Adolescents Babies and Children Pediatric Medical Group Inc.
702 Wake Ave. El Centro CA 92243
(760)352-7216 Fax (760)352-1028

PATIENT NAME/ Nombre: _____ **DOB**/ Fecha De Nacimiento: _____

SEX: **M / F** **RACE: -**American Indian -Asian -African American -White -Hispanic -Other:_____

HOME ADDRESS/Direccion De Residencia _____

CITY/ Ciudad: _____ **STATE**/ Estado _____ **ZIP CODE**/ Codigo Postal _____

HOME PHONE #/ Telefono: (_____) _____-_____ **CELL PHONE**/ Celular: (_____) _____-_____

(IF DIFFERENT FROM ABOVE/Si Es Diferente A La Direccion De Residencia**)**

MAILING ADDRESS / Direccion De Correspondencia _____

CITY/ Ciudad: _____ **STATE**/ Estado_____ **ZIP CODE**/ Codigo Postal _____

FATHER'S NAME/ Nombre Del Padre: _____ **DOB**/Fecha De Nacimineto _____

EMPLOYER NAME/ Nombre Del Empleador: _____ **PHONE #**/ Telefono (_____) _____

MOTHER'S NAME/ Nombre De Mama _____ **DOB**/ Fecha De Nacimiento: _____

EMPLOYER NAME/ Nombre Del Empleador:_____ **PHONE #**/ Telefono (_____) _____

****EMERGENCY CONTACT**** (who may we contact if we are unable to reach the parent?)/ Contacto De Emergencia (En caso que no podamos contactar los padres): _____ **PHONE#**/ Telefono (_____) _____

RELATIONSHIP WITH PATIENT/ Parentesco Con El Paciente: _____

Insurance information /Aseguranza:

Primary Insurance:_____**ID#**:_____ **GROUP #**: _____

Name of Cardholder (Parent) _____ **DOB**: _____

Cardholder Relationship with patient:_____

Secondary Insurance:_____**ID#**:_____ **GROUP #**: _____

Name of Cardholder (Parent) _____ **DOB**: _____

Cardholder Relationship with patient: _____

PATIENT'S SIBLINGS/Nombre de hermanos del paciente:

NAME/Nombre_____ **DOB**/Fecha de Nacimiento:

_____

NAME/Nombre_____ **DOB**/Fecha de Nacimiento:

_____

FAMILY MEDICAL HISTORY/BLOOD RELATIVES (HISTORIAL MEDICA FAMILIAR)

_____ Diabetes _____Tuberculosis _____Cancer _____Epilepsy/Epilepsia _____Asthma _____Allergies/Alergias _____Heart Disease/Efermedades Cardiacas _____Mental Disorder/Trastorno Mental _____Bleeding/Blood Disorders/ Sangrado/Trastornos De La Sangre

_____Kidney Conditions/Trastorno Renal _____Birth Defects/Defectos De Nacimiento _____Arthritis/Artritis

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SIGNATURE/FIRMA: _____DATE/FECHA: _____

RELATIONSHIP WITH PATIENT/PARENTESCO CON EL PACIENTE: _____

I hereby authorize the following adults to bring my child:

(Patient name)_____ DOB: _____, into the doctor's office for necessary testing and treatment in my absence. (Yo autorizo a las siguientes personas para traer a mi hijo a la oficina del doctor para tratamiento y pruebas necessarias en my ausencia).

Name	Relationship with Patient
_____	_____
_____	_____
_____	_____

SIGNATURE_____ Date: _____

Relationship with Patient: _____

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PATIENT PORTAL

Acknowledgement and Agreement:

I acknowledgement that I have read and fully understand this consent form and the procedures regarding Patient Portal. I understand the risks associated with online communications between my physicians and me, and consent to the conditions outlined herein. In addition, I agree to follow instructions set forth herein , including the polices and procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patient s via online communication. I agree to keep my password confidential and notify the office if my email address changes at any time. I understand and agree with the information that I have been provided.

Email: _____

PARENT/GUARDIAN SIGNATURE_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES- HIPPA.

I hereby acknowledge that I received a copy of the medical Practice Notice of Privacy Practices.

PARENT/GUARDIAN SIGNATURE_____ Date: _____

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Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputed with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Physician's or Authorized Representative's Signature	Date	Patient/Representative's Signature	Date

Print Patient's Name

Physician's or Authorized Representative's Signature	Date

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AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO ADOLESCENT, BABIES & CHILDREN PEDIATRIC MEDICAL GROUP TO OBTAIN ALL MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.)

FOR (Patient Name) _____ D.O.B_____.

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

_____ _____

PARENT / AUTHORIZED REPRESENTATIVE SIGNATURE DATE

HOME ADDRESS_____

HOME PHONE (_____)_____

WORK PHONE (_____)_____

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FINANCIAL POLICY

Thank you for choosing ***Adolescents Babies and Children Pediatric Medical Group Inc***. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment.

We do require payment for co-pays and deductibles at the time of service. All patients must complete our information and insurance form before seeing the doctor**.** We cannot bill your insurance company unless you give us accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not part of your contract, if your insurance company has not paid your account in **full within 45 days**, the balance will automatically become your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. So be sure that you read your policy. In the event that your insurance coverage changes to a plan where we are not a participating provider, please contact your insurance to inquire about the change on coverage.

Parents or guardians of the minor are responsible for full payment. In the event that someone other than the parent or guardian accompany the minor, they will be required to pay for the services such as co-pays and deductibles at the time of service. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy and understand and agree to this policy.

Full payment is due at the time of service. We accept cash, checks and/or VISA/MASTERCARD.

In consideration for professional services rendered or to be rendered, and for credit extended. I agree to pay for any office charges incurred within 45 days of the service date.

Furthermore, if any any hospital physician services are provided, I agree to pay the hospitalization charges within 60 days, unless written arrangements modifying this agreement are made between the physician and myself if a collection service or other collection procedures are required for collection of the office charges and /or hospital physician charges. I also agree to pay all additional cost of collection of the office charges and/or the hospital physician charges, including reasonable attorney fees and interest charges.

I fully understand that the medical records of my children will be send to storage after five years of their last office visit, unless I request transfer of said record to another physician. I agree to pay the registered postage and /or storage fees of the records transfer, if such charges applies.

Signature of responsible party/Parent:_____

Relationship with the patient:_____ Date:_____

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_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

PARENT/GUARDIAN SIGNATURE DATE