JAMES A. WEIDMAN, AMC

Child (ren) Information

Name (Last, First) _____ DOB _____ Gender _____

Name (Last, First) _____ DOB _____ Gender _____

Name (Last, First) _____ DOB _____ Gender _____

Name (Last, First) _____ DOB _____ Gender _____

Who does child(ren) Reside with: Mother? _____ Father? _____ Other?: _____

Who is guarantor and responsible for paying balance? Mother? ____ Father? _____

Insurance (Primary): _____ ID# _____

Who is the Insurance Subscriber? Mother? _____ Father? _____ Other?: _____

Name and address of Pharmacy: _____ Phone: _____

Appointment Reminders should be texted to Parent No. 1_____ OR Parent No. 2. _____

INSURANCE: Please give the front office a copy of your insurance card and driver's license for our files. Your insurance card must be presented at each office visit. You must confirm with your insurance company that we are a contracted participating provider for your particular insurance plan.

NEWBORNS: must be added to your insurance plan within the first 30 days after birth.

NO INSURANCE – paying cash. Your balance is due in full on day of visit as we do not send statements.

PARENT NO. 1

Mother? _____ Other: _____ Is Mom the genetic Mother? Yes? _____ No? _____

Last Name: _____First Name: _____

Address: _____City and Zip _____

Gender: _____ Date of Birth: _____ Cell Phone: _____

Email: _____ Social security No: _____

Employer: _____ Occupation: _____

PARENT NO. 2

Father? _____ Other?: _____

Last Name: _____First Name: _____

Address: _____City and Zip _____

Gender: _____ Date of Birth: _____ Cell Phone: _____

Email: _____ Social security No: _____

Employer: _____ Occupation: _____

Name of people who will bring child into office, other than Parents (Babysitter, Nanny, Grandparent)

Name: _____ *Relationship* _____*Phone*: _____

Name: _____ *Relationship* _____*Phone*: _____

DIVORCED or SEPARATED PARENTS:

Name of person(s) who have legal custody: _____

LEGAL RESTRICTIONS*: Are there any legal restrictions that would restrict Parent 1 or Parent 2 from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?*
If yes, please explain, and provide a copy of any court issued ruling or document that supports this restriction.
EXPLAIN:

_____

EMAILS: The Physician DOES NOT read or respond to texts or emails, and no medical advice can or will be given based upon *videos or photographs submitted by you to the Physician. Only* non- emergency information (copies of insurance cards and older medical records) should be emailed to the medical practice. Staff reads emails on an intermittent basis. Email is not a secure form of communication as there is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties.

VIRTUAL OFFICE VISITS – TELEMEDICINE: you understand that if you agree for your child to be treated by the physician via telemedicine, that by doing so, you are consenting to the virtual office visit.

James A. Weidman, A Medical Corporation ("Medical Practice")

Consent, Acknowledgement and Assignment of Benefits

FINANCIAL, INSURANCE & OFFICE POLICIES

I hereby acknowledge that I have contacted my medical insurance company and have confirmed that the Medical Practice is a contracted provider for my particular insurance plan.

I hereby acknowledge that I have read, and I understand Medical Practice's financial and office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time without my prior written consent. I also understand that even if I have insurance, I may be financially responsible for some or all of my child(ren)'s medical services. For instance, if I have a co-pay or a deductible, I agree to promptly pay the Medical Practice for professional and clinical services in accordance with the insurance company's allowable rates and terms. I also understand that the Medical Practice is not a Medi-Cal provider. I also understand that when this Agreement is signed by my spouse, partner, or financial guarantor, then my spouse, partner or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs, and collection expenses) in addition to any other amounts due. Unpaid accounts referred to outside collection agencies for collection bear interest at the current legal rate.

I understand that I am financially responsible for charges not paid pursuant to this Agreement. I further agree that any credit balance resulting from payment of insurance or other source may be applied to any other account owed to the Medical Practice or Dr. Weidman by me.

Initials_____

If I fail to appear for an appointment, cancel on less than 24 hours prior to a scheduled appointment or arrive more than 15 minutes late (and the office needs to reschedule the appointment), then I agree to pay a $80 charge for sick visits and $100 doe Well-Child visits.

