WEST TOWER PEDIATRICS

8635 W. Third St. Suit 260W Los Angeles, CA 90048

Registration

Child 1. Last Name: ___________________ First Name: ___________________ MI: _______
DOB:_____/_____/_______ Sex: _______ Primary Language: ___________________

Child 2. Last Name: ___________________ First Name: ___________________ MI: _______
DOB:_____/_____/_______ Sex: _______ Primary Language: ___________________

Child 3. Last Name: ___________________ First Name: ___________________ MI: _______
DOB:_____/_____/_______ Sex: _______ Primary Language: ___________________

Contact 1. Name: _____________________________ Relationship to Patient:________________
DOB:_____/_____/_______ SS#:___________________ Lives with Patient? **Yes / No**
Primary Phone: _(___)______-__________ Secondary Phone: _(___)______-_________
Email: ______________________________ Work Phone: _(___)_____-______ **ext.**___
Employer: ___________________________ Occupation: _________________________

Contact 2. Name: _____________________________ Relationship to Patient:________________
DOB:_____/_____/_______ SS#:___________________ Lives with Patient? **Yes / No**
Primary Phone: _(___)______-__________ Secondary Phone: _(___)______-_________
Email: ______________________________ Work Phone: _(___)_____-______ **ext.**___
Employer: ___________________________ Occupation: _________________________

Mailing Address: ____
(Street or PO Box) (City) (State & Zip Code)

Preferred Pharmacy: ____
(Street or PO Box) (City) (State & Zip Code)

If parents are divorced or separated, please fill out this section:

Who has custody?____________________________ Relationship to Patient:__________________

Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **YES / NO**

Emergency Contact, other than parents:

Contact 1. ____
(Full Name) (Relationship to Patient) (Phone Number)

Contact 2. ____
(Full Name) (Relationship to Patient) (Phone Number)

All patients must provide a copy of current insurance card and a picture ID if not on file.

PAYMENT OF SERVICES

I REALIZE THAT IF INSURANCE PAYMENT(S) DO NOT REPRESENT THE FULL PAYMENT ALLOWED FOR SERVICES RENDERED, I AM RESPONSIBLE FOR ANY BALANCE DUE. I FURTHER UNDERSTAND THAT MY POLICY MAY HAVE A DEDUCTIBLE AND OUT OF POCKET COSTS WHICH ARE MY CONTRACTURAL AGREEMENT WITH MY INSURANCE.

Signature:____ **Date:**___________

Charges for vaccines or laboratory services may require a "co-insurance" amount, in addition to any office co-payment you may have. Lab fees such as co-insurance and fees for testing are due at the time of service. Our contract with your insurance carrier requires that we discount our fees to their allowable amounts. It also prohibits us from offering further discounts. We are required to collect all deductibles and co-payments in full.

LABORATORY FEES

Our office has a laboratory for our patients' convenience. We bill insurance for the laboratory testing, co-insurance and copayments may be required for these services. Your insurance may require you to visit one of their preferred laboratory facilities. **Our office charges a $10.00 convenience fee for laboratory blood draws.**

Signature:____ **Date:**___________

CANCELLATION POLICY

Our office calls you on your selected primary phone number to confirm all next day appointments. We value each patients assigned time with the physicians. If you need to cancel a scheduled physical exam, we need at least 24 hours' notice to fill the appointment from our waiting list.

A cancellation fee of $60 is charged when an appointment is cancelled with less than 24 hours' notice, or when an appointment is not kept without notice or No Show to an appointment. **You are giving West Tower Pediatrics authorization to automatically charge a fee of $60.00.** This fee is waived when cancelling an appointment 24 hours in advance.

Responsible Party Signature: __________________________ **Date**____________

BILLING DEPARTMENT

Our Billing department sends statements monthly. Patient balances are due in full within 30 days of receipt of our statement. Our accountant will not allow us to carry patient balances beyond 60 days. For billing questions, **please call the number on your statement** or **(310) 448-2693.**

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Responsible Party Signature: ___________________________ **Date:** _____________

Our office policy is to have a credit card on file for on demand fees such as virtual visit copayments, labs fees, camp / school forms.

Type of Credit Card (Visa, MC, or AMEX):_________________________

Credit Card Number:____

Security Code:_______

Expiration Date:_________________

Name on Card:______________________________

Billing Zip Code:_______________

Your signature below signifies that you consent to have you card on file and to be charged.

Responsible Party Signature:_____________________________**Date:**_________________

WEST TOWER PEDIATRICS HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to West Tower Pediatrics, its affiliates and its employees. West Tower Pediatrics will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information under the Federal Health Insurance Portability and Accountability Act ("HIPAA").

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Individuals Involved in Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law; • Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations; • If we suspect child

abuse or neglect or victim of abuse, neglect or domestic violence; or if a threat to your health and safety or health and safety of the public, disclosure will be made to help prevent a threat • To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls; • Court or administrative ordered subpoena or discovery request; • To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid West Tower Pediatrics in full.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please request the form from our Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint. Office for Civil Rights Department of HHS Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278 Voice Phone (212) 264-3313 FAX (212) 264-3039 TDD (212) 264-2355 .

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the West Tower Pediatrics Privacy Officer(Susan Moreno) at the following address: 8635 West Third Street #260w, LA, CA. 90048.

Patient name(s): ____

Parent / Guardian ______________________ **Initials:**____________