Shen Medicine Pediatrics and Associates
www.medicinepediatrics.com
408-296-9800(Phone)

316 Rosewood Avenue
San Jose, CA 95117
408-296-9805 (Fax)

Patient Information

Name: _____ Birthdate _____ Male□ Female□
Last First MI

Social Security: _____ Driver's License: _____ Single□ Married□

If minor, Father/Guardian 1: _____ Birthdate _____
Last First MI

Mother/Guardian 2: _____ Birthdate _____
Last First MI

Home Address: _____ Phone _____
Street City/Zip

Cell Phone _____ Work Phone _____ Email Address: _____

Primary Employment _____ Address: _____
Company Name Street City/Zip

Primary Insurance _____ Address: _____
Company Name Street City/Zip

Insurance Phone: _____

Member Name: _____ ID# _____ Group# _____

Member's relationship to patient: Self □ Spouse □ Parent □ Child □

In case of emergency, please contact:

1). Name_____ Phone _____ Relationship _____

2). Name_____ Phone _____ Relationship _____

3). Name_____ Phone _____ Relationship _____

I certify the above information to be complete accurate and truthful.

Signature _____ Date _____

If minor (younger than 18 years old) and accompanied by an adult *other* then parent/guardian, the following persons have permission to bring patient in for medical care.

Name_____ Phone _____ Relationship _____

Name_____ Phone _____ Relationship _____

Effective Dates _____ (Renew in 1 year)

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NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Shen Medicine Pediatrics and Associates. Our notice provides information about how one may use and disclose medical information we maintain about you. We encourage you to read our foil Notice. If you have any questions about our Notice that our office staff cannot answer, please contact us at 408-296-9800.

I acknowledge receipt of the Notice of Privacy Practices of Shen Medicine Pediatrics and Associates.

I, _____, have received and read a copy of Shen Medicine
Patients Name Date of Birth
Pediatrics and Associates' Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent or Guardian ***Date***

_____ _____
Print Name if other than Patient ***Relationship to Patient***

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Type of Protected Health Information to be restricted or limited (Please check all that apply):

- □ Home Phone
- □ Office Phone
- □ Occupation
- □ Spouse's Name
- □ Patient History
- □ Prescription Info
- □ Home Address
- □ Office Address
- □ Name of Employer
- □ Spouse's Office Phone
- □ Patient Hospital Note
- □ Patient Visit Note

How would you like your Protected Health Information used or disclosed?

_____

_____

_____ _____
Signature of Patient/Parent or Guardian ***Date***

_____ _____
Print Name if other than Patient ***Relationship to Patient***

For internal use only:
Obtained patient's acknowledgement in good-faith effort by:

- □ In-person
- □ By mail
- □ By Email
- □ Other: _____

Acknowledgement not obtained because: _____

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ACKNOWLEDGEMENT OF FINANCIAL LIABILITY

Your signature on this form acknowledges that you agree to accept full financial responsibility for services provided by Shen Medicine Pediatric and Associates. You will be financially liable for charges which are determined not to be covered by your health plan, such as those services that you are not eligible for coverage, or were not properly referred or authorized by your health plan.

Please note that commercial health insurance plans may not cover some medical services, vaccines, preventive health services, medical supplies, after-hour telephone or email advice, and out of network use of providers.

As a courtesy, Shen Medicine Pediatrics and Associates will make reasonable effort to bill your insurer on your behalf. However, in the event that a service or item provided to you is not covered, you will be responsible for that charge and billed for the unpaid amount.

_____ _____

Signature of Patient/Parent or Guardian ***Date***

_____ _____

Print Name if other than Patient ***Relationship to Patient***

REQUEST AND PERMISSION FOR MEDICAL SERVICE

Patient Name: _____ Date of Birth: _____

Please note that CAP-MPT is the medical malpractice carrier for Shen Medicine Pediatrics and Associates. All policies and guidelines of Shen Medicine Pediatrics and Associates are strictly adhered to and insured by CAP-MPT, including the policy of completion of the Physician-Patient Arbitration Agreement.

I, the patient, will be given information about the test(s), treatment(s), procedure(s) and medication(s) rendered by Shen Medicine Pediatric and Associates, including benefits, risks, potential problems complication and alternate choices. I understand that I should ask questions about services rendered if I do not understand and a medical professional is available to answer any pertinent questions I have.

I understand I will be given referrals for further diagnosis or treatment should it be deemed necessary. I understand also if such additional referral or treatment is needed, I will assume responsibility for obtaining this care. I understand no guarantee will be given to me as to the results or outcome that may be obtained from any services I receive from Shen Medicine Pediatric and Associates. I understand it is my choice whether or not to receive the services, and I may change my mind at any time. I have been instructed how to obtain care in case of emergency.

I understand that if a test for certain infectious or sexually transmitted diseases are detected, there are legal requirement to reporting such result to the local public health agency.

I hereby request medical evaluation, testing and treatment by Shen Medicine Pediatric and Associates.

_____ _____

Signature of Patient/Parent or Guardian ***Date***

_____ _____

Print Name if other than Patient ***Relationship to Patient*** Shen

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OFFICE POLICY

Appointments: Patients are seen by scheduled appointment only. As a courtesy, you will be given a 15 minute grace period for late arrivals. Arrivals greater than 15 minutes late will require a longer wait time for you and other patients, you may be asked to reschedule for an appointment for a later or another date.

Missed Appointment: Kindly please allow 24 hours time for all cancellation and for rescheduling. Missed appointments without such notice may subject to a charge.

Co-Pays: Co-pays are due and payable at the time of check-in.

Insurance: Valid insurance must be presented at the time of your appointment. If it is not verifiable at the time of your appointment, you will be expected to pay for that visit. If insurance is later verified, a refund for the covered amount will be mailed to you within 1-2 months.

Prescription Refills: If you need a prescription refilled, please call your pharmacy. If you have no remaining refills, they will contact our office. Please do not call or page after hours for routine prescription refills.

Lab and Test Results: You will be notified by phone, mail or e-mail within two weeks of the completion of your test(s). If you do not hear from us after 14 days, please contact our office.

Forms/Letters: Forms for routine school or sport physicals or any employment or disability work purposes, or any other support letters written on your behalf will be assessed a charge of at least $10 or more. (The charge be assessed based on time and effort required for the completion of your request.)

Medical Record: Transfer of medical information between medical institutions or private offices will be performed with your request and consent. At least $25 (or more depending on time and effort required for duplication) will be assessed if it is required by you personally or by a third party (i.e. insurance company, law firms, work place, etc.).

After hour calls: Non-urgent calls after our normal business hours may be charged a $20 fee.

Our office staff is here to serve you. We appreciate your understanding and patronage.

I have read and understand the above Office Policy for Shen Medicine Pediatric and Associates.

Signature _____ Date _____