PATIENT REGISTRATION

PATIENT REFERRED BY _____ TODAY'S DATE _____

PATIENT NAME _____ SOC. SEC. NO. _____

STREET ADDRESS _____ DATE OF BIRTH _____ AGE: _____

CITY/STATE _____ ZIP _____ TEL NO. _____

FATHER / GUARDIAN INFORMATION

NAME _____ MARITAL STATUS S M W SEP D

STREET ADDRESS _____ CITY/STATE _____ ZIP _____

TEL. NO. _____ DOB _____ SOC. SEC. NO. _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____ CITY/STATE _____ ZIP _____

OCCUPATION _____ CELL NO. _____ WORK TEL. NO. _____

MOTHER / GUARDIAN INFORMATION

NAME _____ MARITAL STATUS S M W SEP D

STREET ADDRESS _____ CITY/STATE _____ ZIP _____

TEL. NO. _____ DOB _____ SOC. SEC. NO. _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____ CITY/STATE _____ ZIP _____

OCCUPATION _____ CELL NO. _____ WORK TEL. NO. _____

EMERGENCY INFORMATION

#1

NAME _____ CEL # _____ HOME # _____

RELATIONSHIP _____

#2

NAME _____ CEL # _____ HOME # _____

RELATIONSHIP _____

INSURANCE INFORMATION

#1

PRIMARY INSURANCE CO. NAME ID# PLAN GROUP

SUBSCRIBER'S NAME RELATIONSHIP SUBSCRIBER'S EMPLOYER

#2

SECONDARY INSURANCE CO. NAME ID# PLAN GROUP

SUBSCRIBER'S NAME RELATIONSHIP SUBSCRIBER'S EMPLOYER

CONSENT TO TREAT AND FINANCIAL AGREEMENT

I/We do hereby consent to and authorize the performance of all treatments, minor surgery and medical services by Mario I. Brakin, M.D. and Pablito G. Nagpala, M.D. which they deem advisable.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including medical, private insurance or any other health plan to Mario I. Brakin, M.D.,F.A.A.P., Inc. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I hereby certify that, to the best of my knowledge all statements contained hereon are true. I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage. I futhermore agree to pay legal interest, collection expense, and attorney's fees, should it become necessary to assign any amount I may owe for collection. I fully understand that this agreement, consent and assignment of benefits will continue until cancelled by me in writing.

REMARKS _____

Signed _____ *Date* _____ *Witness* _____ *Date* _____

PEDIATRIC HISTORY FORM

CHILD'S NAME _____ AGE _____ DATE FORM FILLED OUT _____

A. BIRTH HISTORY

1. Birthplace _____
2. Birthdate _____
3. Was pregnancy normal? _____
4. Was delivery normal? _____
5. Was baby full term? _____
6. Birth weight _____
7. Birth length _____
8. Any nursery problems? _____
9. Any transfusions—mother/child _____

B. GROWTH AND DEVELOPMENT

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   First Teeth _____ Toilet Trained _____
2. School History:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problem? _____
   _____
   Ever seen by Psychologist, Speech Therapist, or Special Teachers? _____
   _____

C. PAST MEDICAL HISTORY

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail Biting? _____
   Nightmares? _____
2. Diet _____
   Nursed or Bottle Fed? _____
   Any Colic problems _____
   Use special diets? _____
   Taking Vitamins? _____
   Taking Fluoride? _____
3. Contagious Diseases (What age?) _____
   Measles _____
   Mumps _____
   Rubella (German Measles) _____
   Chickenpox _____
   Scarlet Fever _____
   Any other? _____
4. Immunizations (Shots)—Please give ages and/or dates.
   DPT series _____ Boosters _____
   Polio series _____ Boosters _____
   HIB _____ Boosters _____
   Measles _____
   Rubella (German Measles) _____
   Mumps _____
   TB (Tine) Test _____
   Others _____
   _____
5. Medications (Does Your Child Take Any Now?) _____

