COASTAL KIDS

New Patient Referral Form

Parents' Names:_____

Children's Names/Sex/Ages:

Name	Sex (circle)	Age
1._____	M or F	_____
2._____	M or F	_____
3._____	M or F	_____
4._____	M or F	_____
5._____	M or F	_____

Please let us know who referred you to Coastal Kids
(We would like to thank them)

Name:_____

Address:_____

_____

E-mail:_____

Do they have children at Coastal Kids? (Circle) YES NO

Please Circle if this referral is a:

Friend

Magazine referral: (circle) OC Kids OC Family Orange Coast

Other_____

OB Referral:_____

COASTAL KIDS

PLEASE COMPLETE ENTIRE FORM:

Patient Name_____ Age_____ DOB_____ Sex_____
Home Address_____
City_____ State_____ Zip Code_____
Home Phone ( )_____

Mother's Name_____ Married / Single / Divorced / Widowed
Home Address_____
City_____ State_____ Zip Code_____
Home Phone ( )_____Work ( )_____ Cell ( )_____
DOB_____ Driver License #_____ SSN_____
Email Address_____
Employer_____ Address_____

Father's Name_____ Married / Single / Divorced / Widowed
Home Address_____
City_____ State_____ Zip Code_____
Home Phone ( )_____Work ( )_____ Cell ( )_____
DOB_____ Driver License #_____ SSN_____
Email Address_____
Employer_____ Address_____

Nearest Relative_____ Relationship_____
City_____ State_____ Zip Code_____
Home Phone ( )_____Work ( )_____ Cell ( )_____

Insurance Company_____ Name of Insured_____
SSN of Insured_____ DOB_____
Policy #_____ Group _____

Previous Doctor_____ Referred By_____

Siblings Name_____ DOB_____
Siblings Name_____ DOB_____
Siblings Name_____ DOB_____
Siblings Name_____ DOB_____

_____ _____
Signature of Parent or Guardian/Responsible Party Date

_____
Print Name

COASTAL KIDS

Patient Name _____

Date _____

Policies Of Coastal Kids

PARENTS: Please initial all boxes to indicate you understand each individual policy. If you have any questions, please ask a member of our staff.

☐ **PAYMENTS—**Are due at the time of service, Coastal Kids works with Orange County Medical Billing Service who will file your insurance claims as a courtesy to you.

☐ **CO-PAYMENTS, DEDUCTIBLES, COINSURANCE**—Are estimated according to your policy coverage, non-covered service or services for which insurance eligibility/coverage cannot be confirmed are due and payable at the time of service.

☐ **COVERAGE TERMS**—Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing the terms and conditions of your policy. It is not the responsibility of Coastal Kids to know your policy details. As a courtesy Coastal Kids attempts to verify eligibility and benefits, however, we are unable to obtain the exact details of payment until the claim is processed.

☐ **OUTSTANDING BALANCES**—Outstanding balances for any and all family members are due and are payable prior to the physician's visit. It is the policy of Coastal Kids that all account balances be kept current.

☐ **BILLING POLICY**—We will bill your insurance company at the time of service. When the Explanation of Benefits (EOB)/insurance payment is received, your account will be credited. If coverage is denied or there is a remaining patient responsibility for any reason, you will be responsible for the payment in full when you receive a statement or at the time of your next appointment (whichever comes first). You will be billed on a monthly basis.

☐ **INSURANCE COMPANY DISPUTES**—It is your responsibility to negotiate payments with your insurance company. Remember, Coastal Kids bills your insurance company as a courtesy to you.

☐ **PPO's and HMO's**—If your insurance plan is a PPO, you can see any of our physicians at any of our locations. If you have an HMO plan, you have the same opportunity but you will need to indicate with your insurance carrier one of our HMO physicians as your primary care physician (PCP). Only two physicians at Coastal Kids are not HMO providers.

☐ **COLLECTION POLICY**—If payment is not made at the time the monthly billing statement is received, you may be responsible for interest and penalties. Coastal Kids subscribes to a collection policy for any unpaid debt. Once your bill goes into collections you will be responsible for attorney fees, interest and penalties. Coastal Kids cannot pull an account out of collections once it is sent to collections. If your account is sent to collection you will be discharged from the practice.

