ActiveKidMD
PEDIATRICS + SPORTS MEDICINE

Co-payments X

Co-payments are due at time of service. We accept cash, check and credit cards. Please make checks payable to *ActiveKidMD*. Nonpayment incurs a service charge of $25, in addition to the co-payment.

Missed Appointments X

By failing to keep an appointment....You will incur a charge....

Please give 24 hours notice.

Receipts X

If you require a receipt for taxes/healthcare spending account please request it at time of service, at no charge. We do charge $25 for year end account summary.

Insurance Cards X

It is your responsibility to update our office of any change in insurance.

500 S. Anaheim Hills Road, Suite 140
Anaheim Hills, CA 92807
tel (714) 974-2220 | fax (714) 974-4385
info@activekidmd.com

WWW.ACTIVEKIDMD.COM

PARENT/GUARDIANSHIP CONTACT INFORMATION #1

Date _____

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell phone: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Telephone: _____ Age: _____ Sex: ___Male ___Female

Date of Birth: _____ Drivers License # _____

Social Security #: _____ Marital Status: ___Single ___Married ___Other_____

Email: _____

PARENT/GUARDIANSHIP CONTACT INFORMATION #2

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell phone: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Telephone: _____ Age: _____

Date of Birth: _____ Drivers License # _____

Social Security #: _____ Email: _____

DEPENDENTS (Names of Children that will be seen as patients in this office)

Last Name, First Middle – **BIRTHDATE**

1) _____ M F

2) _____ M F

3) _____ M F

Last Name, First Middle – **BIRTHDATE**

4) _____ M F

5) _____ M F

6) _____ M F

When patient is 18 yrs. or older need CELL # _____

Contact Person (with phone number) in case of Emergency: _____

PRIMARY INSURANCE COVERAGE FOR PATIENT

Insured's Name: _____

Insurance Name: _____

Insurance Address: _____

Certificate # or Member ID #: _____

Group #: _____

How do you wish to pay? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

How did you hear about us?: _____

AUTHORIZATION (please read carefully before signing)

I request that all surgical or medical benefits, if any, otherwise payable to me for services rendered shall be paid to the provider of service. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the provider of services to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed above by physicians or other medical personnel. Failure to provide complete information may result in you receiving a bill for your charges. If failure to pay your bill leads to your account being sent to collections, you will be assessed late payment and interest fees accruing from the date of service.

Signature _____ Date____/____/____ Staff initials _____

Relationship to child: _____

Drs Gladstien & Koutures comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

Drs Gladstien & Koutures cumple con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of:
Keith Gladstien, M.D. & Chris Koutures, M.D.

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 714-974-2220.

I acknowledge receipt of the ***Notice of Privacy Practices*** of Keith Gladstien, M.D. & Chris Koutures, M.D.

Signature: _____ Date: _____
(parent/patient/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____