PATIENT INFORMATION

PATIENTS NAME:_____ DATE OF BIRTH:_____ ◉M ○F

SIBLING:_____ DATE OF BIRTH:_____ ○M ◉F

SIBLING:_____ DATE OF BIRTH:_____ ○M ◉F

SIBLING:_____ DATE OF BIRTH:_____ ○M ◉F

○ PARENT ○ STEP PARENT ◉ FOSTER PARENT

FATHERS NAME:_____ DATE OF BIRTH:_____ SSN#:_____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

HOME#:_____ CELL#:_____ WORK#:_____

EMPLOYER:_____ OCCUPATION:_____

○ PARENT ◉ STEP PARENT ○ FOSTER PARENT

MOTHER NAME:_____ DATE OF BIRTH:_____ SSN#:_____

HOME ADDRESS:_____ CITY:_____ ZIP:_____

HOME#:_____ CELL#:_____ WORK#:_____

EMPLOYER:_____ OCCUPATION:_____

EMERGENCY CONTACT:_____ PHONE#:_____ ○HOME ◉CELL

ADDRESS:_____ CITY:_____ ZIP:_____RELATIONSHIP:_____

WHO REFERRED YOU TO OUR OFFICE?_____ PRIOR PHYSICIAN:_____

EMAIL ADDRESS:_____

WE USE YOUR EMAIL ADDRESS FOR MEDICAL STATEMENTS AND UPDATES IN THE OFFICE.

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES TO MEDICAL CARE PROVIDED BY DR. KANAN MODI. FEE STATEMENTS FOR INSURANCE CLAIMS WILL BE AVAILABLE TO ME TO SUBMIT TO MY INSURANCE COMPANY OR WITH CERTAIN INSURANCE PROGRAMS, AFTER DEDUCTIBLE ARE VERIFIED, AND THEN BILLING WILL BE SUBMITTED TO THE INSURANCE COMPANY. THIS OFFICE WILLHELP WITH PROBLEMS RELATING TO INSURANCE REIMBURSEMENTS IN WHATEVER WAY POSSIBLE, BUT I AM AWARE THAT PAYMENT IN FULL IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES. I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. KANAN MODI. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO INSURANCE COMPANIES REGARDING MY FAMILY.

SIGNATURE OF PARENT:_____ DATE:_____

CONSENT FOR TREATMENT

I , THE PARENT OF _____ A MINOR CHILD, AUTHORIZE THE PHYSICIAN DR. KANAN MODI AS MY AGENT, TO CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSTIC EVALUATION OR TREATMENT OF HOSPITAL CARE WHICH THE ABOVE NAMED PHYSICIAN DEEM ADVISABLE, WHETHER TREATMENT IS RENDERED AT THE OFFICE OF DR. KANAN MODI OR AT A HOSPITAL. I UNDERSTAND THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC, DIAGNOSIS, TREATMENT, OR HOSPITAL CARE BEING NECESSARY, BUT IS GIVEN TO PROVIDE AUTHORITY TO DR. KANAN MODI, TO EXERCISE ITS BEST MEDICAL JUDGEMENT IN PROVIDING FOR THE CARE OF MY CHILD.

SIGNATURE OF PARENT:_____ DATE:_____

OBSTETRICAL NEONATAL HISTORY

MOTHER: # PREGNANCIES_____ #BIRTHS_____ #AB_____ PRENANTAL CARE BEGUN AT_____

COMPLICATIONS DURING PREGNANCY: (High Blood Pr, Anemia, Infections, Medications, ETC.)

CONDITION:_____MONTH:_____

TREATMENT:_____

DURATION OF PREGNANCY:_____months DURATION OF LABOR:_____ hours

METHOD OF DELIVERY: #VAGINAL_____ #C-SECTION_____ WHY C-SECTION?_____

BIRTH WEIGHT OF THE BABY_____lbs _____oz BIRTH HEIGHT OF THE BABY_____inch

PROBLEMS DURING 1ST MONTH OF LIFE? (Breathing/Feeding, ETC.)_____

_____

DEVELOPMENTAL HISTORY

AT WHAT AGE DID CHILD: WALK ALONE_____ USE SINGLE WORDS_____ TOILET TRAINED_____

FAMILY HISTORY

IS THERE HISTORY OF ANY OF THE FOLLOWING IN THE FAMILY (indicate relationship)?

KIDNEY DISEASE_____ CANCER_____ DIABETES_____

TUBERCULOSIS_____ THYROID_____ HEART DISEASE_____

ALLERGIES_____

HISTORY OF PAST ILLNESSES

HOSPITALIZATIONS: REASON_____ AGE:_____

HOSPITAL NAME_____ LENGTH OF STAY_____

HAS YOUR CHILD EVER HAD?

	YES	NO	DATE
MEASLES (7-DAY).....	____	____	_____
MEASLES (GERMAN).....	____	____	_____
CHICKEN POX.....	____	____	_____
MUMPS.....	____	____	_____
POSITIVE TB TEST.....	____	____	_____

IS YOUR CHILD TAKING MEDICATION NOW?_____

NAME OF MEDICINE_____

DOES YOUR CHILD NOW HAVE?

