Dear Parents:

Thank you for choosing Central Coast Pediatrics as your healthcare provider. We are committed to being an enthusiastic team, excited about caring for our patients and promoting their lifelong health.

Due to the rising practice expenses and the demands placed on our staff in handling the increasing volume of paperwork, we would like to remind you of our charges which are:

Entire Medical Record Copy (*parent request*)	$25.00
Medical Record/ Single Page (*parent request*)	5.00
Prenatal Consultation	25.00
Typed Letters (*patient request*)	25.00
Disability/Insurance Forms	10.00
Forms (*not presented at time of visit, ie: school physical, camp, sports, meds. Etc*)	5.00
Immunization Record (*additional copies*)	5.00
School/Work Excuses (*not presented at time of service*)	5.00
ADD Prescription Refills (*same day*)	10.00
Account/ Financial Statements	5.00

WE ALSO REQUIRE 24-48 HOURS FOR ANY REQUEST OF COPIES AND SIGNED FORMS

We value your confidence in our physicians and staff and thank you for selection our practice for our health needs.

Thank you,

Central Coast Pediatrics, Inc.

RICHARD J. MACIAS, M.D., FAAP DALE W. ROWLAND, M.D., FAAP JAMES D CORYELL, M.D., FAAP
WANDA L. LO, M.D., FAAP JULIE R. ANSELMO, M.D., FAAP TAMARA J. BATTLE, M.D., FAAP
MICHAEL McNERNEY, M.D., FAAP KARA N. BRYDEN, M.D., FAAP SHELLEY LISK, MPAP KATIE SILVA, N.P.

*** PLEASE READ***

IMPORTANT INSURANCE INFORMATION

YOUR INSURANCE CARRIER WILL TELL YOU "YOUR CHILD WILL BE COVERED FOR THE FIRST 30 DAYS" BUT WHAT THIS REALLY MEANS IS THAT YOU HAVE **30 DAYS TO ENROLL YOUR CHILD ON YOUR INSURANCE PLAN IN ORDER TO BE ELIGIBLE BACK TO THEIR DATE OF BIRTH**. IF YOU START THE ENROLLMENT PROCESS AFTER THE 30 DAY GRACE PERIOD, YOUR CHILD WILL NOT BE ELIGIBLE UNTIL THE PAPERWORK IS COMPLETE. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FROM BIRTH TO YOUR INSURANCE COVERAGE EFFECTIVE DATE.

CENCAL HEALTH/MEDI-CAL

CENCAL IN SLO AND SANTA BARBARA COUNTY IS A HMO STRUCTURED PLAN. YOU NEED TO ASSIGN YOUR CHILD TO A PRIMARY CARE PHYSICIAN. THE ASSIGNED PROVIDER IS THE GATEKEEPER TO ALL YOUR CHILD'S CARE. ANY HEALTHCARE SERVICES NEEDED BY ANY OTHER SOURCE WILL REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN. ***IF YOUR CHILD IS NOT ASSIGNED TO CENTRAL COAST PEDIATRICS AS THE PRIMARY CARE PHYSICIAN, WE WILL NOT BE ABLE TO PROVIDE SERVICES TO YOU, YOU CAN ONLY ACCESS CARE FROM THE PHYSICIAN LISTED ON YOUR CENCAL CARD.***

BLUE CROSS/BLUE SHIELD/AETNA/CIGNA HMO PLANS

IF YOU HAVE A PRIVATE OR EMPLOYER GROUP HMO PLAN, YOU WILL NEED TO ASSIGN YOUR CHILD TO A PRIMARY CARE PHYSICIAN. YOU WILL HAVE TWO PROVIDER MEDICAL GROUPS TO CHOOSE FROM:

COASTAL COMMUNITIES PHYSICIAN NETWORK (CCPN)

PHYSICIAN'S CHOICE MEDICAL GROUP OF SLO OR SANTA MARIA

THE ASSIGNED PROVIDER IS THE GATEKEEPER TO ALL YOUR CHILD'S CARE AND ANY HEALTHCARE SERVICES NEEDED BY ANY OTHER SOURCE WILL REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN. ***IF YOUR CHILD IS NOT ASSIGNED TO A PHYSICIAN AT CENTRAL COAST PEDIATRICS, WE WILL NOT BE ABLE TO PROVIDE SERVICES TO YOUR CHILD.***

NAVIGATING THROUGH INSURANCE ENROLLMENT CAN BE DIFFICULT SO IF WE CAN HELP YOU IN ANY WAY OR IF YOU HAVE ANY QUESTIONS REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO CALL OUR SAN LUIS OBISPO OFFICE AND SPEAK WITH OUR BUSINESS OFFICE MANAGER.

