



**KJ Kids**  
**Kjartan D. Armann, MD**  
**Alison Chase, DO**  
**Dana Loo, PNP**  
**Aava Salehi, PNP**  
 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: \_\_\_\_\_.

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**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

<b>To:</b>	<b>From:</b> KJ Kids' Office / Staff
<b>Fax:</b>	<b>Pages:</b>
<b>Phone:</b>	<b>Date:</b>
<b>Re:</b>	<b>CC:</b>

## 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 \_\_\_\_\_