I have provided information that is true and correct to the best of my knowledge:

Parent/Legal Guardian Signature _____ Date _____ Relationship to patient _____



PEDIATRIC VACCINE STATEMENT

The pediatricians at Harbor Pediatric Medical Group have all witnessed tragedies and heartbreaks caused by vaccine-preventable diseases. Because of this ***we are strong advocates*** for vaccinating children to prevent illnesses we so frequently encountered in the past. We are also aware of the presence of misinformation, not validated by scientific studies, on the value and side effects of vaccines.

Not vaccinating your child not only puts that child at risk but also other patients of ours, including children too young to vaccinate and children with immune deficiencies. For the safety of all of our patients, we ask that you please vaccinate your child.

Harbor Pediatric Medical Group strongly supports routine and timely vaccinations.

Confidential Communication Request

I, _____, hereby authorize the use of the following means of communication for information related to my child/children's personal health, treatment, or payment or treatment.

PLEASE FILL OUT ALL THAT APPLY:

Home Phone: _____

Mom Cell: _____

Dad Cell: _____

Other: _____

Fax: _____

E-mail: _____

☐ You have permission to leave a message regarding my child/children's treatment on my voicemail.

☐ **Do not** leave a message regarding my child/children's treatment.

_____

Signature Date

Harbor Pediatric Medical Group, APC
601 Dover Drive, Suite 7, Newport Beach, CA 92663

Consent to Treat Minors

I (We) the undersigned parent, parents, or legal guardian of _____ DOB ___/___/___, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician of Harbor Pediatric Medical Group, licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the aforementioned physicians in the exercise of their best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatments will not be withheld if the undersigned cannot be reached.

This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

I (we) understand the importance of my (our) presence during appointments, but in the case of my (our) unavoidable absence, I (we) give permission for the following person(s) to provide necessary supervision:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I (we) acknowledge that it is my (our) responsibility to immediately notify Harbor Pediatric Medical Group of any changes to the above information.

This authorization shall remain in effect until _____.

Signature of Legal Guardian	Date	Relationship to Patient
Signature of Legal Guardian	Date	Relationship to Patient

Please note, Harbor Pediatric Medical Group, may require copies of legal guardianship papers, if applicable.

Patient Name _____ **Patient Date of Birth** _____

Welcome to
HARBOR PEDIATRIC MEDICAL GROUP, APC.

We are committed to providing you and your children with the best possible medical care. If you have medical insurance we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policies.

Financial Policy

Payments for services are due at the time the services are rendered. We accept cash, checks, Visa and MasterCard.

Initial _____ As a courtesy, we are happy to file insurance claims for the services we render. If you wish to have us file insurance claims for you, it is your responsibility to provide us with all necessary insurance information. You authorize your insurance benefits to be paid directly to Harbor Pediatric Medical Group (HPMG)/the physician. You also authorize HPMG or the insurance company to release any information required to process the claim.

Initial _____ Not all services are covered by all insurance policies. ***Any services that are not covered by your insurance are your responsibility.***

Initial _____ Co-payments and deductible amounts are due at the time of service for each visit.

Initial _____ ** Our Regular business hours are Mon-Fri 9:00am-5:00pm not including Holidays. Any visit that is not during those times are considered "After Hours" The charge for "After Hours" care is $45.00 and will be billed in addition to any charges for the visit/other procedures provided.

Initial _____ Positive verification of your insurance coverage cannot always be made prior to services. ***You will receive services with the understanding that in the event that your coverage is not effective, you will be billed and held financially responsible for all services rendered.***

Charges which have been billed to your insurance and not acknowledged or not paid will be transferred to the **patient's responsibility** and you will receive a statement. All patient due balances are expected to be paid upon receipt of the statement.

There will be a service charge of $25.00 for all returned checks. If the amount of the check plus the service charge is not paid within 30 days of receipt of notification, your account will be subject to additional collection fees, interest and or penalties.

