Rosemarie Tweed, D.O. APC/ Jesse Tweed, MD
Pediatrics

Patient registration Date _______

Patient _______________________________ M / F Birth Date: _______
Last First MI

Home Address _________________________ Home Phone ________________________

Cell Phone ________________________

____
City State zip

Mothers Name __________________________ Employer ______________________

SSN# __________________________ Employer address ____________________

Date of birth __________________________ Employer phone #____________________

Drivers License __________________________

Fathers Name __________________________ Employer ______________________

Date of birth __________________________ Employer address ____________________

SSN# __________________________ Employer phone #____________________

Drivers License __________________________

Emergency Contact________________________ Phone Number ___________________

Closest Relative: _________________________ Phone Number ____________________

Email (Mom or Dads) : _____________________

Please provide us with all pertinent information regarding your insurance coverage. Please list all numbers on your card. It is **your responsibility** to inform us provision of coverage, i.e. Well child benefits, deductible, co-pay, percentage coverage, etc. **Reduction or rejection of your claim by your insurance company does not relive the financial obligation you have incurred with us**

Primary Insurance Carrier: **______________________**

Insured's Name#: ______________________ Relationship: ______________________

Group or ID#: ______________________ Policy #: ______________________

Effective Date: ______________________

Authorization

I hereby authorize the release of information necessary to file a claim with my insurance carrier indicated above and to assign benefits otherwise payable tome directly to Rosemarie Tweed, D.O. APC. I understand that I am financially responsible for this account including any balance not paid by my insurance carrier. A copy of this authorization is valid as the original

_____________ __________________________________
Date Insured or Authorized Person

Identification Data (please print)

Patient's Name ____

DOB _________________________ Male _____ Female _______

Patient lives with _______________________________________

Phone ____

Mother's Name ____________________________DOB________

Occupation ____

Father's Name _____________________________DOB________

Occupation ____H

Siblings:

Name	DOB
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________

Current Medications/Supplements:

____

____

____

Medication Allergies: _______________________________

Other Allergies: _____________________________________

Patient's Illnesses:

Please list any illnesses patient has or has had:

____

____

____

____

Please list any hospitalizations/surgeries patient has had:

	date
_____________________________________	________________
_____________________________________	________________
_____________________________________	________________

Family Illnesses

Allergies ____

Birth Defects ____

Blood disease ____

Bone or joint disorders ________________________________

Cancers or malignancies ________________________________

Chronic lung disease ___________________________________

Glandular disease ______________________________________

Heart trouble ____

Kidney or Urinary disease ______________________________

Intellectual disability _________________________________

Muscle Disease ____

Nerve disease ____

Psychiatric condition __________________________________

Rheumatic fever _______________________________________

Tuberculosis (TB) ______________________________________

HIV positive ____

Other ____

Birth History: (Children Under 5)

Mother's Pregnancy History:

Infections, Medications, High Blood Pressure, Diabetes, Alcohol, Other

Baby's History:

Birth Weight ____________________ Preterm yes no

Birth Length ____________________

Delivery: Vaginal _________ C-section _________

Complications? _________________________________

Breast fed _____________ Formula Fed ___________

Does Anyone Smoke In Patient's Home? ________

Financial Policy

Rosemarie Tweed, D.O. A.P.C., 14114 Business Center Dr. Suite A, Moreno Valley , CA 92553

Insurance coverage can be confusing, and some people assume that their insurance is responsible for their total bill. It is important that you understand that your insurance contract is between you and your insurance company. The final responsibility for payment of professional services belongs to the patient and not to their insurance company.

We want to help you receive the maximum benefits you are entitled to from your insurance policy. We submit claims at no extra charge to our patient as a courtesy. To submit claims, we must have complete and accurate insurance information about both the insured and the patient. If you do not have this information at the time of service, you will be asked to pay for services in full, or you may reschedule. All co-pays are due at the time of service as required by your insurance company.

At each office visit you will be asked to provide a copy of your insurance card and to verify your coverage, address, and phone number. Incorrect information will cause a delay in processing your claims. All charges are your responsibility; including those billed to your insurance company and not paid within 90 days from the date of service.

If you do not have insurance coverage, we ask for payment in full at time of service. A discount is given for payment in full at time of service.

If your account requires a billing statement, the balance is due and payable upon receipt. Charges that have been billed to your insurance plan will be noted on your statement until payment and/or an explanation of benefits (EOB) is received from the insurance company. Again, we will bill your plan directly as a service to you, but not in substitute of your primary responsibility for payment.

If your account goes unpaid for 120s or more without arrangement of a payment plan, collection procedures will be started. **Cancelled or returned checks will incur a $20.00 service charge.**

To avoid misunderstandings, our billing officer encourages early discussion of financial problems or questions regarding fees, insurance payments, billing statements, etc.

Assignment and release

Private Insurance: I, the undersigned, have insurance coverage with: ____________________________ and assign directly to Rosemarie Tweed, D.O. A.P.C., all medical benefits if any, otherwise payable to me for services rendered. I hereby authorize the doctors (Rosemarie Tweed and Jesse Tweed) to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions. This signature also gives consent for treatment to Rosemarie Tweed, D.O. A.P.C. and all of its providers. I have read and understood the financial policy of Rosemarie Tweed D.O. A.P.C., and hereby agree to it.

____________________________	__________________	________
Signature of Parent or Guardian	Relationship to Patient	Date

Medi-Cal: Medi-Cal payments are accepted by the Rosemarie Tweed, D.O A.P.C., as payment in full, and Medi-Cal patients parent or guardian will not be expected nor required to pay for expenses not covered by Medi-Cal. Your signature assigns Medi-Cal benefits to Rosemarie Tweed, DO APC, and authorizes the release of all information necessary to secure the payment of benefits. It also gives consent for treatment to Rosemarie Tweed, DO A.P.C. and all of its providers.

____________________________	__________________	________
Signature of Parent or Guardian	Relationship to Patient	Date

CAIR California Immunization Registry

Decline or Start Sharing/Information Request

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:

MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Street Address:
Patient Date of Birth:	Patient's City/Zip Code:
Patient ID (optional):	Patient County:
Patient Phone:	

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/ tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).***

* *Note: The immunization record/TB Tests may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization/TB test records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in CAIR.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.

☐ I REQUEST to review or correct my/my child's CAIR immunization/TB test record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

Fax or email this form to the CAIR Help Desk at
1-888-436-8320, CAIRHelpDesk@cdph.ca.gov

Consent to Use Telemedicine

Patient's Name________________________ My Doctor's Name________________________

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

________________________ _________________________________

Date Patient's Signature