AV Pediatrics, Allergy & Family Medicine

Lawrence D. Robinson Jr., MD Jenét A. Langjahr, FNP, PA
Dorothy J. Griego, FNP, Richard Allen, MD, Lori Rodriguez, PA-C, Kelly Tomasulo, D.C.

Thank you for choosing AV Pediatrics, Allergy & Family Medicine. In order to provide you with the highest level of care possible, we have established the following financial policy for all patients with insurance coverage:

- The patient is responsible to provide our office with their current insurance card and personal contact information prior to their scheduled appointment.
- Please note this practice is not in-network with Medi-cal. It is the patient's responsibility to notify the practice if they have active Medi-cal coverage. Upon notification of active Medi-cal coverage, the patient will be discharged from the practice.
- The patient is responsible to know and understand their coverage and benefit including, but not limited to, covered and non-covered procedures, authorization requirements and co-pay/deductible amounts.
- The patient is responsible to pay any co-pay, deductible and/or co-insurance at the time of the visit. With so many different insurance policies, it is virtually impossible for our office to know the details of every insurance company. As a courtesy, we will verify eligibility and benefits for most services and inform you at the time of your visit the amount we will need to collect. **Unless otherwise required by state law, verification of eligibility and benefits is not a guarantee of payment. Benefits are subject to all contract limits and the members status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed**. We will try to help as much as possible, but should your insurance deny your bill, you will be liable for any charges.
- Please note that if you have a deductible on your plan, most deductibles are based on a calendar year which means they start over at the beginning of the year, or it could be based on your enrollment date. Payment will be collected at the time of your visit to satisfy the amount. Once you have met your deductible, your insurance company may require you to pay a percentage of the visit which is known as the co-insurance.
- It is the policy of this practice to apply a $25.00 no show, same day cancel, and same day reschedule fee. Please provide the practice with notification of any changes to your appointment within 24 hours.

I have read, understand and agree to the provisions of the financial policy.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature or Parent/Guardian of Minor Date

Authorization to Release Personal Health Information

Please provide us with the authorized person(s) to obtain medical information from our office. If you would like to decline authorization please write decline.

Patient Name: _____DOB_____
Home Phone Number: (_____) _____-_____ Cell Phone: (_____) _____-_____

I authorize AV Pediatrics, Allergy & Family Medicine to release information/ records concerning the patient identified above to the following person(s):

_____ _____

_____ _____

1. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
2. This authorization will automatically expire on: one year from the date of my signature.
3. If there is specific information you do not want disclosed, please list below:

_____

Authorization to Accompany Minor

If the patient listed above is a minor, please provide us with the authorized person(s) that may accompany the minor to future appointments. Please note, we will require picture I.D. for these appointments.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

_____ _____
Patient/Guardian Signature Date

_____
Patient/Parent/Guardian Name (Please Print)

AV Pediatrics, Allergy & Family Medicine

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice our legal duties and privacy practice with respect to protected health information. This notice describes how we may use and disclose your medical information. If you have any questions about this notice, please contact our Privacy Officer.

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Acknowledgement of Receipt of Notice of Privacy Practices
AV Pediatrics, Allergy and Family Medicine

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____
Printed Name: _____ Telephone:_____

If not signed by the patient, please indicate your relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian of conservator of an incomplete patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____ DOB:_____

I read the "Notice of Privacy Practices" and refuse to sign this document. I understand that AV Pediatrics, Allergy and Family Medicine may refuse to continue care for the above-named patient.

I refuse to sign: _____ Date: _____

Print Name:_____ Witness: _____

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Prescription Medication Consent Form

The providers at AV Pediatrics, Allergy and Family Medicine use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Dr. First) which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and your specialists, we ask that patients allow us to access their medication history through Dr. First.

Please check only ONE of the following:

- ☐ I consent to allow my provider to access all of my medication history
- ☐ I consent to allow my provider to access only my medication history for medications prescribed in this office
- ☐ I DO NOT consent to my provider accessing any of my medication

_____ _____

Patient Name Date Patient or Parent/Guardian Signature

1523 West Avenue J, Lancaster, CA 93534
Phone: (661) 945-2221 Fax (661) 945-0831 www.avpeds.com

AV Pediatrics, Allergy & Family Medicine

To: Our Patients
Re: Routine Physical Exam and Pre-Op Appointments

If you are seeing one of the Providers today for a Complete Physical Examination, immunization, or Pre-op Exam, our office would like to make you aware of the submission of your claim to your insurance company for reimbursement.

There are some insurance agencies that do not cover Routine Adult Physicals if no symptoms are found during the exam. Please call your Plan and ask if you have coverage for a Routine Adult Physical.

Many insurance companies are denying payment for lab work ordered before a Routine Physical Exam. Because of this, our providers will give your laboratory orders on the day the Physical is performed in the office.

If this visit is a Pre-op Exam, you could be responsible to pay this bill. Please call your insurance company(s) and verify that the Pre-op Exam can be performed with your Primary Care Provider (PCP). Occasionally, an insurance company prefers you have your Pre-op Exam with the surgeon. If the insurance company will not approve the charges, then you will be responsible.

