Rancho Paseo Medical Group **CHILD, Health History Form**

Child's Last Name:_____
Child's First Name: _____
Date: _____ Phone: _____

PERSONAL HISTORY

Date of Birth: _____ Birthplace: _____

Is the Child Yours by: ☐*BIRTH* ☐*ADOPTION* ☐*STEP CHILD* ☐*OTHER*

Any Medical Problems during pregnancy: ☐*NONE* If yes, specify:

_____

Delivery by: ☐*Vaginal Delivery* ☐*Caesarean (why):*_____ _____

Was your child breastfed? ☐*No* ☐*Yes (how long):* _____

Any feeding or dietary problems? ☐*NO* ☐*YES*

*(specify):*_____

Ethnic Background: ☐*American Indian* ☐*Asian* ☐*African American*

☐*Filipino* ☐*Caucasion* ☐*Pacific Islander* ☐*Other:* _____

Recreation / Play / Exercise:_____

Sleep: Avg Hrs per night: _____

Naps (number & length): _____

ALLERGIES TO MEDICATIONS ☐*NO KNOWN ALLERGIES*

Substance / Medication	Reaction

HOSPITALIZATIONS & SURGERIES

Year	Hospital	Reason for Hospitalization or Surgery

PLEASE BRING CHILD'S IMMUNIZATION RECORD TO EVERY APPOINTMENT

Has your child had: ☐*Chickenpox* ☐*Measles* ☐*Mumps*

☐*Rubella* ☐*Meningitis* ☐*Tuberculosis (TB)*

Date of Last :

Tetanus Shot: _____ Flu Shot:_____

Gardasil: _____

List Over-the-Counter Medications:

_____ _____

_____ _____

SPIRITUAL ASSESSMENT (optional)

Do you believe in God or a higher power? ☐*YES* ☐*NO*

Would you like to speak with our Chaplain about spiritual matters or grief counseling? ☐*YES* ☐ *NO*

Would you like us to pray for: ☐*You* ☐*Your Family* ☐*Your Health*

Other: _____

☐*YES – during office visit* ☐*YES – while I'm not present.* ☐*NO - Not at this time*

FAMILY HEALTH HISTORY

Check (√) if the child or his/her blood relatives have or Have had any of the following:

Disease	Child	Family	Relation to
Alcohol / Drug dependency			
Asthma/ Chronic Lung Disease			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney disease			
Mental illness or Depression			
Migraines			
Peptic Ulcer			
Seizures			
Stroke			
Thyroid trouble			
Tuberculosis			
Other			

Rancho Paseo Medical Group

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you.
Failure to provide all information requested may invalidate this Authorization.

First Name: _____ Mid. Initial _____ Last Name _____

Date of Birth: _____ Social Sec #: _____ Phone: _____

Address: _____ City _____ ST _____ Zip _____

I hereby authorize: _____

Address: _____ City _____ ST _____ Zip _____

Phone: _____ Fax: _____

to release to: Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
Ph: 951-769-0079, Fax: 951-845-6750

the following information:

a. ( ) All health information pertaining to my medical history, mental or physical condition – OR
( ) Only the following records or types of health information. Include date(s) of treatment:

_____

b. I specifically authorize release of the following information (check as appropriate):
( ) Mental health treatment information ( ) HIV test results ( ) Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: Patient request ( ); OR ( ) other:

_____

Expiration date: _____ (This authorization will expire in 6 months unless otherwise indicated).

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to and will receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA).
  If this is checked (), the requestor will receive compensation for the use or disclosure of my information.

Signature: _____ Print: _____
(Patient/representative/spouse/financially responsible party)

Signature: _____ Print: _____
If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____ Date: _____

Rancho Paseo Medical Group. 264 N. Highland Springs Ave. 5A. Banning, CA 92220

FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with Federal Truth-in-Lending Act.

Rancho Paseo Medical Group shall charge a FINANCE CHARGE on any part of the "previous balance" at the periodic rate of 1¼% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any "previous balance" as shown on the periodic statement, which is paid 90 days from the first billing of the "previous balance" or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 90 days unpaid and then to that portion of the "previous balance" which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and then finally to credit.

You may pay your entire balance at any time.

Any credit balances of $5.00 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of Insurance. Rancho Paseo Medical Group cannot accept the responsibility for collecting your Insurance claims or negotiation of a settlement on a disputed claim. Notwithstanding Insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by Insurance benefits.

Rancho Paseo Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Paseo Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued to the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient's Signature: _____ Date: _____

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Rancho Paseo Medical Group professionals and their assistants, appointees, or consultants as is necessary in their judgment.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments of examination by Rancho Paseo Medical Group.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Rancho Paseo Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.

5. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Patient or Guardian: _____ Relationship: _____

Signature of Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

To The Patients of Rancho Paseo Medical Group: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Rancho Paseo Medical Group, 264 North Highland Springs Ave., Ste. 5, Banning, California 92220 (951) 769-0079. Attention Administrator or Safety Officer.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Rancho Paseo Medical Group, 264 North Highland Springs Avenue, Banning, California 92220 (951) 769-0079. Attention: Administrator or Practice Privacy Officer. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Rancho Paseo Medical Group, 264 North Highland Springs, Banning California 92220 (951) 769-0079. Attention Administrator or Practice Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rancho Paseo Medical Group, Attention Administrator or Practice Privacy Officer, (951) 769-0079

Name of Patient: _____ Date: _____

Patient's Signature: _____