



**WEST TOWER PEDIATRICS**

8635 W. 3rd St., Suite 260  
Los Angeles, CA 90048

**Patient Registration**

**Patient:** Name: \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

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**Patient:** Name: \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Preferred Phones for appt. confirmation:** \_\_\_\_\_ **Preferred email:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**1) Parent Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**2) Parent Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**In case of an emergency who should we contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Information:**

**Insurance Company:** \_\_\_\_\_ **Subscriber ID/ Policy #:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**AUTHORIZATION FOR SOMEONE OTHER THAN PARENT TO BRING CHILD TO WEST TOWER PEDIATRICS**

I authorize \_\_\_\_\_ to bring my child / children

\_\_\_\_\_ to the office of Richard Miller, MD. / Jennifer Ouchi, MD.

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Financial Policies

Financial Agreement: By signing below, I hereby certify the correctness of the above information and authorize the release of information to my insurance company. I assign benefits to Richard Miller, MD. / Jennifer Ouchi, MD. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. I also understand that I am ultimately responsible for my bill regardless of my insurance coverage

#### Self-Pay Accounts:

If you do not have insurance and/or choose to proceed with self-pay, please come prepared to pay for your visit in full upon arrival. A price list of services is available upon request. We offer a 25% discount for all self-pay services paid in full on the day of the visit.

#### Credit Card on File:

We require that a valid credit card be kept on file with the practice. Your card will only be charged when a copayment is required and not collected on check or for virtual visits. Once your card is charged, a receipt will be sent to you by email. Missed Co-Pays: West Tower Pediatrics is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and our office in default of the insurance contract.

#### Credit Card Authorization

Card Holder's name: \_\_\_\_\_ Card Holder Signature : \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration date (MM/YY): \_\_\_\_\_ CVV CODE: \_\_\_\_\_

Card type:  Visa  Master Card  AMEX  Discover  HSA billing Zip Code: \_\_\_\_\_

Authorization date: \_\_\_\_\_

#### Missed Appointments:

Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. Cancellations are required 24 hours prior to any well visit appointment via phone call or email to the practice. A "No Show" fee of \$60 will be applied if an appointment is missed or not canceled within the stated time frame.

#### Insurance:

We are contracted with most PPO insurance plans. The office is contracted with Cedars Sinai Health Associates, Regal Medical / Lakeside HMO, and Providence HMO. We are contracted with Health Net Medi-cal managed plans. Please call the office to confirm acceptance of your coverage. Please bring a copy of your insurance card for every visit. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file. **Please present newly issued insurance cards upon check-in at the next scheduled visit.**

If you have an HMO insurance plan, please be sure to select the correct provider as your pcp, Dr. Miller is the only provider accepting new Cedars HMO group patients. If we cannot confirm that our providers are listed as your child's PCP, we will ask that the appointment be rescheduled. It is the account holder's responsibility to verify network participation and provider assignment to your child.

**Change of Insurance/Change of Account Information:**

Please notify the office as soon as possible of any and all account changes, including insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges.

**Divorced/Separated Parents and Custodial Arrangements:**

West Tower Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. It is the responsibility of the parents to inform the office of any custodial or residence changes.

**Screening and Procedures:**

West Tower Pediatrics provides the highest quality care for your child and follows the American Academy of Pediatrics and Bright Futures clinical guidelines on hearing and vision screens, behavior health screens, and labs. However, some insurers do not cover services related to meeting these clinical recommendations such as vision screening via computerized photo screen, visual acuity testing, hearing testing, developmental screenings (done at well visits), child anxiety and depression screenings. These tests are very important in the assessment of any development delays or potential problems. These screenings often lead to diagnoses that can be treated to assist development and mental health.

**In-office lab tests**

Often, patients want to know as soon as possible if their child has the flu, strep, covid, RSV etc. We can effectively and efficiently determine that by performing in-office testing. Some insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests to external labs can result in waiting days for results that we can provide you much more quickly (usually within minutes). We believe it is important to treat your child as quickly as possible, and therefore offer these services in-office.

Screening and Procedures Acknowledgement:

I have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge, in the event that my insurer does not pay for these services in full.

Parent name: \_\_\_\_\_ Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE LIST WHO WE CAN SHARE MEDICAL INFORMATION WITH ON BEHALF OF YOUR CHILD(REN)

Parent(s) Name: \_\_\_\_\_

Sibling(s) Name: \_\_\_\_\_

Grandparent(s) Name: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Other: \_\_\_\_\_

Parent name: \_\_\_\_\_ Parent signature: \_\_\_\_\_

### **Vaccines:**

As pediatricians, we are firm believers that immunizations protect us from illnesses that are known to cause disability and death. We are happy to discuss any questions that you may have regarding our vaccines and available schedules. Please bring vaccine records to wellness appts. New patients are recommended to provide medical records for initial visit.

### **Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

**Treatment, Payment, and Health Care Operations.** Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination. •

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also use and disclose medical information for the following purposes: for Appointment Reminders and Communication with your Family, and for specific situations regarding Public Health, and Public Safety. As warranted and often required by law, your medical information may be used in Judicial and Administrative Proceedings and shared with Health Oversight Agencies, Law Enforcement Agencies, the Medical Examiner's office and Specialized Government Programs. We may also contact you regarding treatment alternatives or other health-related benefits and services that may be of interest to you. We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of the disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The privacy act took effect on April 14, 2003 and will remain in effect until further notice, during which time we are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. If you file a complaint, we will not hold it against you. For More Information about HIPAA or to file a complaint Contact:

The US Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, S.W. Washington, D.C. 20201

(877) 696-6775 (Toll-Free)

Parent name: \_\_\_\_\_ Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_

**West Tower Pediatrics**

8635 W 3<sup>rd</sup> Street, Suite 260w

Los Angeles, CA 90048

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[www.WestTowerPediatrics.com](http://www.WestTowerPediatrics.com)

**RELEASE OF MEDICAL RECORDS**

Facility / provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the use or disclosure of my child / children / personal protected health care information records to the West Tower Pediatrics office of Dr. Richard Miller, MD. and Dr. Jennifer Ouchi MD.

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent / guardian name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ email: \_\_\_\_\_

The purpose of this disclosure is for continuity of care. The authorization is valid beginning \_\_\_\_\_ and expires on \_\_\_\_\_.

I understand that:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to: West Tower Pediatrics 8635 West 3<sup>rd</sup> street Suite 260, Los Angeles, CA 90048
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.

Parent signature / patient signature: \_\_\_\_\_

Name of authorized representative / relation: \_\_\_\_\_