☐ **FINANCIAL HARDSHIP**—If for whatever reason you encounter a financial hardship, Coastal Kids has a policy for payment programs. Financial Hardship qualifications are required to be met prior to payment arrangements. The forms can be obtained from the Office Manager.

☐ **RETURNED CHECKS**—There will be a $35.00 returned check fee applied to your bill for any returned check. This is the charge we incur from our bank.

COASTAL KIDS

☐ **ARBITRATION AGREEMENT**—An Arbitration Agreement form is included in the packet. This form is for your benefit and the doctor's benefit. Please sign and return this form with the rest of the documents in this packet. If you should have any questions after reading the form, our staff will be happy to answer your questions.

☐ **OFFICE HOURS**—Office hours are:
Monday through Friday – 8:00am to 1:00pm and 2:00pm to 5:45pm.

☐ **AFTER HOURS AND WEEKEND HOURS**—Coastal Kids offers after hours appointments and weekend appointments in the Newport Beach office only. After hours consists of appointments after 5:00pm and weekend appointments. A $50.00 after hour/weekend fee is due and payable at the time of service. This fee is your responsibility and will not be billed to insurance companies. It is outside of our contract arrangements with the payers. Monarch does not cover after hours appointments, therefore HMO patients will be referred to an authorized Urgent Care facility for after hours treatment.

☐ **WALK-INS**—Coastal Kids discourages walk-in appointments as we are better prepared to serve you with advanced notice. If a patient comes in without an appointment scheduled, we will triage the situation and determine whether the patient needs to be seen urgently. We would then do our best to work the patient into our schedule. We do charge a $40.00 walk-in fee, which is due and payable at the time of service. This is not billed or covered by insurance plans. If it is determined that the patient does not need to be seen urgently and our schedule does not allow for additions at that time, a later appointment time will be offered.

☐ **NEW BABY SERVICES**—It is the insurance subscriber's responsibility to make sure that the newborn be added to the policy in a timely manner. Coastal Kids will not be responsible for charges incurred and not covered by your insurance company when a newborn has not been properly added to an insurance policy.

☐ **MISSED APPOINTMENT**—A missed appointment fee will be charged if the office is not notified 24 hours in advance. The fee for missed appointments is $35.00. This fee is not covered by insurance and therefore will not be billed to insurance.

☐ **COPY OF MEDICAL RECORDS**—A written request along with a $20.00 fee must be received prior to the release of each medical record. Please allow 2 weeks from receipt of the request and payment.

☐ **FILE REVIEW CHARGES/LETTER WRITTEN**—There will be an additional charge of $40.00 for all requests for review of records or letters written on the patient's behalf.

☐ **AUTHORIZATION TO TREAT MINORS**—Coastal Kids will be unable to treat any minor (ages 17 and under) without a parent or legal guardian present. A minor may be treated in the presence of an adult other than the parent or legal guardian with proper written consent (see attached form).

COASTAL KIDS

To Our Patients:

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time of check in. That information will be held securely until your insurance has paid their portion and have notified both you and us of how much, if any, is your portion. A statement will be mailed to you regarding any remaining balance. If a balance becomes delinquent, the credit card will then be charged to avoid the collections process.

This will be an advantage to you because you will no longer have to write out and mail us a check. It will be an advantage to us as well because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep down the cost of health care.

Much like when you check into a hotel or rent a car, you are asked for a credit card, which is imprinted and later used to pay your bill.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,
Coastal Kids

I authorize Coastal Kids to charge outstanding patient portion balances for me and my dependents to the following credit card:

Visa Mastercard (please circle one)

Account Number _____

Expiration Date _____Signature Code_____ Billing Zip Code_____

Signature_____ Date _____

Full Name on Credit Card (please print) _____

COASTAL KIDS

SERVICE AGREEMENT/ AOB

Patient Name	Start of Care Date	Patients Social Security #
Address	Telephone #	Date of Birth

AUTHORIZATION FOR CARE/ PAYMENT AGREEMENT

I authorize the employees and/or representatives of COASTAL KIDS to render routine and emergency medical, nursing, medications and any other products and services as required and ordered by my physician. COASTAL KIDS shall supervise its staff on an ongoing basis during the term of this agreement. All services will be supervised by the appropriate health care professional.

