REGISTRATION FORM
HOSPITAL DRIVE PEDIATRICS

Patient's Name _____ ☐M ☐F DOB _____

Do you have other children who come here? Names & birth dates: _____

_____

How were you referred to our office? Dr._____ ☐Health Plan

☐Internet_____ ☐Friend/Family_____ ☐Other_____

PARENTS are ☐Married ☐Civil Union ☐Divorced ☐Separated ☐Widowed ☐Never Married

Parent's Name_____ Soc Sec#_____ DOB _____

Street Address_____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Best time to reach you _____ *Please circle best phone number*

Occupation_____ Employer _____

If parents are not married: This parent has: ☐Legal custody (☐sole ☐joint) ☐Physical custody (☐sole ☐joint)

Parent's Name_____ Soc Sec#_____ DOB _____

Street Address ☐Same _____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Best time to reach you _____ *Please circle best phone number*

Occupation_____ Employer _____

If parents are not married: This parent has: ☐Legal custody (☐sole ☐joint) ☐Physical custody (☐sole ☐joint)

EMERGENCY CONTACT

Name_____ Relationship _____

Street Address _____Apt#_____

City_____ State_____ Zip_____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

INSURANCE: (please give us current card to copy)

Insured Person_____ Insurance_____

SECONDARY INSURANCE: (please give us current card to copy)

Insured Person_____ Insurance_____

I AUTHORIZE HOSPITAL DRIVE PEDIATRICS TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR MY CHILD/CHILDREN AND REQUEST THAT THE INSURANCE COMPANY MAKE PAYMENT DIRECTLY TO HOSPITAL DRIVE PEDIATRICS. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES RECEIVED BY MY CHILD/CHILDREN, REGARDLESS OF WHETHER THESE SERVICES ARE COVERED BY MY HEALTH PLAN. ALL COPAYS ARE DUE AT TIME OF SERVICE REGARDLESS OF WHO BRINGS MY CHILD IN.

Signature_____ Date_____

FAMILY MEDICAL HISTORY
HOSPITAL DRIVE PEDIATRICS

Patient's Name _____ DOB _____
Mother's Name _____ Age _____
Father's Name _____ Age _____
Sibling(s) of patient (Name, sex, date of birth) _____
_____

1. Have any children in the immediate or extended family died? ☐No ☐Yes
   Age and cause of death_____
2. Are the parents of this child related to each other by blood? ☐No ☐Yes
3. Is the child adopted? ☐No ☐Yes
   List biological relatives known to you _____
4. Donor ☐egg ☐sperm?

Do any of the child's relatives (siblings, cousins, parents, aunts, uncles, grandparents) have a health problem?

Condition or Organ System	No	Yes	Relationship to Patient (specify if donor or adopted)
Genetic syndrome (Down, etc)	☐	☐	_____
Mental retardation	☐	☐	_____
Autism or other developmental disorder	☐	☐	_____
ADHD or learning disabilities	☐	☐	_____
Alcohol or Drug dependency	☐	☐	_____
Psychiatric disorder (depression, etc)	☐	☐	_____
Seizures (specify type)	☐	☐	_____
Nervous system disorder	☐	☐	_____
Asthma or other lung disease (CF)	☐	☐	_____
Allergies-seasonal (list allergens)	☐	☐	_____
Allergies-food (list allergens)	☐	☐	_____
Eczema or other skin conditions	☐	☐	_____
Cleft lip or palate	☐	☐	_____
Ear (infections, hearing loss, etc)	☐	☐	_____
Eye (glaucoma, lazy eye, etc)	☐	☐	_____
Anemia, clotting or bleeding disorders	☐	☐	_____
Miscarriages (multiple)	☐	☐	_____
Thyroid disease (high, low, cancer)	☐	☐	_____
Gland or hormone problems	☐	☐	_____
Childhood cancer	☐	☐	_____
Adult cancer	☐	☐	_____
Muscle or joint disease	☐	☐	_____
Heart defect	☐	☐	_____
Heart attack or stroke (before age 50)	☐	☐	_____
High blood pressure	☐	☐	_____
High cholesterol	☐	☐	_____
Diabetes (specify type)	☐	☐	_____
Kidney problems	☐	☐	_____
Stomach problems (reflux, ulcers, etc)	☐	☐	_____
Celiac, crohn's disease, ulcerative colitis	☐	☐	_____
Anything else that “runs in the family”	☐	☐	_____

Hospital Drive Pediatrics Financial Responsibility Disclaimer 01/2015

CO-PAYMENT AND DEDUCTIBLE: You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your insurance co-payment is always due at the time of service.