Initials_____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment to the Medical Practice or to Dr. Weidman of all insurance benefits to be paid directly to the Medical Practice for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g., deductibles, co-insurance, and co-pays). I am also responsible for charges not covered by insurance including but not limited to charges for missed appointments or finance fees accrued on late balance. I authorize the Medical Practice to release information to my insurance company when requested by the insurance company.

Initials_____

CONSENT TO TREAT

I hereby give consent to medical treatments or procedures, X-Ray examinations, drawing blood for tests, medications, injections, vaccines, taking of medical photographs, laboratory procedures as deemed advisable by the physicians and health care professionals assisting in my child(ren)'s care. I understand

that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to any and all such diagnoses, treatments, and hospital care which a licensed physician at the Medical Practice recommends.

I voluntarily authorize and consent to the exchange of medical data including medications, consults, vaccinations, diagnostic tests, and hospital records with other providers who have provided care or may provide care in the future. This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Initials_____

MEDICAL DATA SHARING

I voluntarily authorize and consent to the exchange of medical data, including medications, consults, vaccinations, diagnostic tests, and hospital records with other providers, insurance companies, third party entities with whom we have contracted, and hospitals for the purpose of audit, research, and demonstrating continuous quality improvement. This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Initials_____

EMAIL AND TEXTING CONSENT

No medical advice will be given over email or text, by or in response to emails or texts. DO NOT SEND PHOTOS OR VIDEOS. I consent to have appointment reminders, insurance and balance related information emailed/texted to me with the understanding that I may opt out at any time. I understand that if I email the Medical Practice, I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and emailing are not secure communication methods as unencrypted messages could be intercepted. This consent form will be effective until I provide a written notice or revocation to the Medical Practice.

Initials_____

MESSAGES:

The Medical Practice may leave messages on any phone number provided by me or my spouse, partner, or guarantor. I agree unless I indicate otherwise.

Initials_____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the Notice of Privacy Practices, which describes how medical information about my child (ren) may be used and disclosed, and how I can get access to this information. To remain environmentally friendly, I understand that a printed copy of this information is maintained in the Medical Practice will be provided at my request.

Initials_____

My signature below signifies that I have read, understand, and agree to all of the Office Policies of the Medical Practice as indicated in this Agreement. I may request a copy of these terms and conditions of service.

_____ _____

Signature of Financially Responsible Party **Date**

Name: _____ Relationship to Patient _____

James A. Weidman, A Medical Corporation

Office Policies

We would like to thank you for choosing our pediatric medical practice. Our goal is to provide and maintain a good physician-patient relationship. To achieve this, we would like to keep you informed of our current office and financial policies as outlined below. Your clear understanding of these policies is important to our professional relationship.

You must confirm with your insurance company that we are a contracted participating provider for your particular insurance plan.

Remember, newborns must be added to your insurance plan within the first 30 days after birth.

We believe that good health care for newborns, infants, children, and adolescents begins with well-child visit (checkup) and other services that help keep children healthy. These are called "preventive services". The American Academy of Pediatrics (AAP) created "Bright Futures", a plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests, to advise about staying healthy and safe. This may be modified to suit each child, as needed. We also follow the AAP vaccine schedule for newborns, infants, children, and adolescents. After age 3, your insurance and the school districts require well- child checkups annually.

The "Patient Protection and Affordable Care Act "currently requires that certain services and most vaccines must be covered by most health insurance plans. This is not always true, because some insurance plans do not have to pay in full for preventive services and you will be responsible for these charges. There are 1000's of insurance plans and variations currently offered, therefore, it is your responsibility to know and understand your deductible, co-payments and/or co-payments.

Your "Deductible" is the amount that you must pay before your insurance pays for services. Deductibles must be paid at the time of service.

Your "Co-payment" is the fixed amount that you pay for certain health services before the health plan pays. Co pays must be paid at the time of service.