CENTRAL COAST PEDIATRICS, INC.

1235 Osos St Ste 100
San Luis Obispo CA 93401
(805) 549-0888
1320 Las Tablas Rd Ste D
Templeton CA 93465
(805) 434-3796

Dear Parents,

Please see the attached sample letter. It has been provided for you to use in the event that you are unable to bring your child into our office for a visit. It is necessary for one of these letters to be sent with the caretaker for each occurrence. This form may be downloaded from our website or patient portal. If unable to print out form a hand written letter will be taken. The verbiage in this letter essentially gives our practitioners and your caretaker the authority to bring your child in and make medical decisions on your behalf. If we do not receive this authorization in writing we would not be able to proceed with the care that your child needs without speaking to you, the parent or legal guardian.

Thank you,

The Staff at Central Coast Pediatrics

RICHARD J. MACIAS, M.D., FAAP DALE W. ROWLAND, M.D., FAAP JAMES D CORYELL, M.D., FAAP
WANDA L. LO, M.D., FAAP JULIE R. ANSELMO, M.D., FAAP TAMARA J. BATTLE, M.D., FAAP
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1320 Las Tablas Rd Ste D
Templeton Ca 93465
(805) 434-3796

Parental Consent Form

I do hereby authorize and consent to all medical treatment deemed necessary to treat my daughter/son in my absence. I authorize the following person(s) to make decisions on my behalf.

Patient Name:_________________________________

Birthdate:_____________________________________

Date of Service:_______________________________

Parent/Legal Guardian:__________________________

Contact Number:______________________________

Signature:_____________________________________

Accompanied By: ______________________________

Relationship:__________________________________

Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

____ ___________________

Patient or Patient Representative Signature Date

____

Patient or Patient Representative Printed Name

Patient Data Today's Date___________________________

Patient's Name____________________________________ Date of Birth_________________________

Mailing Address____

#/Apt/P.O. Box Street

____

City State Zip

____________________________________ Male____ Female____ ( )_________________________

Social Security # Home Phone/**Appt Reminders**

Contact Email Address____

If you have more than one child that will be seen in this office please give names:

Name: ___________________________ Date of Birth: _____________________ SS# _______________

Name: ___________________________ Date of Birth: _____________________ SS# _______________

Mother: ___Married ___ Divorced ___Physical Custody ___Joint/Legal custody ___ Sole/Legal custody

Name: _____________________________________ DOB________________ SS# XXX-XX-_____________

______________________________ ______________________________ ________________________

Home Phone Cell Phone Work Phone

Employer Name & Address____

Father: ___Married ___ Divorced ___Physical Custody ___Joint/Legal custody ___ Sole/Legal custody

Name: _____________________________________ DOB________________ SS# XXX-XX-_____________

______________________________ ______________________________ ________________________

Home Phone Cell Phone Work Phone

Employer Name & Address____

Primary Insurance Co. Name____

Subscriber____ DOB________________________________

Member ID#____ Relation to patient ____________________

2nd Insurance Co. Name____

Subscriber____ DOB________________________________

Member ID#____ Relation to patient ____________________

Responsible Financial Party/Guarantor for Patient's Acct: ___ Mother ___ Father__________ Other/State relationship

Emergency Contact: ____________________________________ Phone: __________________________

Parent/Guardian Signature: ____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.
Payments for services are due at the time services are rendered unless other arrangements have been made with the business office. Patients participating in PPO/HMO plans must make their co-payments at the time services are rendered. Proper insurance information must be provided to prove eligibility. If eligibility cannot be verified at the time of service, payment in full will be expected.

Medicaid patients must prove eligibility with Central Coast Pediatrics for the current month of service at each visit. WE WILL BE UNABLE TO PROVIDE CARE TO YOUR CHILD IF THEY ARE ASSIGNED TO ANOTHER PROVIDER. All patients who are Medicaid pending status must present proof of application at time of service or payment will be expected.

Not all services are covered benefits in all insurance contracts. Please review your insurance plan so that you are aware of what to expect. You will be expected to make payment on non-covered services at the time they are received.

