Harbor Pediatrics Medical Group, APC

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

Patient Demographic Information

Please list all your children's Legal Names:

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

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

Patients(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 do require copies of legal guardianship papers.

Last _____ First _____ Relationship Status _____

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

Occupation _____ Employer _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Additional Parent/Legal Guardian Information:

Last _____ First _____ Relationship Status _____

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

Occupation _____ Employer _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please List nearest relative:

First and Last name of Relative _____ 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 _____

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Confidential Communication Request

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

PLEASE FILL OUT ALL THAT APPLY:

Home Phone:_____

Mom Cell: _____

Dad Cell: _____

Other: _____

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

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Consent to Treat in My Absence

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.

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

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. ***Any secondary insurance is your responsibility to bill***. We can provide you with a claim to submit. 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 $45.00 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.

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

Initial _____ As of 1/1/24, there is a $15.00 charge for all form completion and $25.00 for all letters. Additionally, there is a $50.00 fee for all California Immunization Registry (CAIR) submissions/letters.

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Acceptance of Financial Policy Agreement

- I have read and understand the 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

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Notice of Privacy

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

Accompanying your paperwork is a 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 et 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
- 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 handed to you along with your paperwork, as required by law. If it was not, please ask the receptionist to hand you a copy. The actual notice can also be found online at www.harborpediatrics.com/form.

We ask that you sign and return this letter to us for records. Your signature only acknowledges that we have provided you a copy of our Notice of Privacy Practices to review as you complete the new patient paperwork. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgement.

After reviewing the notice, please return the copy to our receptionist. If, after reviewing the notice, you would like to retain a personal paper copy, the receptionist can print you one upon request.

I hereby acknowledge receipt of the Notice of Privacy Practices

_____	_____	_____
Printed Name	Signature	Date