Patterson & Tedford Pediatrics
with you every step of the way

A DIVISION OF BASS MEDICAL GROUP

Child's Information:

Last Name	First Name	DOB	Sex at Birth

Responsible Financial Party: Mother____ Father____

Address of parent to mail billing statements to:

Primary Insurance for Patient's Account:

Insurance Company, Subscriber Name and Member ID Number:

Parent Information: Parent/Legal Guardian of child listed above

Court order: Yes_____ No_____

Last Name	First Name	DOB	SSN

Mailing Address	Street Address	City

State & Zip	Home Phone	Cell Phone	Work Phone

Relationship: ☐ Mother ☐ Father ☐ Legal Guardian	Drivers Lic. #/State Issued	Employer
	Email (required):	

Parent Information: Parent/Legal Guardian of child listed above

Last Name	First Name	DOB	SSN

Mailing Address	Street Address	City

State & Zip	Home Phone	Cell Phone	Work Phone

Relationship ☐ Mother ☐ Father ☐ Legal Guardian	Drivers Lic. #/State Issued	Employer
	Email (required):	

Emergency Contact (Other than Parent)

Name	Relationship	Cell Phone	Home / Work Phone

I do hereby authorize and consent to all medical treatment deemed necessary to treat the aforementioned patient. In addition, I authorize release of medical records and payment benefits for services rendered by the physician.

Parent Signature _____ **Date** _____

Updated 02.24.2025

MEDICAL TREATMENT OF A MINOR

Child's Name:_____ Date of Birth:_____

CONSENT BY PROXY

I grant authority to the following to be my legally authorized representative(s) in the medical care of my child listed above. They may consent to necessary treatment or testing for my child as recommended by a Patterson and Tedford Pediatrics provider. (Example: Aunt, Sibling, Grandparent, Step parent, Nanny)

This consent does NOT allow named representative(s) to authorize vaccinations.
This consent by proxy remains in effect for one year.
This consent does not take the place of a court order.

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

Name of Representative:_____ Relationship to Child:_____

UNACCOMPANIED MINOR

☐ I grant permission for my minor child to be seen at Patterson and Tedford Pediatrics without a parent/guardian/named representative present and to give their consent to necessary treatment or testing as recommended by a Patterson and Tedford Pediatrics provider.

Vaccines may be given at an unaccompanied visit only if a parent/guardian is available by phone to give verbal consent at the time of the visit.

Signature of parent/guardian:_____

Printed name of parent/guardian:_____Date:_____

☐ I am a parent with legal custody
☐ I am a guardian with legal custody

FINANCIAL POLICY

• I, the party responsible, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

• It is my responsibility to verify with my insurance if BASS Medical Group is a contracted provider. BASS and/or its representatives will make every effort to assist you, but BASS will not be held accountable for understanding every insurance plan.

• I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

• I authorize the release of any medical or other information necessary to process claims for payment.

• I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

• I also understand that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group, immediately upon receipt.

• I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts.

• I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

• There is a fee to produce a full copy of records. The fee varies as it is calculated based on the individual record. Additionally, the fee to mail a record is the responsibility of the requestor.

• The charge for a non-sufficient funds (NSF) check is $25. You must pay in full for the NSF check and NSF fee within 10 days of notice. For the next 12 months, cash or equivalent payment at the time of service is required.

FINANCIAL POLICY CONTINUED

• We require 24-hour notice to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, a 2-hour notice is required. If you arrive 10 minutes late for your appointment, you have missed your appointment; therefore, a late cancellation fee will be charged, whether you are seen then or not.

• Failure to give proper notice for cancellation or rescheduling will result in:
- A $25.00 charge for missed vaccine appointments or late cancellations, per child
- A $50.00 charge for the first missed appointment, per child
- A $75.00 charge for the second missed appointment, per child
- A $100.00 charge for the third missed appointment, per child
- Your family could be subject to dismissal for a third or subsequent missed appointment.

• I, the patient, or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

My signature below confirms that I have read these billing policies, and my financial obligations as pertains to the laboratory department of BASS Medical Group.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 2 of 3

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  *Conditions and limitations may apply; obtain additional information from our Privacy Officer.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.
- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____
- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name. alternative address. phone number. & email address of Spouse. as applicable:**

  _____

  ☐ **OK to Family Members: Please list name(s). alternative address. phone numbers. & email addresses of Family Member(s). as applicable:**

  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s). alternative address. phone numbers. and email addresses of authorized person(s) or entities:**

  _____

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address:

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing.
You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/ they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

Authorization for Release of Information

Federal Regulations require that we first verify and document your identity, the information you would like to use or disclose, and your purpose(s) in requesting this information. You understand that if you request protected health information without patient authorization, we may refuse to provide you access to this information. Thirty (30) days allowed by law to forward/release medical records.

Patient Name: _____ **Date of Birth:** _____

Release Records ☐ **To** ☐ **From** Patterson & Tedford Pediatrics

☐ 7700 Morro Rd, Atascadero, CA 93422 | Ph: 805-466-6622 Fax: 805-466-6603
☐ 230 Station Way, Suite B, Arroyo Grande, CA 93420 | Ph: 805-473-3262 Fax: 805-473-3707

Release Records ☐ **To** ☐ **From**

Name _____

Street _____

City & State _____

Phone _____ Fax _____

Information Requested:
( ) Care Transfer (Last Well Visit, Past 1yr office visits/tests, Immunizations & Growth Charts)
( ) Immunization Record ONLY **( )** Entire Chart (May include a fee)
( ) Lab/Radiology _____ **( )** Other _____
( ) Visit Notes _____
Note: Hospital Records and Specialist Consultations to be obtained from originator

The purpose(s) for information to be used/disclosed for:
( ) Changing Doctors **( )** Personal Use **( )** Insurance Claim **( )** Attorney/Legal
( ) Moving **( )** School **( )** Continuity of Care **( )** Other _____

Please read and initial:
_____ There are no legal claims/orders pending or in effect that prohibit, limit or otherwise restrict my ability to authorize the use/disclosure of this protected health information.
_____ I understand that, if protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
_____ I understand that a photocopy or fax of this authorization is as valid as the original.

This authorization will expire after this request is fulfilled and shall not extend beyond 180 days from the date of signature.

_____ _____
Signature of Patient or Representative **Today's Date**

_____ _____ _____
Printed Name **Phone Number** **Relationship to Patient**