San Clemente Integrative Pediatrics

Patients Name:	DOB:	Age:
Nickname:	Sex: M / F	
Present health concerns:	Allergies/Reactions:	
Herbs/Home remedies used?	List any medications taken daily:	

Pregnancy & Birth

Is your child…(circle one) Birthed Adopted Stepchild Other:

Any medical problems during pregnancy?	Delivered by:	Birth Weight:
☐ No ☐ Yes Specify:	☐ Vaginal Birth ☐ Cesarean, Why?	_____lbs _____oz Birth Length: _____inches

Please indicate any medical problems, if any, during the baby's newborn period:

Infancy/Childhood/Adolescence

Past Medical History: (Please describe any major medical problems and their dates)

Past Surgical History: (Please list any previous surgeries and their dates)

At what age did your child…

Sit Alone: _____ Walk Alone: _____ Say Words: _____ Toilet Train:_____

Age at first menstrual cycle (if applicable):

Phone: (949) 200-7737
Fax: (949) 336-1949
3553 Camino Mira Costa, Suite D
San Clemente, CA 92672
Email:
scip.miracosta@gmail.com

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Nutrition & Feeding	
Was your child breastfed? ☐ No ☐ Yes, How long? _____	Any unusual/dietary concerns?

Dental History
Has your child been seen by a dentist? ☐ Yes ☐ No How often? _____ Last Visit Date? _____

Family History *(Please check off any of the following and indicate who has/had the condition)*	
☐ Alcoholism/Drug Abuse ☐ High Blood Pressue ☐ Asthma ☐ Kidney Disease ☐ Psychiatric Disorders ☐ Seizures ☐ Hay Fever/Eczema	☐ Heart Disease or Stroke ☐ Thyroid Disease ☐ Bleeding/Clotting problems ☐ Inherited/Genetic Diseases ☐ Birth Defects ☐ Other:

Social History	
Are the child's parents…. ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced, when? _____ Custody situation? _____ *if sole custody please provide legal documentation	Childcare situation: (outside of school hours) ☐ Parents ☐ Day care, Hours per day_____ ☐ Other

Are there any guns in the home? (circle one) Yes No

Exposures/Habits		
Hours of sleep per night:	Naps (number & length):	Sleep problems?

Extracurricular activities/sports?

Any unusual exposures or habit concerns?

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

By signing this form, I consent to the use of disclosure of my protected health information by San Clemente Integrative Pediatrics (SCIP), herein known as "Health Care Provider" for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of "Health Care Provider."

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 health care operations of the practice. "Health Care Provider" is not required if I agree to the restrictions that I may request. However, if "Health Care Provider" agrees to a restriction that I request, the restriction is binding on "Health Care Provider" and Health Care Provider's Practice.I have the right to revoke this consent, in writing, at any time, except to the extent that the "Health Care Provider" 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 "Health Care Provider" (s) Notices of Privacy Practices prior to signing this document that the "Health Care Provider" has provided to me. The Notice of Privacy Practices for "Health Care Provider" is also posted at 3553 Camino Mira Costa Suite D San Clemente CA, 92672.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 "Health Care Provider." This notice of Privacy Practices also describes my rights and the duties of "Health Care Provider" with respect to my protected health information.

"Health Care Provider" 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 by assesing the "Health Care Provider's" office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

I understand that the diagnosing or treatment of my "Health Care Provider" may be conditioned upon my consent as evidence by my signature on this document.

Treatment (includes activities performed by health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone, or in person, as the on-call physician. Other physicians who provide coverage for our office are required to use and disclose your protected health *information consistent with the Notice.*)

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.)

Health Care Operations (includes the necessary administrative and business functions of our office.

Date: _____

_____ _____

Signature of Patient or Personal Representative Description of Personal Representative's Authority

San Clemente Integrative Pediatrics

PARENT/LEGAL GAURDIAN INFORMATION & EMERGENCY CONTACT

Parent/Legal Guardian #1:

Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ Cell Phone:_____ Work Phone: _____

Email: _____ Occupation: _____

Best number to reach me is: __Cell __Work

SCIP may contact me & leave messages including patient information on: ___Cell __Email

Lives with patient? Yes / No

_____

(street) (city/state/zip)

Parent/Legal Guardian #2:

Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ Cell Phone:_____ Work Phone: _____

Email: _____ Occupation: _____

Best number to reach me is: __Cell __Work

SCIP may contact me & leave messages including patient information on: ___Cell __Email

Lives with patient? Yes / No *(If address is same as above leave blank, if different please list below)*

_____

(street) (city/state/zip)

Whom may we contact in case of an emergency? *(Please list someone aside from the two individuals listed above that is allowed to be contacted, and health information is allowed to be shared to, in the case of an emergency.)*

Name: _____Relationship to Patient: _____

Phone: (_____) _____ - _____

Completed by:

Name: _____

Signature: _____

Date:_____

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CONSENT FOR TREATMENT OF MINOR

I, _____, legal guardian of _____ give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including, but not limited to, examination, injection, immunization, and/or diagnostic procedures, including x-ray or laboratory analysis. I understand that only myself, those included in these intake forms as parents/legal guardians, and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen (16 years or older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone fore verbal consent.

(The space below is to authorize someone other than parents/legal guardians to give consent for treatment. This space can be used to include the name of a grandparent, caretaker, nanny, or etc. who may need to bring the child in for an appointment on your behalf.)

Name _____

Relationship to Patient _____

Phone (_____) _____ - _____

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from parents/legal guardians or treatment may be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is revoked. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify SCIP of any changes in the health status of my children or the above information.

Completed by:

Name: _____

Signature: _____

Date:_____

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CONSENT FOR RELEASE OF MEDICAL RECORDS

As required by the Health Information Portability and Accountability of 1996 (HIPPA), this practice may not disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of health information described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Patient: _____ DOB: _____
Address: _____

Previous physician's information

Release From:

_____
Address:_____
_____
Ph: _____
Fax:_____

Release To:
Dr. Yovana Bruno, MD
Address: 3553 Camino Mira Costa Suite D
San Clemente, CA 92672
Ph: (949) 200-7737
Fax: (949) 336-1949

By marking the spaces below, I specifically authorize the use of disclosure if the following health information and/or records:

_____ Entire medical record (all information) and/or records
_____ Office chart notes
_____ X-ray reports
_____ Immunization records
_____ Laboratory reports
_____ Billing statements
_____ Other:_____
_____ Mental Health/ Psychotherapy Notes

_____ _____
Signature of Patient or Patient's Legal Guardian Date

_____ _____
Print Name of Legal Guardian (if applicable) Relationship to Patient

Please note: This release is only valid 1 year from the date of signature. Renewal of this form will be required if medical records are requested after this forms expiration.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

Yovana Bruno, MD
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)