INSURANCE CARD: If you come in without your insurance card, you will be asked to cover the charges at the time of service in form of cash or check. We will be happy to bill your insurance for you if you provide us with a copy of your card, and a refund will be issued to you when your health plan makes payment on your claim.

NON-COVERED SERVICES: If we provide services to your child/children that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature below constitutes agreement to pay for such services. No matter what type of plan you have, it is your responsibility, to know and understand your coverage. Not all services are a covered benefit in all contracts. Contact your insurance company to find out what benefits are covered or excluded under your plan.

APPOINTMENT CANCELLATION CHARGE: A partial appointment fee of $40.00 will be charged for appointments cancelled without a minimum of 24 hours notification. In order to allow sufficient time for your appointment, as well as for other patients, **please arrive promptly for your appointment time.** Be aware that if you are more than 10 minutes late, we may need to reschedule your appointment to another day.

AFTER HOURS NURSE ADVICE: There is a service charge for each phone call made to our pediatric *After Hours* nurse advice line. Currently that charge is **$20.45**, but is subject to change at any time. *After Hours* advice is available when the office is closed.

REFERRALS: When this office makes a sub-specialist, radiology or lab referral for you, it is your responsibility to verify if a physician or facility is participating in your insurance network as a contracting provider, in order to obtain your maximum benefits.

PAST DUE BALANCE FEE: Once your insurance company has made payment, your portion will be billed to you and is due within 30 days of the date of the statement. **A fee of $10.00** will be applied to any unpaid balance that exceed 30 days past due. Your account may be turned over to a collection agency if your unpaid account balance exceeds 90 days.

IMMUNIZATION CARD REPLACEMENT: A charge of $10.00 for replacement cards.

FORM FEE: There is a $15.00 fee per request, which will be waived if you bring the forms at the time of your child's well child visit or routine medication follow-up visit (i.e. Asthma medications, ADD medications, other chronic medications.) We will not fill out forms at "sick" visits.

COLLECTIONS: If it is necessary to assign your account to a collection agency and/or an attorney, you will be responsible for all associated fees and costs.

RETURNED CHECK FEE: The fee for a returned check is $20.00, in addition to the original amount of the check. This charge covers our bank fees as well as additional processing and billing costs.

MEDICAL RECORDS: We require a signed written request to copy a patient's chart, and will provide copies within 15 days. There is a minimal processing fee of $15.00 that must be collected prior to releasing the records.

PATIENT TERMINATION: The office values its patient relationships and it wants to protect all patients' rights. We will only terminate patient relationships with cause and after careful consideration. Reasons for termination include: Repeatedly not showing for scheduled appointments, not complying with recommended medical care, being hostile or abusive to staff, not making an attempt or neglecting to pay your account in a timely manner.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Child's Name: _____

NOTICE OF PRIVACY PRACTICES

Hospital Drive Pediatrics
2500 Hospital Drive #12
Mountain View CA 94040
Attn: Linda Davis (650) 968-6033

Effective Date: September 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **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 other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **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 health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care

providers, health care clearinghouses 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 patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** 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.
6. **Notification and Communication with Family**. 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, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. 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 occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/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.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public

health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

Hospital Drive Pediatrics
2500 Hospital Drive #12
Mountain View CA 94040
Attn: Linda Davis (650) 968-6033

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Hospital Drive Pediatrics
2500 Hospital Drive #12
Mountain View CA 94040

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that a copy of this medical practice's Notice of Privacy Practices is posted in the reception area and on the Hospital Drive Pediatrics website for me to read, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. I understand that I may receive a copy of the current notice at any time if I request one.

Signed: _____Date: _____

Print Name: _____ Telephone: (____) _____-_____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name of Patient: _____

Name of Physician: _____