BEVERLY HILLS
PEDIATRIC SURGERY
PECTUS SURGICAL INSTITUTE

Reason for Consultation:			
Patient's Name:	DOB:	Sex:	Ethnicity:
Address:		City, State, Zip:	
Home #:	Parent's Cell Phone #:	Parent's Cell Phone #:	
Emergency Contact:	Relationship:	Phone #:	

PARENT/GUARDIAN OR NEAREST RELATIVE INFORMATION:

Parent's Name:	DOB:	E-mail
Employer:	Occupation:	
Phone:	Employee Address:	
Parent's Name:	DOB:	E-mail
Employer:	Occupation:	
Phone:	Employee Address:	

PRIMARY CARE PHYSICIAN INFORMATION:

Physician:	
Address:	City, State, Zip:
Phone:	Fax:

REFERRING PHYSICIAN INFORMATION [If Different from Primary Care Physician]:

Physician:	Contact:
Address:	City, State, Zip:
Phone:	Fax

INSURANCE INFORMATION:

Insurance Name:	Phone #
Address:	City, State, Zip:
Subscriber Name:	Social Security #:

8920 Wilshire Blvd., Suite 326 • Beverly Hills • CA • 90211
(310) 598-7738

625 S. Fair Oaks Ave., Suite 286 • Pasadena • CA • 91105
(626) 243-7000

www.bhpediatricsurgery.com • info@bhpediatricsurgery.com • Fax: (310) 657-0096

PATIENT MEDICAL HISTORY

PATIENT'S NAME: ______________________________ DOB: ____________

School Name: ______________________________ Grade: ____________

Local Pharmacy #: ________________ Current Weight & Height: _______/_____

Past Medical History: ____

____

Current Medications: ____

Allergies: ____

Previous Surgery and Hospitalizations: ______________________________

____

Office use only: Today's Date: ____________

HPI:

PE:

Assessment & Plan:

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PEDIATRIC SURGERY

Date: __________

Patient: ______________________

DOB: ______________________

Insurance: ______________________

ID #: ______________________

I, ______________________ have received the attached insurance benefits and have verbalized understanding the instructions provided by Dr. Steve Chen's staff. I understand that I must release any insurance payment(s) sent to me by my insurance to pay for Dr Steve Chen's services. Also, I must include a copy of the explanation of benefits (EOB) within 10 days of receiving it. If payment is not released, I will be responsible for any outstanding balance billed to me by Dr. Steve Chen's office.

I, also do understand that Dr. Steve Chen is an out of network provider with my insurance. Therefore, the payment to pay for his rendered services will be mailed to the subscriber.

Signature: ______________________________ Date: ____________

If signed by other than patient, indicate relationship: ________ Witness Initials: ____

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CONDITIONS OF TREATMENT

PATIENT'S NAME: ______________________ DOB: ______________

The above-named Patient is seen at Beverly Hills Pediatric Surgery ("BHPS") for consultation, outpatient and/or emergency treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned consents to the procedures that may be performed during this consultation or on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or Other services provided to the Patient under the general and special instructions of the Patient's physician or surgeon.

2. PERSONAL BELONGINGS

It is understood and agreed that the BHPS shall not be liable for the loss or damage to any personal belongings while visiting BHPS.

3. CONSENT TO PHOTOGRAPH

The taking of still or moving pictures involving Patient medical or surgical procedures or to document a physical condition, or for scientific, educational, or research purposes, is hereby approved and consented to by the Patient or the legal guardian of the Patient provided that the Patient is not specifically identified whether by writing or depiction unless the photograph is to be part of the medical record for treatment purposes.

4. FINANCIAL AGREEMENT

The undersigned agrees, whether he / she signs as agent or as Patient, that in consideration of the services to be rendered to the Patient, he / she hereby individually obligates himself / herself to pay the account of BHPS in accordance with the regular rates and terms of BHPS. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

The undersigned certifies that he / she has read the foregoing, received a copy thereof, and is the Patient, the Patient's legal representative, or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the professional fee agreement with BHPS

Signature: ______________________ Date: __________

If signed by other than Patient, indicate relationship: ______________ Witness Initials: ________

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WO SIGNS THIS DOCUMENT

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: Beverly Hills Pediatric Surgery-Steve C. Chen,MD
Physician/Healthcare Facility

To release information on ______________________________(Patient's Name)
________________(Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: ____
Name
____
Address
______________________ ________ ____________
City State Zip Code

The medical information/records will be used for the following purpose:

____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

____

____

____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	________(initial)
Psychiatric/Mental Health	________(initial)
Tests for Antibodies to HIV	________(initial)
HIV Diagnosis/Treatment	________(initial)
Genetic Information	________(initial)

DURATION

This authorization shall be effective immediately and remain in effect until____________
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

______________________________ Signature of patient *or legal/personal representative patient*	______________________________ Relationship *if other than*
______________________________ Patient's Name (PRINT)	______________________________ Date
______________________________ Patient's Social Security Number	______________________________ Patient's Date of Birth
______________________________ Witness name	______________________________ Witness signature

Rev Aug 2015

BEVERLY HILLS
PEDIATRIC SURGERY

[Physician Practice Name and Address]

[Name or Title and Telephone Number of Privacy Officer]

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ______________________________________

____

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