If you have any questions regarding your scheduled appointments, please speak to our office manager.

By signing below, you agree that you've read and understand the provisions of this policy.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature or Parent/Guardian of Minor Date

AV Pediatrics, Allergy & Family Medicine

Date: __/__/___

Patient Information
(PLEASE PRINT)

1. Patient:

Last Name: _____First: _____Initial: _____
Social Security #: _____ ( ) M ( ) F
Date of Birth: ____/_____/_____ ( ) Married ( ) Divorced ( ) Separated
Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____
Address: _____ City: _____ State: _____ Zip: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____Zip: _____
Emergency Contact: _____ Relation: _____
Phone Number: (_____) _____-_____ Referring Physician: _____
Location: _____ Business Phone: (_____) _____-_____ Ext: _____

2. Spouse or Guardian of Minor:

Last Name: _____First: _____Initial: _____
Social Security #: _____ ( ) M ( ) F
Date of Birth: ____/_____/_____ ( ) Married ( ) Divorced ( ) Separated
Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____
Address: _____ City: _____ State: _____ Zip: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____Zip: _____
Emergency Contact: _____ Relation: _____
Phone Number: (_____) _____-_____ Referring Physician: _____
Location: _____ Business Phone: (_____) _____-_____ Ext: _____

3. Father of Minor:

Last Name: _____First:_____Initial:_____
Social Security #: _____( ) M ( ) F
Date of Birth: ____/_____/_____ ( ) Married ( ) Divorced ( ) Separated
Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____
Address: _____ City: _____ State: _____ Zip: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____Zip: _____
Emergency Contact: _____ Relation: _____
Phone Number: (_____) _____-_____ Referring Physician: _____
Location: _____ Business Phone: (_____) _____-_____ Ext: _____

4. Mother of Minor:

Last Name: _____First: _____Initial: _____
Social Security #: _____( ) M ( ) F
Date of Birth: ____/_____/_____ ( ) Married ( ) Divorced ( ) Separated
Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____
Address: _____ City: _____ State: _____ Zip: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____Zip_____
Emergency Contact: _____ Relation: _____
Phone Number: (_____) _____-_____ Referring Physician: _____

AV Pediatrics, Allergy & Family Medicine

Date: __/__/___

Location: _____ Business Phone: (_____) _____-_____ Ext: _____

Insurance Information
(PLEASE PRINT)

1. Primary Insurance:

Person responsible for account: _____
Date of Birth: _____/_____/_____ Social Security: _____-_____-_____
Relation to Patient: _____ Cell Phone: (_____) _____-_____
Address: _____City: _____ State: _____Zip: _____
Person Responsible Employer: _____Occupation: _____
Business Address: _____City: _____State: _____Zip: _____
Home Number: (____) _____-_____ Bus. Phone: (____) _____-_____
Insurance Company: _____
Insurance ID: _____ Group#: _____
Is the patient covered by another Insurance? ( ) Yes (continue to #2) ( ) No

2. Additional or Secondary Insurance:

Person responsible for account: _____
Date of Birth: _____/_____/_____ Social Security: _____-_____-_____
Relation to Patient: _____ Cell Phone: (_____) _____-_____
Address: _____City: _____ State: _____Zip: _____
Person Responsible Employer: _____Occupation: _____
Business Address: _____City: _____State: _____Zip: _____
Home Number: (____) _____-_____ Bus. Phone: (____) _____-_____
Insurance Company: _____
Insurance ID: _____ Group#: _____

Please inform the receptionist if there is a third insurance.

3. Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage, or I am paying cash, and assign directly to AV Pediatrics, Allergy, and Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that this office bills my insurance as a courtesy and that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize this office or its agents to release any and all information necessary to secure payment of benefits. I also authorize the release of any and all information requested by a laboratory, insurance company or legal counsel. I authorize the use of this signature on all insurance submissions.

_____ _____ _____/_____/_____

Responsible party signature Relation to patient Date

Patient Intake Form Meaningful Use Measures

Our practice is now using an electronic health record called DrFirst RcopiaMU®. We are participating in the Meaningful Use Incentive program sponsored by the Federal government. We are collecting the data to be compliant with the program to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information about your health information.

Please fill out completely and return to the receptionist.

Required Information	Please fill in information in the area below
Full Name	
Date of Birth	
Gender	
Race	Please indicate your race (circle): Other American Indian Asian Black or African American Native Hawaiian or Other Pacific Islander White Unable to Determine or Not Stated
Ethnicity	Please Indicate your ethnicity(circle) : Other Hispanic/ Latino
Preferred Language	Please select your preferred language (circle): English Chinese Spanish Japanese French Italian Portuguese Russian Declined Unavailable (unknown) Other(Please Specify) _____
Smoking Status	Please select your current smoking status (circle): Current every day smoker Current some day smoker Former smoker- Please list date range you smoked _____to_____ Never smoked Smoker, current status unknown Unknown if ever smoked
Height	Blood pressure: /
Weight	Date of office visit:
Do you have allergies?	If yes, what are you allergic to?
Are you taking any medications?	If yes, which medications?
Pharmacy you use	
Your email address	