Shafter Pediatrics

Patient Information Intake Form

Last Name: _____ First Name: _____

Address: _____ City: _____ State:____ Zip Code_____

Home Phone: (__)_____ Cell Phone: (__)_____ Work Phone: (__)_____

Date of Birth: ___/___/___ Social Security: _____ Sex: ___ Female ___Male

Emergency Contact: _____ Phone: (__)_____

Responsible Party

Relationship to the Patient: ____Parent ____ Guardian

Last Name: _____ First Name: _____

Address: _____ City: _____ State:____ Zip Code_____

Home Phone: (__)_____ Cell Phone: (__)_____ Work Phone: (__)_____

Date of Birth: ___/___/___ Social Security: _____ Sex: ___ Female ___Male

Emergency Contact: _____ Phone: (__)_____

Race: American Indian/ Asian/ Native Hawaiian/ White/ Hispanic/ Other Race

Language: _____ Email Address: _____

Information Needed:

1) Copy of driver's license or ID
2) Must have insurance cards
3) Immunization record

CAIR California Immunization Registry

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

CONSENT FOR TREATMENT

I hereby authorize Shafter Pediatrics to furnish information to all legitimately involved parties concerning my illness and treatments and that I hereby assign Shafter Pediatrics all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for all charges.

I also understand and agree that I am ultimately financially responsible for services provided to my child. These services are to include: charges that are either denied or not covered by my insurance policy, co-pays, and co-insurances as designated by my insurance policy; a deposit of $80 will be required for those services provided without insurance coverage. I understand that I may receive additional billing from outside vendors: e.g. Radiology, Pathology, Laboratory, Durable Medical Equipment, etc.

I voluntarily give my permission to the health care providers of Shafter Pediatrics and such assistants as they may be deem necessary to provide medical care services to my child. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Shafter Pediatrics providers, or until I withdraw my consent.

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name of Parent/ Guardian Date

A duplicate or faxed copy of this form is considered the same as the original document.

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Parent/ Guardian Signature _____

HIPPA Privacy Rule
Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's ***Notice of Privacy Practices*** prior to signing this acknowledgment;
- This facility reserves the right to change their ***Notice of Privacy Practices*** and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

Parent/ Guardian Signature _____