We must emphasize that as a medical care provider, our relationship is with you, the patient, not with your insurance carrier. While we are happy to assist you by filing claims with your insurance, all charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions regarding these policies, please do not hesitate to ask us. We are committed to providing you with the best possible care.

Initial _____ ***There will be a $15.00 charge for all missed appointment which include but are not limited to, sick, follow-ups, consultations and nurse visits. Well Child Exam will have a $25.00 charge for any appointment not canceled or rescheduled 24 hours prior.***

Acceptance of Financial Policy Agreement

- I have read and understand the above policies of Harbor Pediatric Medical Group.
- I agree that I am ultimately financially responsible for any professional services rendered regardless of insurance coverage, child support and/or other outside agreements/arrangements.
- I certify that I have provided information that is true and correct to the best of my knowledge.
- I agree to inform Harbor Pediatric Medical Group of any changes in insurance status or any other patient information.
- I hereby give consent for Harbor Pediatric Medical Group to render medical treatment/care for my child.

_____
Patient Name

_____ _____
Printed Name of Parent / Legal Guardian Relationship to patient

_____ ___/___/___
Signature of Parent / Legal Guardian Date

Harbor Pediatric Medical Group, APC
601 Dover Dr. Suite 7
Newport Beach, CA 92663

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience, the following is a summary of the information discussed in the notice.

- Our pledge
- Your Personal Information
- Our Privacy Practices
- How we may use or share your information for:
  - -Treatment
  - -Payment
  - -Healthcare operations
  - -Notifications
  - -Marketing
  - -Research
  - -Special Circumstances and the Law
- Your written permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices (Effective: 04/14/2004, last reviewed: 01/2014).

_____	_____	_____
Printed Name	Signature	Date

Pt name _____

DOB: ____/____/____

Harbor Pediatric Medical Group 601 Dover Dr., Suite 7* Newport Beach, CA 92663* (949) 645-4670*

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2004* Last Review: January 2017

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

OUR PLEDGE

The protection of our patients' privacy and the confidentiality of their medical information have always been important to us. We understand that you trust us to safeguard your personal information and respect your right to privacy. This notice represents our commitment to maintain the privacy of your protected health information and to inform you of our legal duties and privacy practices, as wells as your rights, as required by California and federal law. We are legally required to provide you a copy of this notice and to follow the terms of this notice currently in effect.

YOUR PERSONAL INFORMATION

We keep records of the medical care we provide you and we may receive similar records from others. We use this information so that we, or other healthcare providers, can render quality medical care, obtain payment for services, and enable us to meet our professional and legal responsibilities to operate our medical practice. We may store this information in a chart and in our computers. This information makes up your medical record. The medical record is our property; however this notice explains how we use information about you and when we are allowed to share that information with others.

OUR PRIVACY PRACTICES

It is our policy to maintain reasonable and feasible physical, electronic, and process safeguards to restrict unauthorized access to and protect the availability and integrity of your health information. Our protective measure may include secured office facilities, locked file cabinets, managed computer network systems and password protected accounts.

Access to health information is only granted on a "need-to-know" basis. Once the need is established, the access is limited to the minimum necessary information to accomplish the intended purpose.

Our staff are required to comply with the policies and procedures designed to protect the confidentiality of your health information. Any staff that violates our privacy policy is subject to disciplinary action.

HOW WE MAY USE OR SHARE YOUR INFORMATION

The following categories describe the situations where the law allows us to use and share your health information. We give examples for each category that illustrate that type of use or disclosure. Not every use or disclosure is listed, but the ways in which we are legally permitted to use and share your health information will fall into one of these categories.

Treatment

We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or health care providers who will provide services which we do not provide. We may share this information with a pharmacist who needs to dispense a prescription to you, or a laboratory that performs a test.

We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Payment

We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other healthcare providers to assist them in obtaining payment for services they provide to you.