D. HOSPITALIZATIONS

(When, Where, Why?) _____
_____
_____

E. SURGERY

(When, Where, Why?) _____
_____
_____

F. SERIOUS INJURIES

(When, Where?) _____
_____
_____

G. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Exzema, Hay Fever) _____
_____
_____

I. FAMILY HISTORY

1. Father: Living? _____ Age now _____ Health _____
2. Mother: Living? _____ Age now _____ Health _____
3. Brothers/Sisters _____ How Many? _____
   Ages _____ Healthy _____
4. Any Family History of:
   Diabetes _____ Allergies _____ Convulsions _____
   Heart Disease _____ TB _____ Cancer _____
   Thyroid Disease _____
   Other? _____

J. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

_____

WHERE DID YOU LIVE BEFORE COMING TO THIS AREA? _____
_____

K. GENERAL SURVEY

Has your child had any unusual problems with the following?:

Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones, Muscles, Joints _____
Skin _____
Blood _____

2. When was your child's last blood test? _____
3. When was your child's last urine test? _____

L. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

_____
_____

M. YOUR LAST DOCTOR WAS _____

MEDICAL PRINTING SERVICE FORM 30491

Pediatric Endocrinology Associates

2650 Elm Avenue, Suite 318
Long Beach, California 90806
(562)595-0166

Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It is convenient (saving you time and postage)
- Your payment is always on time (even if you are out of town), eliminating late charges.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged the amount indicate below each billing period. A receipt will be emailed to you and each charge will appear on your statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Pediatric Endocrinology Associates to charge my credit card.
(full name)

Patient Name _____ DOB: _____ **Acc #** _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; provided the transactions correspond to the terms indicated in this authorization form.

PEDIATRIC ENDOCRINOLOGY ASSOCIATES

2650 Elm Ave. Suite 318 long Beach, CA 90806
(562) 595-0166 Fax (562) 595-6714

FINANCIAL POLICY

Thank you for choosing our Office. We are committed to the success of your treatment. Accurate information and prompt payment will allow us to continue giving you the best possible care.

A. If you DO NOT have insurance coverage, full payment is due at the time services are rendered.
B. If you have insurance coverage:
    1) You must provide current, accurate health insurance information at the time of service. Claims that are denied due to inaccurate insurance information will become the patient's responsibility.
    2) We will be glad to bill maximum of (2) insurance companies.
    3) It is your responsibility to know your insurance plan and to verify coverage for other doctors, recommended test and laboratory. We will bill your insurance company, however any co-payment, co-insurance and or deductible are due at the time of your visit. If insurance does not pay within 45 days, you will be responsible for the bill.
    4) A $10.00 service charge may be applied to patient account balances not paid within 30 days of receipt of our billing statement.
    5) If you fail to make payment in full or arrange for a payment plan with our office for the services that are rendered to you, your outstanding balance (over 60 days) will be subject to 18.5 % year interest and may be sent to a collection agency. A $50.00 collection charge will be applied to your account and you will be responsible for the fees assessed by the collection agency.

C. There will be a fee of $30.00 to complete any work, school DMV or other requested forms and a $30.00 fee to release medical records.
D. Our practice is committed to your health care, and we ask that you do the same. **Please give us a call 24 hours in advance if you are unable to keep your appointment, otherwise you will be subject to a no-show fee of $50.00.**
E. Regardless of your insurance coverage, you are ultimately responsible for full and timely payment of all charges incurred in our practice.

We accept cash, check, Visa, MasterCard, American Express, Discover and Bank Card. Please sign that you have read and agree to this Financial Policy.

X_____ Date Signed_____
Signature of Patient or Responsible Party
Print Name_____

Pediatric Endocrinology Associates of Long Beach
Mario I. Brakin, MD
Pablito G. Nagpala, MD
2650 Elm Ave. Suite 318
Long Beach, CA 90806
Karingforkids2@yahoo.com
(562) 595-0166 Fax (562)595-6714

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Pediatric Endocrinology Associates. When you schedule an appointment with Pediatric Endocrinology Associates, we set aside enough time to provide you with the highest quality care.
Should you need to cancel an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No show Policy below:

* Any established patient who fails to show or cancel/reschedules an appointment and has not contacted our office with at least **24 hours' notice will be considered a No Show and charged $50 fee.**
*If a 3rd No Show or Cancellation/Reschedule the patient may be dismissed from our office/Pediatric Endocrinology Associates and deferred back to Primary Care Physician.

