PATIENT REGISTRATION

After Hour Pediatrics Urgent Care Clinic
210 Baldwin Ave, San Mateo CA 94401
650-579-6581 www.afterhourpeds.net

Patient Name: ________________________, ____________________ _____ **Date of Birth:**______________ **Gender** ______
(Last) (First) (M.I.) (MM/DD/YY) (M/F/Oth.)

Sibling Names and Date of Birth
Sibling Name: ________________________, ______________________ _____ **Date of Birth:**______________ **Gender:** ______
Sibling Name: ________________________, ______________________ _____ **Date of Birth:**______________ **Gender:** ______
Sibling Name: ________________________, ______________________ _____ **Date of Birth:**______________ **Gender:** ______
Sibling Name: ________________________, ______________________ _____ **Date of Birth:**______________ **Gender:** ______

Primary Insurance Subscriber
Name ____

Email ____

Date of Birth _________________ **Gender** ____________

Address ____

City _____________________ **State** _____ **Zip**_________

Home ________ ___________ ___________________

Work ________ ___________ ___________________

Cell ________ ___________ ___________________

Preferred contact:

Parent #2
Name ____

Email: ____

Date of Birth __________________ **Gender** ____________

Address______________________________________

City___________________ **State** _____**Zip**__________

Home _________ ___________ _______________

Work _________ ___________ ________________

Cell _________ ___________ ________________

Preferred contact:

Patient's Primary Physician____

How did you learn about After Hour Pediatrics? Pediatrician Friend Yelp Google Other_____________________

AHP bills to primary insurance only with whom we are contracted. It is patient's responsibility to know their health plan and costs associated with using AHP. Please review and sign the Credit Card Authorization.

Due to our contracts, AHP does not bill for durable goods such as crutches, ace bandages, nebulizers, etc. We sell these items at cost as a convenience for our patients. We will provide you with a receipt so that you may seek reimbursement.

Payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent provides insurance coverage. This is also the person who will receive the bill and is responsible for any outstanding payments.

--CONSENT—

I certify that the above information is true and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.
I may review in detail After Hour Pediatrics' Privacy Practices and may request special privacy considerations.
I understand the above insurance billing and payment information, and hereby accept responsibility for all charges related to this treatment, including any charges which are not covered by insurance.
I would like and hereby authorize AHP to send messages to me via my email, which may be non—secure, and/or to leave telephone messages about Billing and Insurance matters, Medical Information, such as lab and X-ray results and follow-up.

_________________ ____ ____
Date **Signature of Credit Card holder** **Name of Credit Card Holder**

After Hour Pediatrics Urgent Care Clinic
Credit Card Authorization/Credit Card on File Policy

***WITH* confirmed eligibility at check-in:** After Hour Pediatrics Urgent Care Clinic (AHP) will electronically scan the authorized credit/debit or HSA/FSA card into AHP's secure credit card system. You may call at any time to update or change this card. All cards are encrypted and we can only view the last 4 digits of your card and the expiration date.

The insurance company will send an Explanation of Benefits (EOB) to AHP and to the insured. AHP may receive the EOB before the patient. This EOB will explain whether a balance is due to AHP or if a refund is due to the patient. All EOB's can be accessed on line by the insured or by calling the insurance company. The number is on your insurance card. We process credit cards upon receipt of the EOB.

This signed authorization covers charges made by AHP to your credit card due to:

(1) A deductible that has not been satisfied and is your responsibility

(2) A co-pay or co-insurance that your insurance assigns as your responsibility and/or

(3) A denial of payment.

If a refund is due, it will be processed back to your card as we enter your EOB. It is our policy not to hold any overpayments on accounts. Many times you will see a charge made to your card and this is due to the fact that **your copay for urgent care visits is higher than the regular office visit copay**. You may confirm the amount with your insurance company. The amount charged/refunded should match exactly the amount of the "patient responsibility" portion on the EOB provided by your insurance company.

***WITHOUT* confirmed eligibility at check-in:** If insurance eligibility cannot be confirmed at check-in, AHP requires a credit card on file and a deposit of $199.00, which will be held for 10 business days while we work with you to obtain benefits and eligibility so that we can bill on your behalf. If you are eligible for insurance benefits, we will bill the insurance company and you will be refunded the $199 less your assigned responsibility.

If the insurance company determines non-eligibility, the credit card will be charged full service rates.

If you have questions about your charges we are always willing to discuss with you. You may contact AHP billing at 650-579-6581 option 3 or ahpsanmateo@gmail.com. If you reverse a credit card charge, AHP charges a cancellation fee of $25 per charge in addition to your regular fee.

I authorize AHP to keep my credit/debit card information and signature on file in order to charge my credit/debit card for balances due. This Credit Card Authorization/Credit Card On File Policy will remain in effect until notified by responsible party in writing.

I understand statements are not sent by AHP, my EOB serves as a statement of my responsibility and I agree to keep my account current and in good standing.