After discussion and consent with your physician in regards to administering vaccines you will incur a charge for any vaccines that have been drawn up and you choose not to administer. This charge may not be submitted to any insurance company and will be paid in cash.

We are happy to have engaged the services of a group experienced pediatric nurse advice specialist to assist us in handling your child's urgent medical need that may occur during evening, nights, weekends, and holidays. In order to provide this expanded service financial support is necessary. Insurance does not cover this service, thus our office will be adding a $25.00 charge for each time the nurse specialist or the physician is accessed. We cannot bill your insurance for this service and payment will be required. Our goal is to provide the best and most timely care possible and feel there is tremendous value in having well trained pediatric nurses offering advice whenever the office is closed.

We reserve the right to place a $25.00 charge for broken appointments and appointments canceled without 24 hour advance notice. Patient's arriving more than 15 minutes late for a scheduled non-urgent appointment will be asked to reschedule and may be subject to broken appointment charges. After three fail to keep appointments the patient is subject to possible discharge from practice.

We realize that temporary financial problems may affect timely payment and we will be happy to assist you in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance matters, please don't hesitate to ask us, we are here to help.

I ACKNOWLEDGE AND UNDERSTAND THAT THE OFFICE POLICIES EXPLAINED ABOVE. I HEREBY AUTHORIZE AN INSURANCE COMPANY TO PAY DIRECTLY TO CENTRAL COAST PEDIATRICS INC. THE PROCEEDS OF ANY BENEFITS DUD ME AND A COPY OF THIS AUTHORIZATION CAN BE CONSIDERED AN ORIGINAL FOR INSURANCE PURPOSES.

SIGNATURE:____ DATE:_____________

RELATIONSHIP:_____________________________________

SEE REVERSE SIDE

1235 Osos Street Ste 100
San Luis Obispo, Ca 93401
(805) 549-0888
1320 Las Tablas Rd Ste D
Templeton, Ca 93465
(805) 434-3796

PERMISSION TO RELEASE MEDICAL INFORMATION

Patient Name:____DOB:____________________

I give permission to release medical information that may include but not limited to appointments, prescriptions, and test results to the following designated people. I understand that due to HIPPA guidelines, medical information will only be discussed with me and those listed below.

1.____________________________DOB:_________Relationship__________Tel#________________

2.____________________________DOB:_________Relationship__________Tel#________________

3.____________________________DOB:_________Relationship__________Tel#________________

I give permission to have telephone messages left on answering machine ____Yes____No

I give permission to have mail sent to my home address: ____Yes____No

I give permission to leave MESSAGES/CALL BACK NUMBERS at my work: ____Yes____No

Work #___________________

Signature: ____Date: ____________________

____Parent with ____joint legal custody ____sole legal custody ____Guardian with legal custody

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY　　　DATE COMPLETED

BIRTH DATE　　　AGE　　　M　F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. ____________________

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

____

Birth History ☐ Don't know birth history

Birth weight ________ Was the baby born at term? ________ OR ________ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain ____________________

Was a NICU stay required? ☐ Yes ☐ No Explain ____________________

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No　Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What ____________ When ____________

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?
____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? ________

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ____________________

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain ____________________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ____________________

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ____________________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ____________________

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ____________________

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain ____________________

Biological Family History DK = don't know

Have any family members had the following?

Condition					
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Nasal allergies	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Asthma	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Tuberculosis	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Anemia	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Dental decay	☐ Yes	☐ No	☐ DK	Who ________	Comments ________
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ________	Comments ________

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain ______
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ______
HIV	☐ Yes	☐ No	☐ DK	Explain ______
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ______
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ______
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ______
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ______
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ______
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ______
Cancer	☐ Yes	☐ No	☐ DK	Explain ______
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ______
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ______
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ______
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ______
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ______
Obesity	☐ Yes	☐ No	☐ DK	Explain ______
Diabetes	☐ Yes	☐ No	☐ DK	Explain ______
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ______
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ______
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ______
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ______
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ______
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ______
Dental decay	☐ Yes	☐ No	☐ DK	Explain ______
History of family violence	☐ Yes	☐ No	☐ DK	Explain ______
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ______
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ______
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain ______

Has had first period ☐ Yes ☐ No Age of first period ______

Any other significant problem ______

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

☐ Parent refused to fill out form

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Physician's Signature: ______ Date: ______