KJARTAN D. ARMANN, M.D.

Infant, Child and Adolescent Medicine

2516 Samaritan Dr., Suite J
San Jose, CA 95124
Phone: (408) 356-0578
Fax (408) 356-3986
www.kjkidmd.com

Date: _____ Referred By: _____

Patient Information

Name: _____ Male: ☐ Female: ☐
Last First

Social Security Number: _____ Date of Birth: _____

Parent/Guardian Information

Name: _____ Male: ☐ Female: ☐
Last First

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____
Street

_____
City State Zip

Employer: _____ _____ _____
Name Address Phone

E-Mail Address: _____

Parent/Guardian Information

Name: _____ Male: ☐ Female: ☐
Last First

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____
Street

_____
City State Zip

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Patient's General and Emergency Contact Information Sheet

Please complete this form by indicating a check mark in each section that would be an acceptable manner in with our practice can contact you.

□ In case of an emergency, I authorize Dr.Armann and/or staff to contact _____ at (____) _____-_____. My relationship to this contact is: _____ and I hereby give permission to Dr. Armann and/or staff to release medical information to that person.

I wish to be contacted by Dr.Armann and/or staff in the following manner (please check all areas that would be an acceptable manner for Dr.Armann and/or staff can contact you):

□ Please contact me on my home telephone: (_____) _____ - _____

□ Dr.Armann and/or staff can leave their name and phone number ONLY when they call.

□ Dr.Armann and/or staff can leave a detailed message when they call.

□ Please contact me on my cellular telephone: (_____) _____ - _____

□ Dr.Armann and/or staff can leave their name and phone number ONLY when they call..

□ Dr.Armann and/or staff can leave a detailed message when they call.

□ Please contact me at work telephone: (_____) _____ - _____

□ Dr.Armann and/or staff can leave their name and phone number ONLY when they call..

□ Dr.Armann and/or staff can leave a detailed message when they call.

□ Dr.Armann and/or staff can mail or email me information such an appointment reminder, and future clinic sponsored programs.

□ Dr.Armann and/or staff can mail information to my home address.

□ Dr.Armann and/or staff can mail information to my work address.

□Dr.Armann and/or staff cannot mail information to my home or work address except a statement of my account.

□ Dr.Armann and/or staff may send me e-mail messages such as appointment reminders at the following email address: _____.

_____ _____ _____

Patient's Name (Please Print) Signature of Patient, Parent or Legal Guardian Date

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Member Advance Notice Form for the Involvement of a Nonparticipating Provider

Your physician may decide to involve a non-participating physician, facility or other health care provider in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your option to utilize a participating provider and you have agreed to receive services from a non-participating provider despite the potential increased out-of-pocket costs associated with that decision.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. However, your insurance believes it is important you understand that you may have higher out-of-pocket costs when using a non-participating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a non-participating provider, you may be responsible for the entire cost of the services.

If you have questions or would like to find a participating provider that can perform the services you require, contact your Insurance Customer Care at the telephone number on the back of your health plan ID card. You may also log onto your insurance's web site to search the online provider directory for a participating provider in your area.

To be completed by the member or the member's legal guardian:

I am aware that the physician, facility or other health care provider involved in my care may not be a participating provider in my insurance network. **I was provided** with the information above regarding choosing a non-participating provider to provide my Health Care Service and I voluntarily choose to obtain services from a non-participating provider. **I am aware that I may be responsible** for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan. **I understand** that non-participating providers are generally prohibited from waiving member cost share amounts such as co-payments, deductibles and coinsurance.

_____
Signature of Member, Parent (if the member is under age 18) or Legal Guardian

_____
Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian

_____
Date

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FINANCIAL AGREEMENT AND CONSENT OF TREATMENT

Patient Name:
_____D.O.B._____

IF YOU HAVE MEDICAL INSURANCE: We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments and Coinsurance: Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy. If your co-payment is not paid at the time of service an additional $45 fee will apply.

Authorizations:
A copy of your insurance card is required at the time of the service. The card is descriptive and indicates whether an authorization is needed. **If a copy of the card is not on the file at the time of service and the claim is denied for "no authorization." you will be responsible for the payment.**

Consent for treatment of a minor: I authorize Kjartan D. Armann, M.D. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

PAYMENT METHODS AND OTHER INFORMATION:
• We accept cash, check and VISA, MasterCard or Discover.
• Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
• All late cancellations and no-shows will be billed $50 automatically. (We require 24-hour notice in advance to avoid charges.) We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.
• Any appointment 15 minutes late on arrival, will be rescheduled.
I acknowledge that I have read and agree to the above Financial Policy.
Signature:
_____Date:_____

Print: _____ Mother Father Other

Witness:_____Date:_____

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Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act of 1995 (HIPAA) requires medical practices to establish policies to protect the privacy of patient health information and inform patients how their personal information will be used or disclosed.

By signing this form, you consent to the use and disclosure of protected health information about you or your children for treatment, payment and health care operations.

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

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You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.
If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Ilenia Cuna, at (408) 356-0578 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Privacy Practices for Kjartan Armann, MD

Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient

_____

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Fax

To:	**From:** Dr. Armann Office / Staff
Fax:	**Pages:** 0
Phone:	**Date:**
Re:	**CC:**

Release of Medical Records

Name of Patient(s):_____

_____

Date of Birth:_____

Date of Service (if applicable):_____

Signature:_____

Relation to Patient(s):_____

If you have any questions / concerns please feel free to contact our office at (408)356-0578

Thank you

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Consent of Treatment

Patient Name: _____D.O.B. _____

CONSENT FOR TREATMENT OF A MINOR:
I authorize Kjartan D. Armann, M.D. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, immunizations, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

_____
Parent's Initials

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Kjartan D. Armann, M.D. to release any information acquired in the course of my child's examination or treatment to insurance companies or others as designated by me.

_____
Parent's Initials

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to Kjartan D. Armann, M.D. for the surgical and/or medical services provided.

_____
Parent's Initials

ACKNOWLEDGEMENT OF MISSED APPOINTMENT POLICY:
I agree to cancel any scheduled appointment for my child that I do not plan to keep. I understand that failure to do so will result in an additional charge of $50.00. I understand that at least 24 hours prior notification is required.

_____
Parent's Initials

I have read, understood and agree to the above consent, authorizations and acknowledgement.

Parent Signature: _____ Date: _____
Parent Name: _____
○ Mother ○ Father ○ Other _____