____
(Name on Credit Card)

Note: To protect your data, we will only collect your credit card number by phone or in person. Please be prepared to provide this info when you call to schedule your visit

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(Credit Card Billing Address [Address, City, State, Zip])

______________	______________________________	______________________________
(Date)	**(Signature of Credit Card holder)**	**(Name of Credit Card holder)**

****BENEVOLENCE FUND****

AHP wants to care for children. If you struggle to pay the fee, please write a letter to AHP so we may assist you.

PATIENT HISTORY

210 Baldwin Avenue. San Mateo, CA 94401.
Phone (650) 579-6581 Fax (650) 579-7851

Name:________________________________

DOB:________________________________

PCP: ________________________________

Age: _____

CC

____

________________________ ________
Receptionist Initials

REASON FOR VISIT

____

Onset ❑ Hours___ ❑ Days___ ❑ Weeks___
Severity ❑ Mild ❑ Moderate ❑ Severe
Condition ❑ Constant ❑ Intermittent ❑ Improving ❑ Worsening

Better with ________________________

Worse with ________________________

If pain: ❑ Dull ❑ Sharp ❑ Achy ❑ Crampy ❑ Throbbing
If injury, occurred at ❑ Home ❑ School ❑ Public ❑ Private Location

Current Medications: ________________________
Medicine *Time of last dose*
____
Medicine *Time of last dose*

Allergies: ❑ No ❑ Yes________________________
(Medication)
❑ Yes________________________
(Environmental/food)

During day is patient: is primarily at ❑ Home ❑ Day Care ❑ School

Has patient been exposed to anyone with similar symptoms?

❑ No ❑ Yes (who?)______________________

Has patient been exposed to Second Hand Smoke? ❑ No ❑ Yes

FAMILY HISTORY

What medical conditions run in your immediate family?
❑ Asthma ❑ Allergies ❑ Autism ❑ Intestinal ❑ Eczema ❑ Ear Infections
❑ Cancer ❑ Headaches ❑ Croup ❑ Neurologic ❑ Diabetes ❑ Kidney/UTI
❑ Heart disease ❑ Other______________________
❑ Family History – negative (except as indicated above)

OTHER CONCERNS / ROS

Does patient have other problems or concerns?

No Yes
❑ ❑ Head: headache light-headed dizzy seizure
❑ ❑ Eyes: red itchy painful discharge swollen
❑ ❑ Ears/Nose/Throat: pain congestion sneezing bleeding
❑ ❑ Neck: stiff sore swollen glands
❑ ❑ Heart: palpitations fast heart rate
❑ ❑ Lungs: dry moist barky cough wheezing rapid breath
❑ ❑ Abdomen: vomit diarrhea pain constipation w/ blood
❑ ❑ Skin: rash itchy burn cut dry hives eczema blisters
❑ ❑ Muscle/Bones pain broken weak achy swollen
❑ ❑ Genital/Urinary burning frequency urgency rash
❑ ❑ Fever? If yes, how high? ______________
❑ ❑ Other Problems______________________

CONSENT / FOLLOW UP INFORMATION

For follow-up, such as lab results, X-Ray reports, or billing matters, I prefer AHP to notify me by phone or email at:

____

If AHP cannot reach me by phone, I authorize AHP to leave a detailed message about the care of the patient. I certify that the above information is true and I consent to any medical or surgical treatment rendered to the patient under the general or special instructions of the physician. I understand I may review in detail AHP's Privacy Practices. I am aware of my right to request special privacy considerations.

Signature of ❑ Mother ❑ Father ❑ Grandparent ❑ Self
Parent/Guardian X________________________

PAST, RECURRING OR CHRONIC CONDITIONS

No Yes
❑ ❑ Hospitalizations?______________________
❑ ❑ Operations?______________________
❑ ❑ Neuro/Behavioral ______________________
❑ ❑ Autism ______________________
❑ ❑ Developmental______________________
❑ ❑ Emotional______________________
❑ ❑ Eyes/Ear/Throat ______________________
❑ ❑ Breathing/Lungs ______________________
❑ ❑ Heart ______________________
❑ ❑ Abdomen ______________________
❑ ❑ Urine/Kidney ______________________
❑ ❑ Genital/STD/LMP ______________________
❑ ❑ Skin ______________________
❑ ❑ Other ______________________

Birth History: Wgt. _________Problems?______________

Date of last physical/well care visit______________________

Vaccines current? ❑ No ❑ Yes Flu Vaccine? ❑ No ❑ Yes

PLEASE DO NOT WRITE BELOW THIS LINE

Rev 6/26/18

❑ History reviewed by RN/MA______________________

❑ Allergies noted by RN/MA______________________ ❑ NKDA

PROVIDER SUMMARY OF ROS/PMH

❑ All ROS negative except as noted.

❑ Family History non-contributory except as noted.

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❑ Hx reviewed and verified by MD/NP______________________