PEDIATRIC ASSOCIATES

Coastal Kids - Oxnard

CHILDREN INFORMATION

	CHILD 1	CHILD 2	CHILD 3
Last Name:			
First Name:			
Middle Initial:			
Date of Birth:	__/__/_____	__/__/_____	__/__/_____
Biological Sex at birth:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Cell phone (if > 13 yrs old)	( )____-_____	( )____-_____	( )____-_____
Primary Address:	_____ City:_____ Zip:_____	_____ City:_____ Zip:_____	_____ City:_____ Zip:_____
Secondary/other Address (if any):	_____ City:_____ Zip:_____	_____ City:_____ Zip:_____	_____ City:_____ Zip:_____
Lives with/legal guardians: (please provide court documents if applicable)	☐ Both parents ☐ Mother ☐ Father ☐ Shared custody ☐ Foster parents	☐ Both parents ☐ Mother ☐ Father ☐ Shared custody ☐ Foster parents	☐ Both parents ☐ Mother ☐ Father ☐ Shared custody ☐ Foster parents

PEDIATRIC ASSOCIATES

Coastal Kids - Oxnard

PARENT INFORMATION

	Parent 1 ☐ Mother ☐ Father	Parent 2 ☐ Mother ☐ Father
Last Name:		
First Name:		
Middle Initial:		
Date of Birth:	___/___/_____	___/___/_____
Social Security number:		
Employer:		
Occupation:		
Address (if different from child):	_____ City:_____ Zip:_____	_____ City:_____ Zip:_____
Cell phone number:	( )___-_____	( )___-_____
Work phone number:	( )___-_____	( )___-_____
Home phone number:	( )___-_____	( )___-_____
Email Address:		
Relationship?	☐ Married ☐ Divorced ☐ Single ☐ Separated	☐ Married ☐ Divorced ☐ Single ☐ Separated
Main Insured?	☐ Parent 1 ☐ Parent 2 ☐ Double insured ☐ Other	☐ Parent 1 ☐ Parent 2 ☐ Double insured ☐ Other
Preferred language?		
Referred by:		

Preferred Pharmacy Name and location:_____

Appointment Reminders should be sent to: ☐ Parent 1 ☐ Parent 2

GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT, & RELEASE FORM

PATIENT LEGAL FULL NAME: _____ **DATE OF BIRTH:** ___/___/___

LEGAL GUARDIAN FULL NAME: _____ **RELATIONSHIP:** _____

CONSENT TO TREAT: I, legal adult patient or the legal guardian, consent for myself or the patient listed above (the "Patient") to receive medical care, testing and treatment by Coastal Kids & Pediatric Associates Family of Companies (the "Practice") and the providers. This may include medically necessary examinations, treatments, prescribing and giving medications, injections, immunizations, screenings and questionnaires, diagnostic testing, laboratory procedures, in-office procedures, arrangement for healthcare services, emergency services by the provider, other licensed staff members or staff under the supervision of licensed provider for this visit, future visits, and telehealth visits. Patient understands the providers may include physicians, nurse practitioners, physician assistants, and other clinicians as well as students, trainees, and clinicians both employed and not directly employed by the Practice.

Patient understands the right to consent or refuse to consent to any medically necessary treatment or procedure, except as otherwise required by law. Patient understands they have the right to discuss all medical treatments with the providers. Patient understands that the practice of medicine is not an exact science, and that diagnosis and treatment may involve the risk of injury or death. Patient understands that no guarantees have been made regarding diagnosis, treatment or care the Patient may receive. Patient understands that this consent to treatment must be signed, in order, for the Patient to be seen and will be considered valid until such time that the Patient revokes this consent in writing.

CONSENT TO TELEHEALTH: Patient agrees to care and treatment involving the use of electronic communications between the Patient, legal guardian, and provider transmitted by telephone and/or by video or other transmitted information to a provider who is at a different place than the Patient. Telehealth services allows healthcare providers at remote locations to share the Patient's medical information for diagnosis, therapy, follow-up, and education purposes. Patient gives consent and authorizes the Practice and the providers to forward the Patient's information to a third party as needed to receive telehealth services, and Patient understands that existing confidentiality protections apply.

Patient understands that while telehealth services can be used to provide improved access to medical care, as with any medical service or procedure, there are potential risks. These risks include but are not limited to technical problems with the information transmission and equipment failures that could result in lost information or delays in treatment. Patient understands that they have a right to withhold or withdraw their consent to the use of telehealth services during treatment at any time, without affecting the Patient's right to future treatment.

GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT, & RELEASE FORM

PATIENT LEGAL FULL NAME: _____ **DATE OF BIRTH:** ___/___/___

CONSENT TO MEDICATION HISTORY: Patient authorizes the Practice and providers to request, use, and disclose the Patient's medication prescription history from and to other healthcare providers and/or third-party pharmacies as necessary for treatment purposes.

MEDICAL TEACHING & TRAINING: Patient understands and gives consent to the providers, clinicians, and other health professionals may be involved in training during the Patient's treatment. Patient understands and give consents to the Practice and providers to allow non-employees, such as students and associated health care providers who are participating in educational programs, access to the patient care areas. Patient understands that they may have access to incidental health information. Patient understands they have the right to question the provider regarding such training and can choose not to authorize such access during the Patient's examination and treatment.

MEDICAL IMAGES: Patient authorizes photos may be made of the Patient for the purpose of care or medical teaching. Patient understands these images will be stored in the Patient's medical record in a secure manner that will protect the Patient's privacy. The images will be kept for the time-period as required by law.

RELEASE OF HEALTHCARE INFORMATION: Patient authorizes the Practice to share the Patient's protected health information for treatment and payment purposes with the non-custodial adults listed below when these individuals bring the Patient to his/her visits. Patient understands they have the legal right to preauthorize treatment, and request that the Practice deliver medical treatment when the legal guardian is unable to be present for the Patient's visits and may the legal guardian telephonically. However, I understand that this authorization to treat is not contingent upon their ability to successfully reach myself as the Patient's legal guardian.

USE AND DISCLOSURE OF INFORMATION: Patient consents to the use and disclosure of information from the Patient's medical records, including protected health information, by the Practice for treatment, payment, and health care operations as permitted by law. All uses and disclosures will abide by the terms identified in the Notice of Privacy Practices.

Patient authorizes the Practice to release all immunization records upon request directly to the Patient's educational institute and/or day care facility. Patient understands this authorization will remain in effective until such time the Patient revokes this consent in writing. Patient understands that, in order, to restrict disclosure of immunization records, the Patient must request and complete the Request for Limitation and Disclosure of Protected Health Information Form, which would include the Patient's immunization records to schools.

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT: Patient hereby assigns and authorizes payment of insurance benefits directly to the Practice. Patient understands they are financially responsible for any charges not paid by the insurance company. Patient authorizes the release of Patient's health and financial information to the applicable health insurance payer, including

commercial and governmental payers. All fees not covered by insurance must be paid at the time at which services are rendered. At the time of the visit, the Patient understands the person who brings the Patient to an appointment may be financially responsible.

The Practice may assess fees for missed appointments, returned checks for insufficient funds, and collections activities. Patient acknowledges they are able to access the Missed Appointment Policy on the website.

OFFICE POLICIES: Patient has reviewed any office policies that have been presented, and any questions regarding the policies have been answered to my satisfaction. Patient agrees to comply with the policies.

CONSENT TO ELECTRONIC COMMUNICATION: Patient authorizes the Practice to use Patient's information to send reminders regarding upcoming appointments, to obtain feedback on the practice experience and to provide general health information via e-mail and/or text messaging.

NOTICE OF PRIVACY PRACTICES:

○ By selecting this section, Patient acknowledges that they have received information on the Notice of Privacy Practices, which sets forth the ways in which health information may be used or disclosed by the Practice and outlines the Patient's rights with respect to such information. Patient understands the Notice is also available on the Practice's website or in the office upon request.

HEALTH INFORMATION EXCHANGE:

○ By selecting this section, Patient elects to authorize the release of the Patient's health information to the applicable regional California health information exchange, and I understand that the information may be accessed by authorized participating health care providers. I understand that I may revoke this authorization, and that the revocation will become effective on the date it is made and will not apply to health information already released or exchanged.

OTHER LEGAL GUARDIANS:

1. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

2. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT, & RELEASE FORM

PATIENT LEGAL FULL NAME: _____ **DATE OF BIRTH:** ___/___/___

3. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

OTHER NON-CUSTODIAL ADULTS WHO MAY BRING PATIENT TO VISITS & RECEIVE PATIENT'S HEALTH INFORMATION:

1. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

2. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

3. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

SIGNATURE OF LEGAL GUARDIAN OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER): By my signature below, Patient certifies they have read, understood, and agreed to the terms on this General Consent, Financial Agreement, and Release Form. Patient certifies that information given of the Patient's identity, demographic, financial, and insurance information is truthful. Patient certifies that they were given the opportunity to ask questions and all questions (if any) have been answered to their satisfaction.