Your "Coinsurance", if any, is the portion of the approved charges that is not paid by your health plan (and is usually a fixed percent of each amount paid by the plan). You must pay this. We do not determine this amount.

There may also be times when a child needs medical services that your insurance does not consider "preventive" on the same day as your child is receiving their well-child check-up visit. For example, if your child is feeling sick or is having a problem that needs to be addressed during a well-child checkup visit, then the doctor also may need to provide an additional office visit service (called a "sick" visit) to address these problems. This is a different service and when billed to your health plan in addition to the preventive services provided on that day, may result in a separate co-pay for the sick visit as required by your insurance. Also, if you have a co-payment, or coinsurance or deductible amounts required by your insurance for office visits that you must pay before your health plan pays for these services, our office must charge you these amounts.

We value your time and want to make the most of each appointment for the child. Therefore, we will try to address any problem that needs a doctor's care during well-child visits so that only one trip is needed. However, if your child is also sick, we will try to see your child for both a sick and preventative visit but may have to ask you to book a separate preventative visit. Some services that may be provided and billed in addition to preventive services may include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (e.g., if the doctor gives a prescription, orders tests, or changes care for a known problem)
- Medical treatments (e.g., breathing treatments)
- Any surgery (e.g., removing splinters or something the child put in his or her nose or ear)
- Tests performed in the office that are not included in the Bright Futures plan

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health pan on the day of your visit. It is our pleasure to help.

Financial Policies

We will bill your insurance company after each visit. It is your responsibility to provide us with current insurance information. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

After your visit charges have been paid, adjusted, and reconciled with your insurance, you will receive a billing statement from our outside billing office. Any balance remaining on your account for services not covered by your insurance company is your responsibility. If you have no insurance, payment for an office visit is to be paid in full at the time of service. The amount on your statement will reflect your balance, and that balance is payable on receipt. A $25 fee will be charge for any returned checks. A $25 late fee will be automatically added to your bill for every 30 days your payment is late. Any balance outstanding longer than 45 days will be forwarded to a collection agency and you will be discharged from our practice. It is your responsibility to understand your insurance policy and what benefits are covered and not covered including for well check-ups. As a courtesy we will bill your insurance for you. However, all charges not covered by your insurance company are your responsibility. Please be sure to notify us of any changes in insurance, address, or phone numbers.

Appointments

In order to see our patients on time, we encourage our patients to arrive 15 minutes prior to the schedule appointment time. Patients who arrive more that 15 minutes late may be rescheduled. In order to receive your preferred date and time for your well-child visits, we will schedule your next appointment as you exit the office. If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow us time to provide that time slot to another patient. If you fail to appear for an appointment, cancel on less than 24 hours prior to a scheduled appointment or arrive more than 15 minutes late (and the office needs to reschedule the appointment), then this will result in a $50 charge for sick visits and $100 for Well-Child visits.

Forms and Prescription Refills

If you need a school or camp form filled out, please give us a minimum of 3-5 business days to complete and return them. For monthly medication refills, we require 24 hours' notice, during regular business hours. Please plan accordingly.

Vaccine Policy

We feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. If you should absolutely refuse to vaccinate your child despite all our efforts, we will respect your decision, but we will ask you to find another health care provider who shares your views. Please feel free to discuss any concerns you may have about vaccines with us.

Privacy Practices - **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND 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 child(ren)'s 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 your child(ren) as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this Medical Practice Medical Practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your child(ren)'s medical information. It also describes your rights and our legal obligations with respect to your child(ren)'s medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this notice.

How this Medical Practice May Use or Disclose Your Health Information

This Medical Practice collects health information about you and stores it in your medical record. The medical record is the property of this Medical Practice, but the information in the Medical Practice's record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment: We use medical information about your child(ren) to provide their medical care. We disclose medical information to our employees and others who are involved in providing the care your child(ren) need. For example, we may share your child(ren)'s medical information with other physicians or other health care providers who will provide services, which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to your child(ren), or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help your child when he/she is sick or injured.

Payment: We use and disclose medical information about your child(ren) to obtain payment for the services we provide. For example, we give your child(ren)'s health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to your child(ren).