*Any New Patient who fails to show for their initial visit will not be rescheduled.
*The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit and any other balance they may owe.

*As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder, call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you're not being able to keep your scheduled appointment. If should experience extenuating circumstances, please contact our office and our office manager maybe able to waive the No Show fee.

_____
Patient's Name Date of Birth

_____
Guarantor's Signature Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Pediatric Endocrinology Associates** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of . **Pediatric Endocrinology Associates** I understand that diagnosis or treatment of me by **Mario I. Brakin, MD and Pablito G. Nagpala MD** be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Pediatric Endocrinology Associates** is not required to agree to the restrictions that I may request. However, if **Pediatric Endocrinology Associates** agrees to a restriction that I request, the restriction is binding on **Pediatric Endocrinology Associates** and **Mario I. Brakin, MD and Pablito G. Nagpala .**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Mario I. Brakin, MD and Pablito G. Nagpala, MD.** or **Pediatric Endocrinology Associates** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Pediatric Endocrinology Associates** Notice of Privacy Practices prior to signing this document. The **Pediatric Endocrinology Associates** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Pediatric Endocrinology Associates** The Notice of Privacy practices for **Pediatric Endocrinology Associates** is also provided **2650 Elm Avenue, Suite 318 Long Beach, CA 90806**.This Notice of Privacy Practices also describes my rights and the **Pediatric Endocrinology Associates** duties with respect to my protected health information.

Pediatric Endocrinology Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

PEDIATRIC ENDOCRINOLOGY ASSOCIATES of LB
MARIO I BRAKIN, MD, FAAP, INC.
DBA/ PEDIATRIC ENDOCRINOLOGY ASSOCIATES
PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your child's ***best possible health*** requires a "partnership" between the parent/guardian, patient and doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule visits with the Doctor for recommended routine exams

I understand that the doctor will explain to me which regular health exams and screenings are appropriate for my child's age, gender, personal and family history. I understand I will need to complete these recommended health exams / screenings (labs, MRI, ultrasound, stimulation tests etc...). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put my child at risk of letting serious health problems go undetected. I will schedule regular visits with my child's doctor to complete his physical exam and to discuss results of these health screenings.

Keep follow-up appointments and reschedule missed appointments

I understand my child's doctor will want to know how my child's condition progresses after I leave the office. Returning to my child's doctor on time gives him the chance to check his/her condition, his/her response to treatment. During a follow-up appointment, my child's doctor might order tests, refer me to another specialist, prescribe medication, or even discover a serious health condition. If I miss an appointment and I do don't reschedule, my child will run the risk that his physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the office when I do not hear the results of labs and other tests

I understand that my child's physician's goal is to report my child's lab and test results to me as soon as possible. However, if I do not hear from my child's physician's office within the time specified, I will call the office for my child's test results.

Inform my child's Doctor if I decide *not* to follow his or her recommended treatment plan

I understand that after examining my child, the doctor may make certain recommendations based on what he or she feels is best for my child's health. This might include prescribing medication, referring to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my child's treatment plan can have serious negative effects on my child's health. I will let the doctor know whenever I decide *not* to follow his recommendations for my child so that he may fully inform me of any risks associated with my decision to delay or refuse my child's treatment.

Thank you for your partnership. As our patient's parent/guardian, you have the right to be informed about your child's care. We invite you and your child at any time to ask questions, report symptoms, or discuss any concerns you or your child may have. If you need more information about your child's health or condition, please ask.

_____	_____	Pablito G. Nagpala, MD
Parent / Guardian signature	Date	Physician signature

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Representative's Name and Relationship (Type or Print)

_____

Patient's Representative's Signature

Original to be maintained in patient's medical records.