_____ _____

Signature of Legal Guardian or Patient (if patient is 18 or older) Date

_____

Printed Full Name of Legal Guardian or Patient

through vaccination, **we require that ALL our patients to be vaccinated.** Infants will receive all age-appropriate recommended vaccines by 2 months of age, with additional recommended vaccines as well as booster doses by two years of age. Children will receive additional recommended booster doses by the time they are 5 years old and will be given recommended 11–12-year preteen vaccinations by the time they are 13 years old. We will complete 16-year teen vaccinations before each child's 17th birthday. And, we will also give your child/teen an annual influenza vaccination unless they receive it at a school clinic or pharmacy. Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, **we will ask you to find another healthcare provider who shares your views.** We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness, disability, and even death. As medical professionals, we feel very strongly that vaccinating your child per CDC recommendations with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

This said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky. The boy contracted smallpox and died at the age of 4, leaving Franklin with a lifetime of guilt and remorse. In his autobiography, Franklin wrote: "In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results. After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many Europeans chose not to vaccinate their children. As a result of refusing immunizations, Europe experienced large outbreaks of measles, with several deaths from disease complications. In 2012, there were more than 48,000 cases of pertussis (whooping cough) in the United States, resulting in 22 deaths. Most victims were infants younger than six months of age. Many children who contracted the illness had parents who made a conscious decision NOT to vaccinate. In 2015, there was a measles outbreak in Disneyland, California (probably started by an infected park visitor who had traveled from the Philippines). The outbreak eventually spread to 147 people and, again, many were too young to have been vaccinated. The death toll from influenza continues to be staggering, 80,000 deaths in 2018 in the US, most in unvaccinated individuals. When you don't vaccinate, you take a significant risk with your child's health and the health of others around them. By not vaccinating, you also take selfish advantage of thousands of others who do vaccinate their children, thereby decreasing the likelihood that your child will contract a vaccine preventable disease.

Adapted from Immunization Action Coalition • Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org
www.immunize.org/catg.d/p2067.pdf • Item #P2067 (8/16)

Signature_____ Date_____

VACCINE POLICY STATEMENT

We firmly believe it is our moral and ethical obligation to produce this vaccine policy statement maintaining our Hippocratic Oath promise to all our patients to offer evidence-based medicine and do no harm.

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that **ALL** healthy children and young adults should receive **ALL** the recommended vaccines according to the schedule recommended by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe that vaccinating children and young adults is one of the MOST important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccine schedule is the results of MANY years of extensive scientific study and data gathering on millions of children and adults by thousands of our brightest scientists and physicians.

We KNOW, based on all available literature, evidence, and current studies, that vaccines DO NOT cause autism or other developmental disabilities.

We take pride in the fact that every child that comes to our office to receive medical care is fully vaccinated according to the CDC and AAP recommended standards. Your infant child is unlikely to be exposed to any vaccine preventable diseases in our waiting room.

We DO NOT agree to delay vaccines based on parental fear. Please be advised that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, can put your child at risk for serious illness (or even death). It also goes against our medical advice. Such additional visits would require additional co-payments or charges on your part and imparts increased number of pain experiences for your child. We do not carry individual vaccines if combination vaccines are available precisely to reduce the number of injections and pain experiences any child will receive from us.

We feel that refusing to vaccinate your children is ill-informed and unacceptable. We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents that have been persuaded by false information from the media, entertainment industry, and internet sources. We will do everything we can to reassure you and provide you with accurate and scientifically based information that vaccinating according to the CDC schedule is the best way to make sure your child stays healthy.

Please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement if you refuse any vaccination. Because we are committed to protecting the health of your children

Lilia Fernandez Coppa, MD, Inc.
451 W. Gonzales Rd, Ste 130
Oxnard, CA 93036
(805) 981-7691

Well-Child Visit Insurance Notice to Patient

Patient's Name: _____ **DOB:** _____

Dear Parents,

While many preventive services are 100 percent covered by insurance, there's a chance that you will be asked to pay for additional services provided during this visit. If a preventive screening uncovers something that your doctor determines needs to be addressed right away, then that visit may switch from preventive to treatment. Also, if you see a doctor to diagnose, monitor, or treat an illness or injury, the visit is not considered preventive care. In these cases, your normal cost-sharing would apply (copayments, coinsurance, or deductible). *The Affordable Care Act allows certain health insurance plans that went into effect before March 2010 to be considered "grandfathered," meaning they are not required to cover 100 percent of preventive care services.*

Yes_____ No_____

Parent Signature: _____ Date: _____

We appreciate you and thank you for placing your trust in us for the care of your children.

