Sindu Pillai, M.D.

Patient Information: (legal full name) *New_____ *Update_____

Last:_____ First:_____ Middle:_____

Birth Date:_____ Age:_____ Sex:_____

Street Address:_____ City-State:_____ Zip:_____

Any appointed custodial court orders in place? [ ] yes [ ] no

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Mother Information: [ ] Biological parent [ ] Step parent [ ] Legal Guardian [ ] Foster parent

Last:_____ First:_____ Birth Date:_____

SS:_____ Marital Status: Married Divorced Single Widowed

Street Address:_____ City-State:_____ Zip:_____

Home:_____ Cell:_____ Wrk:_____

Employer Name-Address:_____

Email:_____ *as a courtesy, we can email referrals, etc

Father Information: [ ] Biological parent [ ] Step parent [ ] Legal Guardian [ ] Foster parent

Last:_____ First:_____ Birth Date:_____

SS:_____ Marital Status: Married Divorced Single Widowed

Street Address:_____ City-State:_____ Zip:_____

Home:_____ Cell:_____ Wrk:_____

Employer Name-Address:_____

Email:_____ *as a courtesy, we can email referrals, etc

Emergency Contact: (other than parent)

Name:_____ Relationship:_____ Ph:_____

Insurance Information:

_____ _____ _____

insurance company | insurance id | group

_____ _____ _____

policy holder last name | policy holder first name | date of birth

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I authorize treatment for my child and consent to the administration of all treatment that may be considered advisable and necessary by my doctor. I hereby authorize Dr. Pillai to release any information acquired in the course of my child's examination and treatment. I understand that I am financially responsible for all expenses incurred regardless of insurance coverage. Authorization to pay physician: I hereby authorize payment directly to Dr. Pillai by my insurance for the services she provides to my child/children.

Signature:_____ Date:_____

Relationship to Patient:_____ How did you hear about our office? _____

Standardization for Health Care Quality Improvement

We Ask Because We Care

An increasing number of federal policies emphasize the need for obtaining gender, race, ethnicity and language information. It is important for hospitals and clinics to conduct studies to make sure that all patients get the same high-quality care regardless of their race or ethnic background.

The American Recovery and Reinvestment Act of 2009 (ARRA) requires providers to collect patient race, ethnicity and language data. Your race and ethnicity are to be recorded in accordance with the Office of Management and Budget (OMB) Standard.

Thank You,

Sindu Pillai, M.D.

Name: _____

Phone Number: _____ ☐ Phone - Cell ☐ Phone - Home

Preferred method of receiving Confidential Communications: ☐ Phone - Cell ☐ Phone - Home ☐ Mail

☐ Email- _____

MARITAL STATUS

☐ Single ☐ Separated ☐ Widow ☐ Domestic Partner

☐ Married ☐ Divorced ☐ Other _____

LANGUAGES

What is your Preferred Language: _____

☐ **Declined (I prefer not to provide the following race and ethnicity information)**

What do you consider your Race to be?

☐ American Indian or Alaska Native
☐ Asian
☐ African American
☐ Other
☐ Filipino
☐ Mexican American/Hispanic
☐ Caucasian
☐ Native Hawaiian or Pacific Islander

Which of the following best describes your Ethnicity?

☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Andalusian
☐ Argentinean
☐ Asturian
☐ Belearic Islander
☐ Bolivian
☐ Canal Zone
☐ Canarian
☐ Castilian
☐ Catalonian
☐ Central American
☐ Central American Indian
☐ Chicano
☐ Chilean
☐ Colombian
☐ Costa Rican
☐ Criollo
☐ Cuban
☐ Dominican
☐ Ecuadorian
☐ Gallego
☐ Guatemalan
☐ Honduran
☐ Latin American
☐ Mexican
☐ Mexican American
☐ Mexican American Indian
☐ Mexican American/Hispanic
☐ Mexicano
☐ Nicaraguan
☐ Other Pacific Islander
☐ Pacific Islander
☐ Panamanian
☐ Paraguayan
☐ Peruvian
☐ Puerto Rican
☐ Salvadoran
☐ South American
☐ Spaniard
☐ South American Indian
☐ Spaniard
☐ Spanish Basque
☐ Valencian
☐ Venezuelan