Health Care Operations: We may use and disclose medical information about your child(ren) to operate this Medical Practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your child(ren)'s medical information with our "business associates", including but not limited to our electronic medical records company, our billing service and healthcare clearing house, which perform administrative services for us. They in turn will share this information with your insurance payer. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you or your child(ren), to help their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities, which collectively provide health care services.

Appointment Reminders: We use and disclose medical information to contact and remind you about your child(ren)'s appointments, insurance and balances. If you do not answer your phone, we may leave this information via text or email or on your answering machine or leave a message with the person who answers the phone.

Sign in sheet: We may use and disclose medical information about your child(ren) by having you sign in when you arrive at our office. We may also call out your child(ren)'s name when we are ready to see you.

Notification and communication with family: We may disclose your child(ren)'s health information to notify or assist in notifying a family member, your child(ren)'s personal representative or another person responsible for their care about your child's location, his/her general condition or in the event of your child's death. When attempting to collect unpaid and past due medical charges after several statements have been mailed to you by our billing agency, we may email or use the numbers provided and inadvertently disclose certain information. This could happen if several children live in the same household and have different parents. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your child(ren)'s care or helps pay for his or her care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or

object, our health professionals will use their best judgment in communication with your family and others.

Other Services: We may contact you to give you information about products or services related to your child(ren)'s treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to your child(ren), or to provide your child(ren) with small gifts such as toothbrush provided by local pediatric dentists. We may also encourage you to purchase a product or service when we see you. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.

Required by law: As required by law, we will use and disclose your child(ren)'s health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health: We may and are sometimes required by law to disclose your child(ren)'s health information to public health authorities for purposes related to preventing or controlling disease, injury, or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health oversight activities: We may and are sometimes required by law to disclose your child(ren)'s health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and administrative proceedings: We may, and are sometimes required by law, to disclose your child(ren)'s health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about your child(ren) in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. If you or your attorney requests our Medical Practice's physician(s) to provide a deposition and/or testify in court in a divorce or family related matter, that physician will not be able to work and a fee of $500 per hour will be charged for each applicable ½ and/or full day plus driving time to/from the courthouse,

Law enforcement: We may, and are sometimes required by law, to disclose your child(ren)'s health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Public safety: We may, and are sometimes required by law, to disclose your child(ren)'s health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions: We may disclose your child(ren)'s health information for military or national security purposes or to correctional institutions or law enforcement officers that have your child in their lawful custody.

Change of Ownership: In the event that this Medical Practice is sold, merged, or transferred with another organization, your child(ren)'s health information/record will be transferred to the new owner, although you will maintain the right to request that copies of your child(ren)'s health information be transferred to another physician or medical group.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the Medical Practice will not use or disclose health information, which identifies your child(ren) without your written authorization. If you do authorize this Medical Practice Medical Practice to use or disclose your child(ren)'s health information for another purpose, you may revoke your authorization in writing at any time.

Patient Rights

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your child(ren)'s health information, by a request in writing specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your child(ren)'s health information in a specific way or at a specific location. For example, we will text your appointment reminders to your cell phone and that of the other parent. You may request that we send information to a particular e-mail account. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to a Copy of Health information: You have the right to a copy of your child(ren)'s health information, with limited exceptions. To access your child(ren)'s medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We may charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

Right to Amend or Supplement: You have a right to request that we amend or supplement your child(ren)'s health information that you believe is incorrect or incomplete by submitting a written request to amend. Your request must include the reasons you believe the information is inaccurate or incomplete. The Medical Practice can deny your request to change your records if it believes that the information is accurate and complete, if the physician did not create the record or does not have the record, or if you don't have the right to access the record. If your request is denied, you will have the right to provide a written statement of up to 250 words regarding anything in your records that is incorrect or incomplete, and the statement will be added to your child(ren)'s records and disclosed to any third party.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Complaints

Complaints about this Notice of Privacy Practices or how the Medical Practice handles your health information should be directed to Dr. James A. Weidman at E-mail: Dr.Weidman50@gmail.com. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to THE Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, Washington