Sindu Pillai, M.D.

Nombre de Pasiente: (nombre legal completo) *Nuevo_____ *Cambio_____

Apellido:_____ Primero:_____ Segundo:_____

Fecha de Nacimiento:_____ Edad:_____ Sexo:_____

Domicilio:_____ Ciudad-Estado:_____ Codigo Postal:_____

Alguna orden de la corte de custodia? [ ] si [ ] no

Informacion de la Madre: [ ] madre biológica [ ] madrastra [ ] guardián legal [ ] madre tutor de crianza

Apellido:_____ Primero:_____ Fecha de Nacimiento:_____

SS:_____ Estado Civil: Casada Divorciada Sola Viuda

Domicilio:_____ Ciudad-Estado:_____ Codigo Postal:_____

Telefono:_____ Celula:_____ Trabajo:_____

Empleador y Domicilio:_____

Correo electronico:_____ *como cortesía , podemos email referidos, etcetera

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Informacion de la Padre: [ ] padre biológico [ ] padrastro [ ] guardián legal [ ] padre tutor de crianza

Apellido:_____ Primero:_____ Fecha de Nacimiento:_____

SS:_____ Estado Civil: Casada Divorciada Sola Viuda

Domicilio:_____ Ciudad-Estado:_____ Codigo Postal:_____

Telefono:_____ Celula:_____ Trabajo:_____

Empleador y Domicilio:_____

Correo electronico:_____ *como cortesía , podemos email referidos, etcetera

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Contacto de emergencia: (excepto padres)

Nombre:_____ Relacion:_____ Tel:_____

Informacion de Aseguransa:

_____ _____ _____

compañía de aseguransa | id de aseguransa | grupo

_____ _____ _____

appellido de la titular de aseguransa | nombre de la titular de aseguransa | fecha de nacimiento

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Yo autorizo el tratamiento para mi hijo y doy consentimiento para la administración de todo tratamiento que se considere conveniente y necesario por mi médico. Autorizo por este medio a Dr. Pillai para liberar cualquier información adquirida en el curso de la examinación y el tratamiento de mi hijo. Entiendo que soy financieramente responsable por todos los gastos incurridos independientemente de la cobertura de seguro. Autorización para pagar médico: por la presente autorizo pago directamente al Dr. Pillai por mi seguro para los servicios que ella ofrece a mis hijos.

Firma:_____ Fecha:_____

Relación con el paciente?_____ Cómo se enteró de nuestra oficina?_____

Standardization for Health Care Quality Improvement

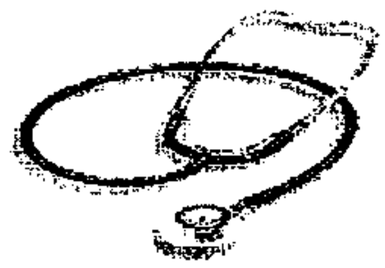
We Ask Because We Care

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 ☐ Filipino

☐ Asian ☐ Mexican American/Hispanic

☐ African American ☐ Caucasian

☐ Other ☐ Native Hawaiian or Pacific Islander

Which of the following best describes your Ethnicity?

☐ Not Hispanic or Latino ☐ Central American Indian ☐ Honduran ☐ Paraguayan

☐ Hispanic or Latino ☐ Chicano ☐ Latin American ☐ Peruvian

☐ Andalusian ☐ Chilean ☐ Mexican ☐ Puerto Rican

☐ Argentinean ☐ Colombian ☐ Mexican American ☐ Salvadoran

☐ Asturian ☐ Costa Rican ☐ Mexican American Indian ☐ South American

☐ Belearic Islander ☐ Criollo ☐ Mexican American/Hispanic ☐ Spaniard

☐ Bolivian ☐ Cuban ☐ Mexicano ☐ South American Indian

☐ Canal Zone ☐ Dominican ☐ Nicaraguan ☐ Spaniard

☐ Canarian ☐ Ecuadorian ☐ Other Pacific Islander ☐ Spanish Basque

☐ Castillian ☐ Gallego ☐ Pacific Islander ☐ Valencian

☐ Catalalonian ☐ Guatemalan ☐ Panamanian ☐ Venezuelan

☐ Central American

HISTORIAL MEDICO DEL NINO

HISTORIAL MEDICO DE SU EMBARAZO CON ESTE NINO:

