



Pediatric Partners

Office Policies

The following policies have been established to ensure that all patients have safe and timely access to our clinics. Please read them carefully.

APPOINTMENTS:

Patients are required to be in the clinic 15 minutes prior to their scheduled appointment time. This time allows our staff to verify insurance, make any necessary address changes and weigh/measure your child. An authorized adult must accompany your child to the examination.

We have set some time aside for same-day appointments. Please call as early as possible to obtain such an appointment when your child is ill. If all same day appointments are filled, you may be transferred to our nurse triage or your Doctor's nurse for further instructions.

If you are more than 10 minutes late to your scheduled appointment you may, at the discretion of the physician, be asked to reschedule. Please call ahead and inform us if you're running late...we will make every effort to fit you in, but you may have to wait until we can accommodate your timing.

***Failure to keep your appointment without notifying us 24 hours prior to your scheduled appointment time will result in a "no-show" and may incur a fee. A warning notice will be issued after the second "no-show" appointment. If a third "no-show" appointment occurs, your doctor may dismiss you from the practice.

Patients with unpaid balances will be required to make a payment on their prior balance before being seen by a provider.

BEHAVIOR:

- Your child should be cleaned/bathed prior to his/her appointment.
- Anyone using profanity will be asked to leave and will not be seen.
- While in our clinic your child's behavior is your responsibility. Unruly children will not be seen.

CONFIDENTIAL – PATIENT INFORMATION SHEET / CONSENT FORM

Patient _____ Nickname _____

Male Female Birth Date _____ Age _____ Home Phone # _____

Address _____ City _____ Zip Code _____

Child lives with: Mother Father Both Guardian/Foster Parent

Guardian/Mother’s Name _____ Cell # _____ EMAIL _____

Guardian/Father’s Name _____ Cell # _____ EMAIL _____

Responsible Party _____ Relationship _____

Address _____ Phone # _____

Insurance Information

Patient does not have medical insurance

Name of Insured (Subscriber) _____

Insured’s Birthdate _____ Soc. Sec. # _____

Insured’s Employer _____ Employer’s Address _____

Insur. I.D.# _____ Group/Policy# _____

Additional Insurance _____

CONSENT FOR TREATMENT: I hereby authorize medical treatment for the above named child. I authorize emergency medical treatment for the above named child, in the event, that he/she is brought into this medical practice by any person other than myself.

_____ Initials

AUTHORIZATION AND RELEASE:

I hereby acknowledge that I have received a copy of this medical practice’s HIPAA-Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available/posted in the waiting area, and that I will be offered a copy of any amended notice of Privacy Practices at each appointment.

_____ Initials

I hereby authorize Pediatric Partners to access medication history, without limitation or exclusion, as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view the patient’s medication.

_____ Initials

I hereby authorize and request my insurance company to pay directly to the physician benefits otherwise payable to me. I understand that my medical insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

_____ Initials

Emergency Contact Information

(OTHER THAN PARENT/GUARDIAN)

(this is not a 3rd Party Auth to Treat – Please complete additional form):

Name _____ Relationship _____

Address _____ Phone # _____

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____ Relationship: _____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov



Hemet ~ Temecula ~ Redhawk ~ Menifee ~ Lake Elsinore ~ Corona ~ Fallbrook

Name of Child(ren): _____

I have read and understand Pediatric Partners Office Policies and agree to comply with those policies. I understand that failure to comply may result in termination of our patient-physician relationship.

Signed: _____

Print Name and Relationship to Patient:

Date: _____