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH CHILD

During which month of pregnancy did you first see the doctor? _____ month			Where was baby born? _____		
How long was your pregnancy? _____ months			If baby was born at home, were blood tests for newborn screening done? ☐ YES ☐ NO		
Did you have any illnesses or problems during the pregnancy, including sexually transmitted or other communicable diseases?	YES	NO	Did you use any non-prescribed drugs like tobacco, alcohol, "street drugs" or over-the-counter or home remedies?	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficult or abnormal delivery or C-Section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the first week of life?	YES	NO	Did the baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐MALE ☐FEMALE ADOPTED? ☐YES ☐NO

BIRTH WEIGHT: _____POUNDS _____OUNCES LENGTH: _____INCHES

Has your child ever had any of the following?					
Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating or refusing to eat	YES	NO
Tuberculosis or positive TB test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis or frequent Sore Throat	YES	NO	Skin problems	YES	NO
Problems with Eyes or Vision	YES	NO	Headaches or Dizziness	YES	NO
Problems with Ears or Hearing	YES	NO	Convulsions, Seizures, Epilepsy	YES	NO
Difficulty Breathing or Snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, Bronchitis, Pneumonia	YES	NO	Allergies	YES	NO
Anemia, Bleeding problems, Blood transfusions	YES	NO	Problems with Development or School performance	YES	NO
Stomachaches	YES	NO	Serious Illness or Accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or Hospitalization	YES	NO
Bladder or Kidney problems, Wetting self or bed	YES	NO	GIRLS – Has she started her periods?	YES	NO
Constipation	YES	NO	GIRLS – Are there problems with periods?	YES	NO

FAMILY HISTORY: Does child's mother(M), father(F), sister(S), brother(B), aunt(A), uncle(U), or grandparent(GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High Blood Pressure	
YES	NO	Epilepsy or Convulsions		YES	NO	Bleeding Disorder	
YES	NO	Mental Retardation		YES	NO	Tuberculosis	
YES	NO	Heart Disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or Breathing Problems	
YES	NO	Kidney or Urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or Joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

Mother: Age _____ Height _____

Father: Age _____ Height _____

HOUSEHOLD INFORMATION: Number of people in home: _____

Are both parents living in the home? ☐Yes ☐No

Does anyone in the home smoke or use alcohol or drugs? ☐Yes ☐No

Do you live in a: ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Home

Language spoken in the home: _____

Do you or your child have a hearing impairment? ☐Yes ☐No

Are Interpreter Services needed? (Staff Use Only) ☐Yes ☐No

PATIENT IDENTIFICATION:	Signature: _____ Date: _____ Relationship to Child: _____ Reviewer's Signature: _____ Date: _____

revised 1-04 aa

Sindu Pillai, M.D.

AUTHORIZATION TO TREAT A MINOR

I hereby consent to and authorize the administration of all diagnostic, therapeutic treatments, and **immunizations** that may be considered advisable or necessary in the judgment of the attending physician for the treatment/diagnosis of:

_____ _____

Minor's Name Minor's Birth Date

I hereby authorize the physician to release any information acquired in the course of the minor's examination or treatment.

_____ _____

Signature of Parent/Guardian Date

_____

AUTORIZACION PARA DAR TRATAMIENTO MEDICO A UN MENOR DE EDAD

(Yo)(Nosotros), Padre(s), del suscrito(a) y con las custodia/tutela legal de _____, menor de edad, pro medio de esta authorize (amos) a

Nobre del Menor

_____Como agente(s) del suscrito(a) y doy (damos) nuestro consentimiento para que le tomen radiografias, le haga pruebas de dianostico, **vacunas** y tratamiento medico externo (no incluyendo cirugia). Que se considere prudente ye que se efectue bajo la supervision general o especial de un Doctor de Medicina, con autoirzaction para practicar de acuerdo a lo previsto en el Acta de Practica Media (Medical Practice Act), ya sea que dichos tratamientos or diagnosticos se efectuen en:

Sindu Pillai, M.D., Inc _____(Nombre de la Clinica)

_____ _____

Padre/Madre/Tutor Legal Date

SINDU PILLAI, M.D.
25485 Medical Center Drive, Suite 106 • Murrieta, CA 92562
Office (951) 600-9093 • Cell (951) 541-8319 • Fax (951) 600-1132

COPAY ACKNOWLEDGMENT

I am aware that my copay is due at the time of visit. I am also aware that for some reason it is not paid on that day I will be charged an additional $5.00.