Health Care Operations

We may use and disclose medical information about you to properly operate and manage our medical practice. For example, we may use and disclose this information to review and improve the quality of the care we provide, or the competence and qualification of our professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose the information as necessary for medical reviews, legal services and audits, including fraud, waste and abuse detection, compliance programs and business planning and management. We may also share your health information with our business associates, such as our billing service, which performs services for us. However, we will not share your health information with then unless they agree in writing to protect the privacy of that information. Under California law, all recipients of healthcare information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other providers, clearing houses, or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce healthcare costs, their review of competence, qualifications and performance of healthcare professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud, war and abuse detection and compliance efforts.

We may disclose information to someone who is involved with your care or helps pay for your care. We may disclose your health information to notify, or assist in notifying, a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may also disclose information to a relief organization so that they may coordinate these notification efforts.

Marketing

We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage your to purchase a product or service when we see you.

Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process.

Special Circumstances and the Law

Special situations and certain laws may require us to use or release your health information. For example, we may be required to release your health information to others for the following reasons:

- Whenever we are required to do so by law; for example, to the extent your care is covered by Workers' Compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupation related injury or illness to the employer or Workers' Compensation insurer.
- To report information to agencies that regulates our business, such as the U.S. Department of Health and Human Services and the California Department of Health and Managed Care.
- To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating and tracking a prescription drug or medical device malfunctions.
- To report information to public health agencies if we believe there is a serious threat to your health and safety or that of another person or the general public; this includes disaster relief efforts.
- To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer reviews.
- To assist courts or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena, or when required by the investigation of a duly authorized administrative agency.
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness, or missing person
- Correctional institutions, law enforcement officials or military authorities that have you in their lawful custody
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues
- To report information regarding job-related injuries as required by your state workers' compensation laws
- To share information related to specialized government functions, such as military and veterans activities, national security and

counter-intelligence purposes, or in support of providing protective services for the President, foreign heads of state and other designated persons.

- To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure; (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstance, based on our professional judgment, that you would not object.
- In the event that our practice is sold or merged with another organization, your medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
- We may use or share your health information when it has been "de-identified". Heath information is considered de-identified when it has been processed in such a way that it can no longer personally identify you.
- We may also use a "limited data set" that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or healthcare operation. For example, a limited data set may include your city, county and zip code, but not your name or street address.

YOUR WRITTEN PERMISSION

Except as described in this Notice of Privacy Practices, or as otherwise permitted by law, we must obtain your written permission- called an authorization- prior to using or sharing health information that identifies you as an individual. If you provide an authorization and then change your mind, you may revoke your authorization in writing at any time. Once an authorization has been revoked, we will no longer use or share your health information as outlined in the authorization form; however you should be aware that we won't be able to retract a disclosure that was previously made in good faith based on what was then a valid authorization from you.

Except as specified above, under California law we may not share your health information with your employer or benefit plan unless you provide us an authorization to do so.

OTHER RESTRICTIONS

California has additional laws regarding the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health, and mental retardation. Generally we will be bound by whatever law is more stringent and provides more protection for your privacy.

YOUR RIGHTS

The following are your rights with respect to your health information. You have the right to:

- Ask us to restrict how we use or share your health information for treatment, payment or health care operation. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved your health care or payment for your health care. Please note that while we will try to honor your requests, we are not required to agree to these types of restrictions.
- Request confidential communications of health information. For example, you may ask that we send information to your work address. We will accommodate all reasonable requests submitted in writing.
- Inspect and copy your heath information, with limited exceptions. To access your record, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We may charge you a reasonable fee for copies as allowed by law. Under certain circumstances we may deny your request. If we deny your request, we will notify you in writing and may provide you the opportunity to have the denial reviewed;
- Request an amendment to your health information that you believe is incorrect or incomplete. We may require your request be in writing and that you provide a reason for the request. If we make the amendment, we will notify you. If we deny your request, we will notify you of the reason in writing. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement f disagreement be included with your health information for any future disclosures.;
- Receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee.

