Riverwalk Pediatric Clinic, Inc.

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FECHA ____________________

No. DE EXPEDIENTE ____________________

Indio Amricano
Asiatico
Moreno
Filipino
Mex-Amer/Hisp
Blanco
Otrro
Islas del Pacifico

INFORMACION DE EL PACIENTE

NOMBRE: ____________________
APELLIDO | PRIMER NOMBRE | 2do INICIAL | SEXO | FECHA DE NACIMIENTO | SS#

DIRECCION: ____________________
NUMERO Y NOMBRE DE LA CALLE | CIUDAD | ESTADO/ZONA POSTAL | TELEFONO

SECCION 1 – INFORMACION REQUERIDA SI EL PACIENTE ES MENOR DE EDAD –INDIQUE LA PERSONA RESPONSABLE CON UNA (X)

NOMBRE DE PADRE ____________________

FECHA DE NACIMIENTO __________ SS# __________

OCUPACION ____________________

NOMBRE DEL EMPLEADOR ____________________

DIRECCION ____________________

TELEFONO ____________________

NOMBRE DE MADRE ____________________

FECHA DE NACIMIENTO __________ SS# __________

OCUPACION ____________________

NOMBRE DEL EMPLEADOR ____________________

DIRECCION ____________________

TELEFONO ____________________

SECCION 2 – INFORMACION DE LA ASEGURANZA

ASEGURANZA PRIMARIA ____________________

NOMBRE DE EL SUBSCRITOR ____________________

ID# __________ Agrupe# __________

ASEGURANZA SECUNDARIA ____________________

NOMBRE DE EL SUBSCRITOR ____________________

ID# __________ Agrupe# __________

PERSONA(S) RESPONSABLES ____________________

REFERIDO POR ____________________

EN CASO DE EMERGENCIA CONTACTARSE CON ____________________

____
NUMERO Y NOMBRE DE LA CALLE | CIUDAD, ZONA POSTAL | TELEFONO

ASIGNAMIENTO DE LOS BENEFICIOS DE LA ASEGURANZA
Yo, por la presente authorizo Hasmukh C. Amin, M.D. poporcionar informacion con respecto a esta enfermedad y con respecto a yo por la presente asigno a ellos todos pagos para servicios medicos rendidos. Una copia de esta authorizacion es valida como la original. Entiendo que soy financieramente responsable por los cobros que no son cubiertos por esta authorizacion..

FIRMA (de la persona Asegurada) ____________________ FECHA __________

Medical Record: ____________

Riverwalk Pediatric Clinic, Inc. 9508 Stockdale Hwy # 150, Bakersfield Ca, 93311, 661-663-7500

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Keeping track of shots you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots. If you change doctors, your new doctor can use the registry to see the shot record. It's your right to choose if you want shot records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots, so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot record from the doctor
- Can show proof about shots needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots children in their programs need
- Make sure children have all shots needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot records
- who has seen the records or to have the doctor change any mistakes

<u>If you DO want your or your child's records in the registry, do nothing. You're all done.</u>

<u>If you DO NOT want your doctor's office to share your immunization information in the registry: Please request an "*Immunization Registry Refusal Form*" from your doctor's office.</u>
For more information about your rights, call **(800) 578-7889**

Patient Name: ______________________ **D.O.B.** ______________________

* *By law, public health officials can also look at the registry in the case of a public health emergency.*

rev 1/08

California Child Health and Disability Prevention Program

CONSENT FORM

I hereby give my consent for ______________________________ to receive the health screening tests and
(Name of patient)

immunizations recommended by the CHDP Program from ______________________________ .
(Name of provider)

I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below.

I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

☐ School

Name			
Address (number, street)	City	State	ZIP code

☐ Health care provider

Name			
Address (number, street)	City	State	ZIP code

☐ Other

Name			
Address (number, street)	City	State	ZIP code

Name of parent, guardian, or emancipated minor

Signature of parent, guardian, or emancipated minor	Date

Screening Provider: This form, signed by parent, guardian, or emancipated minor, must be retained in patient's file.

Chart # ________________

Riverwalk Pediatric Clinic, Inc.
9508 Stockdale Hwy, Suite 150
Bakersfield, CA 93311

Patient Name: ______________________________________ D.O.B ________________

IMPORTANT INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

Riverwalk Pediatric Clinic, Inc. is contracted with most major health plans. Insurance coverage is an agreement between you and your insurance company. We will be happy to bill your insurance company directly for medical services rendered. It is your responsibility to contact the insurance company to verify coverage when being treated at Riverwalk Pediatric Clinic, Inc. If problems arise regarding coverage issues, we will attempt to work with you and your insurance company to resolve them.

It is your responsibility to keep your insurance and personal information current in our files. We ask that you present your insurance card at every visit. Copayments and coinsurance are due at time of service.

If you do not have medical insurance at time of service, you must pay in full before services are provided. We accept cash, personal checks, and Visa, Master Card, Discover, and American Express. If your financial situation is such that you are unable to pay in full, please contact our billing office to discuss possible payment options.

Cash Patients:
As a courtesy, we are able to provide information, which may assist you in obtaining specific medical services at a minimal/or no cost.

Riverwalk Pediatric Clinic, Inc. is committed to providing quality service. Thank you in advance for your cooperation and patience

_____________________________________ ________________________
Patient/Parent/or Guardian Name Date

____
Patient/Parent/or Guardian Signature

FORM 15-1

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

HASMUKH AMIN, M.D. ACKNOWLEDGEMENT OF RECEIPT

Patient Name: ______________________ Date of Birth: ______________

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by coming by the office at 300 Old River Rd. Bakersfield, Ca. 93311

If you have any questions about our *Notice of Privacy Practices*, please contact:

Tina Lujan, Privacy Officer at 661-663-7500

I acknowledge receipt of the *Notice of Privacy Practices* of Dr. Amin's office.

Patient/Parent Name: ______________________

Signature: ______________________ Date: ______________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name: ______________________

Reasons why the acknowledgment was not obtained:

- ☐ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- ☐ Other: ______________________

Signature of provider representative: ______________________ Date: ____________