Child Name _____ Date _____

Parent Signature _____

Sindu Pillai, M.D.
25485 Medical Center Dr. #106
Murrieta, CA 92562
Ph. (951) 600-9093
Fx. (951) 600-1132

OFFICE FINANCIAL POLICY

We are committed to providing all our patients with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

ALL PATIENTS: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payments rests with YOU.

CASH PATIENTS: All services are rendered on a cash basis and must be paid in full at the time of service. Financing and financial assistance is available.

PRIVATE INSURANCE: We must have a fully completed and signed insurance form at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Deductible and co-payment amounts are due at time of service.

PPO: We must have a copy of both sides of your insurance card on file. All co-payments are due at time of service.

HMO: Unless Dr. Pillai is your primary care physician it is your responsibility to have a referral each time you are seen. Without a referral you have NO insurance coverage. Without a referral you will be responsible for the charges should you HMO deny payment. Co-payment must be made at the time of registration.

Amounts which are over 60 days pasts due by an insurance company are immediately due from the patient. Amounts which are over 90 days past due are subject to collection procedures which could include small claims court or a 1-1/2% service charge per month on the unpaid balance. Accounts sent to a collection agency will include an additional $10.00 transferring fee.

If at any time you should experience financial hardship, please make this office aware of the situation. We are always willing to make special arrangements for those patients who need extra help. If you need to make arrangements, please ask o speak with the office manager.

I have read and understand all of the above.

_____

Patient or responsible party signature Date

SINDU PILLAI, M.D.
25485 Medical Center Drive, Suite 106 • Murrieta, CA 92562
Office (951) 600-9093 • Cell (951) 541-8319 • Fax (951) 600-1132

CONSENT TO SHARE/DISCUSS PRIVATE HEALTH INFORMATION

I _____ give consent to Sindu Pillai, M.D. to discuss my child's condition with any Doctors/Educators. I also permit contact via message machine or family member to the following phone number: _____ regarding my child's health.

I understand that this agreement does not serve as a medical release of records and that Dr. Sindu Pillai and/or staff can refuse to discuss private health information if believed that is in the best interest of the patient.

Child's Name _____
Legal Guardian Signature_____
Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

HIPAA Notice of Privacy Practices

Sindu Pillai, M.D.
25485 Medical Center Dr. #106
Murrieta, CA 92562
Ph. (951) 600-9093
Fx. (951) 600-1132

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

SINDU PILLAI MD PEDIATRICS

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I am the: [ ] parent [ ] guardian [ ] other person having legal custody

Of (name of minor): _____ Dob: _____, a minor.

I hereby authorize (name) _____, who is (relationship to minor) _____ to act as my agent to consent to any medical diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general supervision of, any licensed doctor, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital cae being required, but is given to provide authority to the above named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor recommends. This authorization is given pursuant to the provisions of Family Code Section 6910. I hereby authorize any hospital providing treatment to the above named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

These authorizations shall remain in effect until _____, unless sooner revoked in writing delivered to the agent named above. (1 year maximum)

Date: _____ Signature of parent or guardian: _____

RECORDS RELEASE AUTHORIZATION

Facility/Provider Name: _____

Facility/Provider Address: _____

Facility/Provider Phone: _____

Facility/Provider Fax: _____

I hereby authorize the release or disclosure of the medical information as indicated below to the healthcare provider, entity, or person I have indicated below.

This authorization shall become effective immediately and shall remain in effect until _____ or for 1 year from date of signature if no date is entered.

This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that the requesting party may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specially required or permitted by law.

A copy of this authorization is valid as an original.

Please release/disclose records and information regarding:

Name of Patient: _____ DOB: _____

Send Records Pertaining to:

_____General Medical Rec. from _____ to _____

_____Lab Results

_____X-ray Results

_____Immunization History

_____Other

Send Medical Records to: _____ **Sindu Pillai, M.D. and Van Nguyen, P.A.**

Office Contact: _____

24910 Las Brisas Road., Ste 114
Murrieta, CA 92562
Phone 951-600-9093
Fax 951-600-1132
Email: sindupillai@drsindupillai.org

_____ ***Other Provider / Facility**

_____

_____

I request the health information released/disclosed be used for the following purpose: to continue care thru new doctor / facility

_____ Date

_____ Signature of Patient or Responsible Party

_____ Relationship to Patient