¿En qúe mes de su embarazo visitó usted por primera vez al doctor?_____mes ¿Dónde nació su bebé?_____
¿De cuántos meses fue su embarazo?_____ Si nació el bebé en casa, ¿le hicieron análisis de sangre de detección básica para un recien nacido? ☐Sí ☐No

¿Tuvo usted alguna enferedad o problemas? (Esto incluye enfermedades transmitidas sexualmente o enfermedades contagiosas)	Sí	No	¿Usó usted alguna droga? (Tabaco, bebidas alcohólicas, drogas de la calle, remédios caseros o de la farmacia)	Sí	No
¿Tomó usted alguna medicina recetada por su doctor?	Sí	No	¿Le dieron de alto a su bebé juntamente con usted?	Sí	No
¿Tuvo un parto difícil/anormal/cesárea?	Sí	No	¿Le nacio a usted más de un bebé?	Sí	No
¿Tuvo el bebé algún problema durante la primera semana de vida?	Sí	No	¿Se le puso al bebé alguna vacuna para la hepatits B?	Sí	No

HISTORIAL MEDICO DEL NINO: ☐M ☐f ¿Fué adoptado este niño? ☐Si ☐No Peso al nacer:_____lbs._____oz. La medida:_____pulgadas

¿Ha tenido alguna vez:

Sarampión, varicela, paperas, sarampión alemán	Sí	No	Vómitos después de comer, se rehusa a comer	Sí	No
Tuberculosis o una prueba positiva de tuberculosis	Sí	No	Problemas de los músculos, articulaciones o huesos	Sí	No
Amigdalitis/Dolor de garganta	Sí	No	Problemas de la piel	Sí	No
Problemas con los ojos o con la vista	Sí	No	Dolores de cabeza o mareos	Sí	No
Problemas con los oídos o para oir	Sí	No	Convulsiones, ataques, epilepsia	Sí	No
Dificultad al respirar/roncar en la noche	Sí	No	Diabetes	Sí	No
Problemas del corazón	Sí	No	Problemas con la tiroides	Sí	No
Asthma, bronquitis o pulmonia	Sí	No	Alérgias	Sí	No
Anemia, problmeas de hemorrágia, transfusiones de sangre	Sí	No	Problemas con el desarollo o con el desempeño escolar	Sí	No
Dolores de estómago	Sí	No	Enfermedades o accidentes graves	Sí	No
Diarrea, manchándose con el excremento	Sí	No	Cirugía o hospitalización	Sí	No
Problemas con la vejiga/ los riñones, orinarse en la cama/ la ropa interior	Sí	No	(Niñas)¿Ha comenzado con su menstruación?	Sí	No
Estreñimiento/constipación	Sí	No	(Niñas)¿Hay problemas con su menstruación?	Sí	No

HISTORIAL MEDICO DE LA FAMILIA: Tiene alguien de la familia: madre(M), padre(P), hermano(HO), hermana(HA), tío(TO), tía(TA), abuela(AA), abuelo(AO)

			¿Cual miembro familiar?				¿Cual miembro familiar?
Sí	No	Diabetes		Sí	No	Alta presión de sangre	
Sí	No	Epilepsia o convulsiones		Sí	No	Trastornos sanguineos	
Sí	No	Retraso mental		Sí	No	Tuberculosis	
Sí	No	Cancer		Sí	No	Alérgias	
Sí	No	Enfermedad de los riñones o urinaria		Sí	No	Problemas de los pulmones o con la respiración	
Sí	No	Problemas con los huesos o las aricuiaciones		Sí	No	Anormalidad funcional de los ojos	
Sí	No	Enfermedad del corazón		Sí	No	Anormalidad funcional de los oidos	

INFORMACION SOBRE LOS PADRES:

	Madre:	Padre:
Edad:		
Altura:		
Ocupación:		

INFORMACION DOMICILIARIA: ¿Cuántas personas viven en su casa?_____
¿Viven ambos padres en la casa? ☐Sí ☐No
¿Alguien en la casa fuma o usa drogas o bebidas alcoholicas? ☐Sí ☐No
¿Qué idioma se habla en casa?_____
¿Vive usted en una ☐Casa ☐Apartamento ☐Refugio ☐Casa Remolque ☐Sin casa ni hogar

Identifición del Paciente:

Firma:_____ **Fecha:**_____
Parentezco con el niño:_____
Reviewer's Signature:_____ **Date:**_____

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@or sindupillai.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