I agree to pay for any services provided to me or requested by me or on my behalf, which are not paid by my insurance company or other party responsible for paying for my care. I agree that I will be charged a service fee for all payments made by credit card. I also understand that I am responsible for interest and penalties, any collection costs, court costs, and reasonable attorney's fees incurred in the enforcement of this agreement.

Further, I understand that if such amounts are not paid within a reasonable time, COASTAL KIDS reserves the right to bill me directly or discontinue services rendered after notice to me.

INSURANCE ASSIGNMENT

In consideration of services, supplies or equipment rendered or to be rendered, I hereby assign and transfer to COASTAL KIDS any benefits payable to or for my benefit under any insurance coverage payment for such services and products rendered. I agree to cooperate and assist COASTAL KIDS in procuring all possible insurance benefits. I further assign and transfer to COASTAL KIDS any insurance benefits accruing to me under uninsured motorist coverage.

RELEASE OF INFORMATION

I authorize COASTAL KIDS to release any medical information requested by representatives of any governmental agency, insurance company or any other organization or entities as may be required by said representatives for payment of claim due COASTAL KIDS. I authorize release of physicians' plan of treatment and records for my medical records to regulatory agencies, third party payers and related entities requiring patient medical records. I authorize Dr. Abelowitz, Coastal Kids and related parties to leave messages on my telephone answering machine or with a household member related to appointments, medication and or medical information, health care and payment/financial/insurance information.

INFORMED CONSENT

I acknowledge that I have received information and have fully been informed of and understand the areas noted below and agree that I am solely responsible for any charges that arise out of services and products provided to me. I further agree that I release COASTAL KIDS and its staff from any liability whatsoever, due to failure to follow protocols and/or instructions. I hereby instruct all parties to accept a copy of this agreement to be as valid as the original.

I have been informed of, taught and/or understand the following:

- RIGHTS AND RESPONSIBILITIES
- DRUG COUNSELING/INFORMATION
- NOTICE OF PRIVACY POLICIES (HIPAA)
- ARBITRATION AGREEMENT
- FINANCIAL OBLIGATION FOR SERVICES AND PRODUCTS
- COMPLAINTS PROCESS
- POLICIES ATTACHED

Insured	Signature	Relationship	Date
Legal Guardian/Responsible Party	Signature	Relationship	Date
Witnessed By	Signature	Relationship	Date

Positive verification of your coverage cannot be made at this time. You will receive services, as long as necessary, with the understanding that in the event your coverage is not in effect, you will be held financially responsible for all services rendered. If your insurance cannot be verified before the time of discharge, a deposit may be required. This deposit will be refunded to you upon receipt of insurance payment in full or may be applied to your portion of the bill. By signing this you acknowledge financial responsibility and authorize charges for services provided.

Drivers License No:_____ Social Security Number:_____
Credit Card Type: Master Card_____ Visa_____ Name on the Credit Card:_____
Credit Card Number:_____ Expiration Date:_____
Deposit Amount:_____ Estimated Charges:_____

Credit Card Holder	Signature	Relationship	Date
Witnessed By	Signature	Relationship	Date

Nearest Relative Not Living With You:_____ Relationship:_____
Address:_____ Telephone #:_____

COASTAL KIDS

Patient's Name:
Date of Birth:

Date:

Pregnancy and Birth History

Problems during pregnancy	no	yes _____
Medications	no	yes _____
Smoking/Alcohol/Drugs	no	yes _____
Diabetes	no	yes _____
Illness during pregnancy	no	yes _____
Other		_____

Delivery: Vaginal Cesarean Section
Reason for C/S_____
Full Term Premature (# mths _____)
Birth Weight_____ Birth Length_____

Problems immediately after birth:

Infection	no	yes _____
Breathing Difficulty	no	yes _____
Jaundice	no	yes _____
Home with mother	no	yes _____
Other	no	yes _____
		_____

Medical History

Current Medication_____
_____
Medication Allergies_____
Food Allergies_____
Hospitalizations_____
_____

Previous infections/problems:

Anemia	no	yes _____
Asthma	no	yes _____
Bedwetting	no	yes _____
Behavior problems	no	yes _____
Bladder or kidney infection	no	yes _____
Chicken pox	no	yes _____
Constipation	no	yes _____
Convulsions or seizures	no	yes _____
Ear infection	no	yes _____
Eczema	no	yes _____
Hay fever	no	yes _____
Hearing problems	no	yes _____
Learning problems	no	yes _____
Pneumonia	no	yes _____
Sleep problems	no	yes _____
Speech problems	no	yes _____
Transfusion	no	yes _____
Vision problems	no	yes _____
Weight problems	no	yes _____

Other_____
_____
_____
_____

Completed by_____

Developmental History

Child was able to do the following at what age:
Smile_____
Roll over_____
Sit alone_____
Crawl_____
Walk alone_____
First words_____
Toilet trained_____

Family History

Alcohol or drug problems	no	yes _____
Allergies	no	yes _____
Asthma	no	yes _____
Birth defects	no	yes _____
Blood diseases	no	yes _____
Blindness	no	yes _____
Cancer	no	yes _____
Convulsions	no	yes _____
Elevated cholesterol/trig	no	yes _____
Deafness	no	yes _____
Death in childhood (incl. SIDS)	no	yes _____
Diabetes	no	yes _____
Headaches/migraines	no	yes _____
Heart defects (incl. congenital)	no	yes _____
Heart attacks	no	yes _____
At what age?		_____
Hip dislocation	no	yes _____
Hypertension	no	yes _____
Immun deficiency (incl. AIDS)	no	yes _____
Learning problems	no	yes _____
Liver disease	no	yes _____
Lung disease	no	yes _____
Mental retardation	no	yes _____
Psychiatric disorders	no	yes _____
Thyroid disease	no	yes _____
TB test—positive results	no	yes _____

Conditions that run in the family _____
_____

Social History

Exposure to passive smoke	no	yes _____
Smoker in the household	no	yes _____

Household Parent/Caretaker:

Name	Age	Employer
_____	_____	_____
_____	_____	_____

Married Divorced Separated Widowed Other_____

Others in the home:

Name	Age	Relation to patient
_____	_____	_____
_____	_____	_____

Others important in child's life:

Name	Age	Relation to patient
_____	_____	_____
_____	_____	_____

This information has been reviewed with the parent(s):
Signature:_____

COASTAL KIDS

Authorization for Release of Medical Records

Attention: _____

Address: _____

_____

Phone: _____ Fax: _____

Please release a complete copy of my child's medical records to:

Coastal Kids, A Professional Medical Corporation

1401 Avocado Ave., Ste. 709
Newport Beach, CA 92660
(949) 759-1720
Fax: (949) 759-1442

25500 Rancho Niguel Rd., Ste. 110
Laguna Niguel, CA 92677
(949) 448-8821
Fax: (949) 448-8831

4870 Barranca Parkway, Ste. 300
Irvine, CA 92604
(949) 387-4900
Fax: (949) 387-4945

800 Corporate Dr., Ste. 280
Ladera Ranch, CA 92694
(949) 347-7200
Fax: (949) 347-7217

Patient's Complete Name: _____

Date of Birth: _____

Please mail/fax these records for an appointment on:_____

Parent/Guardian
Name:_____ Signature:_____

Witnessed by:_____ Date: _____

COASTAL KIDS

Authorization To Treat a Minor

I (parent/guardian), _____, give Coastal Kids authorization to treat my child (patient), _____-_____, in my absence when under the direct supervision of **COASTAL KIDS**. I give _____ my permission to make all healthcare decisions for my child in my absence, including authorization to make decisions regarding immunizations and other procedures. I understand that I am financially responsible for all charges incurred for services rendered in my absence.

This authorization is valid from _____ / _____ /_____ - _____ /_____ /_____

_____
Parent Signature

_____
Date

COASTAL KIDS

Primary Contact Number
and
Authorization to Release Lab Results

In order to more efficiently convey lab, test results and other communication, Coastal Kids is requesting that you provide a secure telephone number/s, which our staff may call and leave messages regarding your child. This will help prevent the delay of pertinent information relating to your child (patient). If you have not heard from Coastal Kids regarding your child's lab work in the expected time, please do not hesitate to contact the office.

Phone #: _____ (Primary)

Phone #: _____ (Secondary)

I, (parent/guardian) _____, give Coastal Kids permission to leave messages regarding my child, (patient) _____, on the above telephone lines.

Signature: _____

Relationship to patient:_____