CAIR California Immunization Registry

Decline or Start Sharing/Information Request

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	RELATIONSHIP TO PATIENT ☐ self ☐ parent/guardian
Name of Patient:	Patient's Street Address:
Patient Date of Birth:	Patient's City/Zip Code:
Patient ID (optional):	Patient County:
Patient Phone:	

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/ tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).***

* *Note: The immunization record/TB Tests may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization/TB test records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in CAIR.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.

☐ I REQUEST to review or correct my/my child's CAIR immunization/TB test record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	Date:

Fax or email this form to the CAIR Help Desk at
1-888-436-8320, CAIRHelpDesk@cdph.ca.gov

Permission to Share Your Child's School Immunization/Tuberculosis (TB) Screening Test Information with the California Immunization Registry (CAIR)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you have may have TB infection and can be required for school entry. Keeping track of your child's shots/TB tests can be hard, especially if more than one doctor gave them. The California Immunization Registry (CAIR) is a secure computer system that doctors and authorized health care providers use to keep track of your child's shots and TB tests. If you change doctors, your new doctor can use the registry to see your child's shot/TB test record. CAIR is supported by the California Department of Public Health.

How does CAIR help you?

- Keeps track of all your child's shots and TB tests (skin tests/chest x-rays), so he/she doesn't miss any or get too many
- Gives you a copy of your child's most up-to-date shot/TB test record (from the doctor)
- Helps child care or school officials confirm that your child got shots/TB tests needed to start child care or school
- Helps your doctor send you reminders when your child needs shots

How does CAIR help your school?

Under California law, schools, child care, and other agencies may use CAIR only to:

- See which shots/TB tests children in their programs have received or need
- Make sure children have all shots/TB tests needed to start child care or school

What information can be shared in CAIR?

- Your child's name, sex, birth date, and birthplace
- Parents' or guardians' names
- Details about your child's shots/TB tests, such as type of vaccine/TB test and date given
- Limited non-medical information to correctly identify your child

Your child's information is safe! What's entered in CAIR is treated like private medical information. Under California law, *only* your doctor's office, health plan, or public health department may see your address and phone number. Misuse of the registry can be punished by law.

Parent and Guardian Rights

It's your legal right to:

- Say no, if you don't want to share shot/TB test information from your child's school record with CAIR
- Change your mind later if you want to stop or start sharing your child's shot/TB test information with CAIR
- Look at a copy of your child's shot/TB test record in CAIR and ask your doctor to correct any possible mistakes
- Know who has looked at your child's CAIR record

If you want to allow your school to share information from your child's school record with the California Immunization Registry, please SIGN and DATE below. Your child's school will do the rest!

_____ _____

Parent/Guardian Signature **Today's Date**

_____ ____/____/____/_____

Child's Full Name (please print) **Child's Birth Date (MM/DD/YYYY)**

_____ **Child sex: M F**

Mother's First and Last Names (please print) **(circle)**

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

How It Works: A Guide for Patients and Families

1. **Ambience Autoscribe listens in the background.** AutoScribe securely records the audio and automatically summarizes the conversation for your medical record.
2. **Speak with your clinician like you always do.** Without the burden of multitasking, you get your clinician's undivided attention for the entirety of the visit.
3. **Your clinician will receive a summary to review and share with you.** With AutoScribe, you and your family can go home with a detailed summary of everything you discussed with your clinician, including any medications, testing, or home care instructions that you'll need to remember.

"The dilemma is that clinicians don't have time to write down everything while they're in the room with the patient... Ambience's technology allows clinicians to avoid multitasking, focus on their patients, and create a person-centered clinical record.

Dr. Kendell Cannon
Assistant Professor at Stanford School of Medicine

Learn more at
ambiencehealthcare.com

Ambience

Pediatric Associates x Ambience

Bringing Human Connection Back Into Medicine

Pediatric Associates & Ambience are partnering together because we believe that the heart of healthcare lies in the relationships that clinicians build with patients and their families. We want to give clinicians the ability to give you their undivided attention in order to build a deep human connection, and relationship. This means that your clinician can be truly focused on what matters most: You.

What is AutoScribe?

AutoScribe is a fully automated medical scribe that captures and understands the details of the conversation between a clinician and patient. It then creates a detailed medical note from this conversation.