	YES	NO	DATE
FREQUENT EAR INFECTION....	____	____	_____
HEADACHES.....	____	____	_____
BEDWETTING.....	____	____	_____
SKIN PROBLEMS.....	____	____	_____
EAT NON-FOOD STUFF.....	____	____	_____
REPIRATORY PROBLEM.....	____	____	_____
STOMACH PROBLEM.....	____	____	_____

ALLERGIES

FOODS:_____ MEDICATION:_____

PETS:_____ HAY FEVER:_____

DOES YOUR CHILD HAVE ANY OTHER MEDICAL PROBLEMS?_____

USUAL SOURCE OF MEDICAL CARE_____ DATE LAST SEEN_____

SOCIAL HISTORY

GRADE IN SCHOOL_____ SCHOOL PERFOMANCE_____ DOES HE/SHE GET ALONT WITH OTHERS?_____

PARENTS QUESTIONS OR CONCERNS? _____

_____

PATIENTS NAME:_____ SEX: _____ DATE OF BIRTH:_____

GENERAL CONSENT

I hereby request and consent to diagnostic procedures, tests and medical treatment. Including immunizations deemed advisable by the professional staff of KANAN MODI, MD, INC.

I acknowledge that I have read this Consent Form and understand its contents. I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction.

_____ _____

Witness Signature of Patient

Date:_____ _____

Signature of Parent/or Legal Guardian

CONSENTIMIENTO GENERAL

Por este medio hago peticion y consiento un procedimientos dianosticos, examenes y tratamiento medico, inclusive immunizaciones, las cuales se crean aconsejables por el personal de KANAN MODI, MD, INC.

Reconozco que leido este formulario de consentimiento y entiendo su contenido. He tenido la oprtunidad de discutirlo, y las preguntas que he hecho han contestado a mi satisfaccion completa.

_____ _____

Testigo Firma De Paciente

Fecha:_____ _____

Firma Del Padre O Madre
Del Paciente O Del Tutor

KANAN MODI MD INC
1305 WEST ARROW HIGHWAY #104
SAN DIMAS, CA 91773
P: 909.394.9004 F: 909.394.9461

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability act of 1996 ("HIPPA"); I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple Healthcare providers involved in that treatment directly and indirectly.
2. Obtain payments from third party payers, if necessary.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

My signature below confirms that I have had the opportunity to read and understand your **Notice of Privacy Practices**. This contains a more complete description of the uses and disclosers of my health information. I understand that KANAN MODI MD, INC. has the right to change the **Notice of Privacy Practices** from time to time, and that I may contact this office during normal working hours to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that your restrict how my private information is used to disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print name of patient:_____

Parent of Guardian Signature:_____

Date:_____

KANAN MODI MD INC
1305 WEST ARROW HIGHWAY #104
SAN DIMAS, CA 91773
P: 909.394.9004 F: 909.394.9461

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this form, you give consent to our use and disclosure of protected health information about you or your child for our treatment, payment and healthcare operation purposes. Federal Law requires that we obtain a written consent of this kind from you or those uses and disclosures. If we use or disclose your protected health information for any other purposes, we must obtain separate written authorizations from you with details about the proposed use of disclosure.

Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclose protected health information about your child. You have the right to review the *Notice of Privacy Practices* before signing this consent. We reserve the right to change the *Notice of Privacy Practices* and if we do, you may obtain a copy of the revised *Notice of Privacy Practices* from,

KANAN MODI MD, INC.
ATTN: OFFICE MANAGER
1305 WEST ARROW HIGHWAY #104
SAN DIMAS, CA 91773

Once you give us the consent we can rely on it until you revoke it. You can revoke it by delivering a dated and signed letter to KANAN MODI MD, INC at the address about. We are not requiring agreeing to those restrictions, but if we do, we will be bound to comply with that agreement.

If not signed by the patient, please indicate relationship.
( ) Parent or Guardian of minor

I understand that I have the right to receive a copy of this authorization.

Print name of patient:_____

Parent of Guardian Signature:_____

Date:_____

KANAN MODI
1305 West Arrow Highway #104
San Dimas, CA 91773

Patients Name:_____ Date Of Birth:_____

BASIC POLICY Pay for service is due in full at the time services is provided in our office.
PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
COPAY/CO-INSURANCE/DEDUCTIBLES Any copayments, co-insurance and deductibles are due at the time services are rendered. If not paid at the time of service, there will be a $10.00* fee added to your account.
NON-COVERED SERVICES Any services not covered for by your insurance carriers (i.e. Immunizations, Vision, etc.) will require payment in full at the time services are provided or upon notice of insurance claim denial.
MEDI-CAL PATIENTS All medi-cal patients must provide a current BIC before being seen.
CASH PATIENTS Payment-in-full is due at the time services are rendered. We accept cash, checks, and credit cards (Visa & MasterCard).
PERSONAL INJURY CASES Our office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be recommended by your physician.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You will be charged $25.00* for missed appointments.
FILL OUT FORMS There will be a charge of $10.00* PER page to be filled out that is brought in AFTER services were rendered.
RETURNED There will be a $25.00* charge for that returned check.
IMMUNIZATION CARDS There will be a charge of $5.00* for a new immunization card.
CHARTS Copies of the patients chart start at $25.00* and could go up depending on the size of the chart. Please allow up to 15 business days before calling our office to check on records. If you fax a release of records to our office please call to verify receipt of fax.
LABS You are responsible to call 2-3 days after you get your labs don, unless instructed differently by the Physician. Our office will call you if your labs come back abnormal.
BILLING If you have billing/balance questions, they can be answered on Tuesday and Thursdays from 12PM-3PM. If you call out of these days or hours you may be asked to leave a message and the Billing Department will return your call at their earliest convenience.

By signing this form, I acknowledge that I have read and understood the above listed policies.

Parent or Guardian Signature	Parent or Guardian Print Name	Date

Office Staff Witness

PRICES SUBJECT TO CHANGE.