NEW PATIENT HISTORY FORM

Today's Date: _____

Please fill in the following information prior to your first visit and bring this form with you:

PATIENT NAME:_____**DOB:**_____**HOME PHONE:** _____

ADDRESS: _____ **CELL PHONE:** _____

CITY: _____**STATE:**_____ **ZIPCODE:** _____

PARENT 1 NAME_____**PARENT 2 NAME** _____

EMAIL ADDRESS: _____

***PRIMARY CARE DOCTOR*:**

NAME: _____**PHONE:** _____**FAX:** _____

What is your child's illness? How long? _____

Parent 1 occupation:_____Parent 2 occupation : _____

Review of Symptoms your child may have experienced: (Please check all that apply)

☐ Headaches	☐ Hearing problems	☐ Language Problems	☐ Pneumonia	☐ Asthma/ Wheezing
☐ Chest Pain	☐ Abdominal Pain	☐ Spitting up/ vomiting	☐ Abdominal bloating	☐ Joint pain or swelling
☐ Rash	☐ Painful urination	☐ Gas	☐ Burping	☐ Constipation
☐ Excessive Crying or Irritability	☐ Painful bowel movements	☐ Blood in Stool	☐ Rapid weight loss or gain	☐ Loss of Appetite
☐ Fever	☐ Fatigue	☐ Cough	☐ Choking	☐ Diarrhea
☐ Yellow eyes	☐ Dark Urine	☐ Light Colored Stool	Other:	

Family History: Does anyone in the family have any of the following? (Please check all that apply)

☐ Seizures	☐ Migraines	☐ Asthma	☐ Eczema	☐ Allergies
☐ High Blood Pressure	☐ Thyroid disorder	☐ Diabetes	☐ Ulcers	☐ Gallstones
☐ Heartburn/ Reflux	☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Apnea	☐ SIDS
☐ Celiac Disease	☐ High cholesterol	☐ Intestinal Polyps	☐ Liver Disease	☐ Kidney Problems
☐ Chronic Intestinal Problems				Other:

Age and gender of brothers and sisters: _____

Medications:	**Hospitalizations:**	**Allergies to Medications/Foods:**	**Birth Weight:** **Any Prematurity** **Y N**
Immunizations Current: **Y N** **Hepatitis vaccine: Y N**	**Grade in school:** **Performance:**	**Additional info:**	

Signature: _____ **Date:** _____

Relationship to patient: _____

Mindful Pediatric Gastroenterology, Inc.
65 N. Madison Ave., Suite 709
Pasadena, CA 91101

PAYMENT POLICY FOR SERVICES RENDERED

- **If You Have Health Insurance:** Please **Initial** the Line Next Your Insurance in **Section 1 Or 2**.
- **If You Do Not Have Health Insurance**: Please Read **Section 3**.
- **Everyone:** Please sign at the bottom of form and give us your card (if applicable) so that we may make a copy for your file.

1. **IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES,** please initial the appropriate line. We will bill these companies directly and will follow up on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office. You are responsible to present updated referral authorizations from your insurance carrier when required.

___ Cigna	___Anthem Blue Cross	___Multiplan	___ MediCal
___ Galaxy Health Network	___Aetna	___ Blue Shield	
___ Three Rivers Network	___Blue Cross Blue Shield	___ Regal Medical Group	
___ Humana	___United HealthCare	___ Allied Physicians IPA	
___ Pacific Health Alliance	___Tricare	___ HealthCare Partners	

2. **IF YOU HAVE COVERAGE WITH INSURANCE COMPANY, NOT LISTED ABOVE.** We can provide a superbill so that you can submit a claim to your insurance company for out of network benefits. Please review the following procedure and sign.

   "I understand that I am responsible for full payment of my account. The insurance company should send payment directly to me (the patient). If the payment is received at our office the payment will be forwarded to the patient. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

   Insurance Co Name: _____Signed: _____ Date: _____

3. **IF YOU DO NOT HAVE HEALTH INSURANCE,** you are responsible for payment of your bill at the time of your visit. We accept credit cards and cash. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit.

   "I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the office to make timely payment arrangements. I understand that if my account becomes delinquent and the Mindful Pediatric Gastroenterology, Inc. incurs any collection charges, they will be my responsibility."

Patient or Guardian Signature_____ **Date**_____

MINDFUL PEDIATRIC

PATIENT AUTHORIZATION & CONSENT

I, _____,(if minor, for _____ ___ __)
hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by Mindful Pediatric Gastroenterology, Inc. or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care.

I authorize Mindful Pediatric Gastroenterology, Inc. to submit claims to my insurance company for services rendered by my medical providers.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment be made to Mindful Pediatric Gastroenterology, Inc. for services provided by them.

_____ _____

PARENT SIGNATURE (or authorized representative) **Date**

_____ _____

PRINTED NAME (or authorized representative) **Date**

_____

RELATIONSHIP TO PATIENT

MINDFUL PEDIATRIC

E-MAIL POLICY

We do communicate with parents via e-mail however due to federal privacy regulations, by signing this form you understand that e-mail is not confidential and you give us permission to communicate with you via-email. We will answer brief questions over e-mail, however if there are concerns that require a physical exam or a more lengthy discussion, we may ask you to make an appointment for your child in the office. This is in the best interest of your child and so that we can provide the appropriate level of care. Also due to privacy regulations, we cannot communicate with minors via e-mail.

_____ _____

PARENT SIGNATURE (or authorized representative) **Date**

_____ _____

PRINTED NAME (or authorized representative) **Date**

_____

RELATIONSHIP TO PATIENT

MINDFUL
PEDIATRIC
GASTROENTEROLOGY, INC

Policy Note

As of September 1, 2017

Date: 08/24/2017

Mindful Pediatric Gastroenterology will charge $25 for school forms/notes that need to be completed by the physician at the time of visit or within 4 months of last medical visit. This will be a **one-time** charge for any number of forms per 4-month period time frame. If another form is needed past 4-months, another fee of $25 will be charged for the upcoming 4-months. **School excuse notes for day of visit will not be charged.**

Please call me if any questions. (626) 800-4059

Thank you in advance,

X _____ Date: _____