Please note that we are not required to provide you with an accounting for any information:

- Disclosed prior to April 14, 2003
- Shared for treatment, payment of health care operations as described above;
- Previously disclosed to you
- Shared as part of an authorization request;
- Incidental to a use or disclosure that is otherwise permitted;
- Provided for use in a facility directory;
- Provided to persons involved in your care or for other notification purposes
- Shared for national security or counter-intelligence purposes;
- Shared or used as part of a limited data set for research, public health or healthcare operations purposes;
- Disclosed to correctional institutions, law enforcement officials, military authorities, or health oversight agencies.

CHANGES

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all health information that we maintain, regardless of when it was created or received. We will provide you a copy of the revised notice and will post it publicly as required by law.

QUESTIONS OR COMPLAINTS

If you have any questions regarding this notice of privacy practices, if you require additional information, or you believe your privacy rights have been violated, please contact our Privacy Officer at:

601 Dover Dr., Suite 7
Newport Beach, CA 92663
(949) 645-4670

No action will be taken against you and you will not be penalized in any way for filing a complaint with us.

If you prefer, you may direct your complaints to the Secretary of the United States Department of Health and Human Services.

Health Information Exchange

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722

HARBOR PEDIATRIC
MEDICAL GROUP, Inc.

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www.harborpediatrics.com

Eugene Chen, MD
David Michelis, MD
Amy Lau, MD
Hilda Mendoza, MD

**********PLEASE READ**********

Newborns:

› Contact your employer or Human Resource department for enrollment forms or information on how to add your child to your current policy **AS SOON AS POSSIBLE.**

› Contact your insurance company for specific instructions and deadlines for adding your newborn to your insurance policy.

› Take the time to **READ** and **UNDERSTAND** your policy. Find out exactly when your child is eligible to receive services from Harbor Pediatric Medical Group.

› If Mom is contracted with any other Medical Group other than Greater Newport IPA, your insurance company will deny all services provided to your child in our office, until he/she is a member of Greater Newport IPA, and one of Harbor Pediatric Medical Group physicians selected as their PCP.

MOST INSURANCE COMPANIES REQUIRE THAT NEWBORNS NEED TO BE ADDED TO YOUR POLICY WITHIN THE FIRST 30 DAYS OF BIRTH. FAILURE TO ADD YOUR CHILD MAY RESULT IN YOUR INSURANCE COMPANY DENYING COVERAGE TO YOUR CHILD.

If you have an HMO insurance plan:

› Physicians at Harbor Pediatrics are contracted only with ***GREATER NEWPORT PHYSCIAN IPA***.

› Your child may see any provider in our practice however, you must choose a Primary Care Physician within Harbor Pediatric Medical Group.

If you have a PPO insurance plan:

› Contact your employer or Human Resource department for enrollment forms as soon as possible.

› Contact your insurance carrier for specific instructions and deadlines for adding your newborn to your insurance policy.

› Insurances will not process/pay any claims until you add your child to your policy.

Thank you

Harbor Pediatric Medical Group

Parent Signature _____ Patient's Name _____ Date _____

IMPORTANT INFORMATION REGARDING YOUR NEWBORN

If you have an HMO insurance plan

- Our physicians are only contracted with ***Greater Newport Physicians.*** Our tax ID number is **952834746**.
- If your newborn isn't added to one of our doctors by their 2 week physical, that office visit will be considered cash until the baby is added with our group.
- Your child may see any provider in our practice; however you must choose a Primary Care Physician within Harbor Pediatric Medical Group.

If you have a PPO insurance plan

- Contact your insurance plan for specific instructions and deadlines for adding your newborn to your policy.
- Failure to add the baby within the 31 days allowed will result in Hospital charges & office visits not being covered, and become your financial responsibility.

Please ask to speak to billing while you are here or call the number listed below regarding any questions.

(949) 645-4670

Extension 121 or 122