KJ Kids

Kjartan D. Armann, MD
Alison Chase, DO
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: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

Parent/Guardian Information

Name: _____ DOB: _____ Gender: _____
Last First

Social Security Number: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____ City: _____ Zip Code: _____

Employer _____
Name Address

E-Mail: _____

Parent/Guardian Information

Name: _____ DOB: _____ Gender: _____
Last First

Social Security Number: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____ City: _____ Zip Code: _____

Employer _____
Name Address

E-Mail: _____

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Insurance Information

Primary Insurance Name: _____

Insurance ID Number_____

Group Number_____

Subscriber's Name:_____

If subscriber name is different than patient name, please provide the following:

Subscriber's D.O.B.: _____ Relationship to Patient: _____

Employer Name: _____

Secondary Insurance Name: _____

Insurance ID Number_____

Group Number_____

Subscriber's Name:_____

If subscriber name is different than patient name, please provide the following:

Subscriber's D.O.B.: _____ Relationship to Patient: _____

Employer Name: _____

By signing below, I acknowledge that the information I provided is correct. I understand that if it is not accurate, I will be responsible to pay the bill for the service provided.

Patient Signature: _____ Date: _____

Guarantor Signature (if other than patient): _____Date: _____

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CREDIT CARD ON FILE

KJ Kids office utilizes a Credit Card on File as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance.

Your credit card information will be kept confidential and secure. I, the undersigned, authorize and request that KJ Kids charge my credit card for the balance due that my health plan has identified as my financial responsibility.

This authorization relates to all charges not covered by my insurance company for services provided to me by KJ Kids. My card will remain securely stored for future use by AdvancedMD, under the management of AWS, a secure program used by KJ Kids to collect payments. This authorization will remain in effect until revoked by me in writing.

Patient's name: _____ DOB: _____

We will keep your credit card on file and charge your account to pay for charges not paid by my insurance plan. Charge limits: You will be contacted prior to charging your account for balances exceeding $100. Charges under this amount require no further authorization and will be charge automatically.

Patient/Guardian signature: _____

Credit card information:

Card type: Amex Visa Mastercard Discover

Is this card a Flexible Spending/Health Savings card? Yes No

Card number: _____ Expires: _____ CVV #_____

Cardholder name: _____

Card's bill to address: _____

City_____ State_____ Zip_____

Contact phone: _____

Transaction type: AUTHORIZATION Email receipt to _____

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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 which our practice can contact you.

□ In case of an emergency, I authorize KJ Kids' staff to contact _____

at (____) _____-_____. My relationship to this contact is: _____ and I hereby give permission to KJ Kids 'staff to release medical information to that person.

I wish to be contacted by KJ Kids' staff in the following manner (please check all areas that would be an acceptable.):

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

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

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

□ KJ Kids' 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

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.**

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, Discover, America Express and Apple Pay
• 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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Fax

To:	**From:** KJ Kids' Office / Staff
Fax:	**Pages:**
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 KJ Kids 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 KJ Kids 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 KJ Kids 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

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I acknowledge that I have read the notice of Privacy Practices which is available at our front office

Parent's Initials

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

Parent Signature: _____

Parent Name: _____

Relationship to the patient _____

Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 11/1/2023

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

The terms of this Notice of Privacy Practices ("Notice") apply to KJ Kids, its affiliates and its employees. KJ Kids will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by KJ Kids. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

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Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved in Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;

- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;

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• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;

• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;

• To your employer when we have provided health care to you at the request of your employer;

• To a government oversight agency conducting audits, investigations, civil or criminal proceedings;

• Court or administrative ordered subpoena or discovery request;

• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;

• To coroners and/or funeral directors consistent with law;

• If necessary to arrange an organ or tissue donation from you or a transplant for you;

• If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and

• To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

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Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies, you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

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Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid KJ Kids in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself. **Paper Copy of this Notice:** You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

Office for Civil Rights
Department of HHS
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Voice Phone (212) 264-3313
FAX (212) 264-3039
TDD (212) 264-2355

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the KJ Kids Privacy Officer by phone at 408-356-0578 or at the following address: 2516 Samaritan Dr. Suite J, San Jose, CA 95124