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

316 Rosewood Ave
San Jose, CA 95117-1647
Fax: 408-296-9805

PATIENT INFORMATION

Name (first,middle,last) _____D.O.B _____ SS#_____

Home Address _____City _____State _____Zip _____

Phone (Cell) _____ (Home) _____ (Work) _____

Email Address: _____

If minor, Father/Guardian 1: Name _____D.O.B _____

Mother/Guardian 2: Name _____D.O.B _____

Primary Employment _____ Employment Phone _____

Primary Insurance Name _____

Insurance Address _____ Insurance Phone _____

Member Name _____ Member 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 all information is true and correct to the best of my knowledge

X Signature _____ Date _____

If minor (younger than 18 years old) is accompanied by an adult other than the parent or 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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OFFICE POLICY

Appointments: Patients are seen by scheduled appointment time only. NO WALK IN APPOINTMENTS AVAILABLE. As a courtesy, you will be given a 20 minute grace period for late arrivals. However, we do require a call to inform us that you are running late. Arrivals greater than 20 minutes will be rescheduled with a cancellation fee.

Missed Appointments: A 24 hour cancellation period is required to cancel or reschedule all appointments. Missed, cancelled, and rescheduled same day appointments will result in a cancellation fee.

Copayments and Self-pay: All copays, balances, and self-pay amounts must be paid in full at the time of the visit. Copayments will also be collected at the time of the vaccine as well as for ppd skin tests.

Insurance: Valid insurance must be must be presented at the time of your appointment. If insurance is unable to be verified at the time of the visit, payment is expected for that visit. A refund will be issued if the insurance is later verified with the date of service on or after the coverage start date.

Prescription Refills: If a prescription refill is needed, please call your pharmacy one week prior to running out of your medication. If you have no remaining refills, they will contact our office. Refills for controlled substances may require a service fee.

Lab and Test Results: You will be notified by phone or mail within seven to ten business days of the completion of your tests. Please inquire about gaining access to the patient portal to view all your results online. If you do not hear from us after two weeks, please contact our office.

Forms and Letters: Forms for routine school or sports physical forms, including letters for employment, military, or disability will be charged a service fee.

Medical Records: Transfer of medical record information between medical facilities or private offices will be performed with your request and consent. There will be a processing fee required if it is a personal and/or a third party request (ie. insurance companies, law firms, employment, etc.).

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

X Signature _____ Date _____

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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, preventative 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.

REQUEST AND PERMISSION FOR MEDICAL SERVICE

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 may have.

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 disease are detected, there are legal requirement to reporting such results to the local public health agency.

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

Patient Name _____ D.O.B _____

X Signature _____ Date _____

Print Name if Other Than Patient _____ Relationship_____

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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 full Notice. If you have any questions about our Notice that our 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, the patient, have received and read a copy of Shen Medicine Pediatrics and Associates' Notice of Privacy Practices.

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

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

- ☐ Phone Numbers
- ☐ Employer Name
- ☐ Patient History
- ☐ Prescription Info
- ☐ Home Address
- ☐ Patient Hospital Note
- ☐ Patient Visit Notes
- ☐ Other: _____

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

_____

_____

Patient Name _____ D.O.B _____

X Signature _____ Date _____

Print Name if Other Than Patient _____ Relationship_____

For internal use only:

Obtained patient's acknowledgement in good-faith effort by:

☐ In-person ☐ By Email ☐ By Mail ☐ Other: _____

Acknowledgement not obtained because _____

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EMAIL CONSENT FORM

You and your health care provider have agreed to correspond using electronic mail (e-mail). This form provides guidelines for the intended use of this type of communication and documents your consent.

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL. PLEASE CALL 911.

Email use: In most cases you must be 18 years or older, or an emancipated or self-sufficient minor before your provider can send you an email about your or your child's personal health information.

Privacy and Confidentiality: Unless your provider tells you specifically that the e-mail will be conducted via a secure server, consider e-mail like a postcard that can be viewed by unintended persons. In addition, the content of the email may be monitored to ensure appropriate use. Discuss with your provider who will process your e-mail messages during business hours, vacations, or illness. All e-mails regarding your care will be included in your medical record.

Creating a Message: The "Subject" line, should include the general topic of the message, for example, Prescription, Appointment, or Advice. In the body of the message, include the patient's name and date of birth.

Content of the Message: E-mail should be used only for non-sensitive and non-urgent issues. Types of information appropriate for e-mail include:

- questions about prescriptions
- routine follow up inquiries
- appointment scheduling
- reporting of self-monitoring measurements, such as blood pressure and glucose determinations.

According to the California law, your provider may not communicate any lab results unless your e-mail correspondence is conducted through a secure server. Additionally, e-mail must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues.

Response time: Discuss with your provider the expected time in which to receive a response. If the expected time is exceeded, call your provider at the phone number above.

Ending e-mail relationship: Either you or your provider may request via e-mail or letter to discontinue using e-mail as a means of communication.

Disclaimer: ***Shen Medicine Pediatrics and Associates*** are not responsible for e-mail messages that are lost due to technical failure during composition, transmission, and/or storage.

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for e-mail communication. I hereby release and hold harmless ***Shen Medicine Pediatrics and Associates, its officers directors employees and agents*** *from any claim I may have arising from use of e-mail to communicate with me.*

Patient Name _____ D.O.B _____

X Signature _____ Date _____

Print Name if Other Than Patient _____ Relationship_____

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AUTHORIZATION FOR RELEASE/DISCLOSUE OF PATIENT HEALTH INFORMATION

I understand that the Physician will not base treatment, payment, enrollment, or eligibility on my providing or refusing to provide this authorization.

I hereby authorize _____

Address _____ City _____ Zip _____

Phone _____ Fax _____ Attention: **MEDICAL RECORDS**

To release/disclose medical information to:

SHEN MEDICINE AND PEDIATRICS A PROFESSIONAL CORPORATION

316 Rosewood Avenue

San Jose, CA 95117-1605

Phone: 408-296-9800 Fax: 408-296-9805

Concerning (Patient's name) _____ D.O.B _____

Address _____ City _____ Zip _____

Phone (Cell) _____ (Home) _____ (Work) _____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature, unless a different date is specified here.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me, or unless such use or disclosure Is specifically required or permitted by law.

Specific Records:

Laboratory	Yes ☐ No ☐ Initial ____	Drug/Alcohol	Yes ☐ No ☐ Initial ____
Mental Health Info	Yes ☐ No ☐ Initial ____	Radiology Records	Yes ☐ No ☐ Initial ____
HIV Info	Yes ☐ No ☐ Initial ____		

Other (specify records) _____ Initial _____

The recipient may use the health information authorized on this form for the following purposes:

_____

A copy of this authorization is as valid as the original.

X Signature _____ Date _____

Print Name if Other Than Patient _____ Relationship_____