



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: _____



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 _____



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).



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) _____



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: _____



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



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: _____