YING PENG MD PhD
comprehensive neurology care

333 Corporate Drive #110
Ladera Ranch, CA 92694
(949) 215-6662 Phone
(949) 215-6663 Fax
office@pengmd.com

Diplomate, American Board in Neurology and Special Qualification in Child Neurology
Diplomate, American Board in Clinical Neurophysiology

PEDIATRIC PATIENT PACKET

General Information:

Mother's Name_____DOB _____

Father's Name_____DOB _____

Child's Name _____DOB _____Age _____ Sex_____

Home Address_____

Home Phone _____ Cell Phone _____

Email Address _____

Child's Primary Care Physician:

Name of Physician _____

Address_____

Physician's Phone Number _____ Fax _____

Who has referred this child? _____

Insurance Verification I Carrier and Eligibility Information:

If the insurance is only under the patient, please provide patient's SS# _____-_____-_____

Subscriber Name: _____DOB_____SS#: _____-_____-_____

Employer: _____ Phone # _____

Insurance Name: _____ Circle Type: HMO POS EPO PPO

Policy ID# _____ Group ID# _____Other _____

Effective Date _____

Phone # _____

Please describe why you are bringing your child to our Neurology Clinic:

_____

_____

_____

Medication History:

Please list any medications the patient is currently taking:

_____

Does the patient have any drug allergies? If so, specify below:

_____

Pregnancy, Birth and Newborn History

Mother's age at time of pregnancy _____ # of weeks of pregnancy with this child _____

Total # of pregnancy_____ Total # of live birth_____

What happened to other pregnancies _____?

Exposure to Medications and Drugs during Pregnancy _____

C-section? If yes, specify reason _____

Child's length of hospital stay after birth _____

Describe any difficulties during birth/newborn period:

_____

Developmental Delay: Describe any concerns you have regarding your child's development (such as delays in walking or talking):

_____

_____

Past Medical History: Briefly describe any past medical events your child experienced since birth:

_____

_____

Family History:

Neurological Disease: History on either the mother's or father's side of the family (include siblings, grandparents, aunts, uncles, cousins, etc.):

_____

_____

Systemic Disease:

_____

Social History:

Education and School Performance: Name of School or Center, grade, special/regular/Honor/AP, GPA:

_____

Family Situation: #of people living in the house, # of siblings and ages, any changes in the family:

_____

Welcome

Patient care is our primary priority and concern. We want your relationship with us to be a positive experience. This brief orientation has been prepared to familiarize you with our policies. If you have questions, please ask us. We believe the most important part of staying healthy is to have regular check-ups, and prompt follow up if you have any diagnostic procedures.

Appointments

Appointments should be made in advance. Please call us at (949) 215-6662 or email us at office@pengmd.com to schedule an appointment.

Cancellations

If you need to cancel an appointment, email or call 48 hours in advance and during office hours between 8 am to 5 pm Monday through Thursday and Saturdays so that the time can be given to another patient. Missing appointments can be detrimental to patient care and deprives other patients of the physician's time. Any appointment not handled in this manner will be charged a NO SHOW Fee for an amount of $100. Fee must be paid prior to scheduling another appointment.

Emergencies and After-Hours Care

If your child has an emergency call the paramedics or go to the nearest emergency room and ask the staff to contact us. Our phones are answered during our regular business hours of Monday-Thursday and Saturday between the hours of 8am-5pm. If it is after hours you can call our office and follow the prompts to page the doctor.

Updates

It is essential that we have your current information in our records. If you have an address, insurance or phone number change please inform us immediately.

Form Fee

There is a form fee for school medication forms, disability forms, IHSS, DMV, Jury Duty, Financial affairs, Narrative report and for copies of medical records. This is not the insurance's responsibility, but for the patient or their legal guardian.

Health Plans

We are participating providers for several types of health plans. While we do contract with most of the major insurances in the area, we do ask that our patients call and verify that we are in network with your specific policy. Please check with our office staff if you have questions or concerns.

Financial Policy

Co-payments are due at the time of service. If we are contracted with your health plan and you have a deductible and/or coinsurance you will be billed for your out of pocket responsibility. Payment for services that are not covered benefits under your health plan is due at the time of service. You will also be asked to pay your deductible (if applicable) at the time of service. *Non-sufficient checks (bounced checks) will be charged an additional amount of $25.00*

Patient Name (print) _____ Date _____

Patient/Legal Guardian signature X _____ Date _____

Financial Agreement (Applies to Out-of-Network Patients)

I understand that If Dr. Ying Peng is an "Out-of-Network Provider" for my insurance plan; I am financially responsible for all charges incurred for services rendered.

Patient Name (print) _____ Date _____

Patient/Legal Guardian signature X _____ Date _____

Collection Accounts

Dr. Peng exhausts all effort to research and resolve aged accounts prior to sending to an outside agency. In the event that your account is sent to a collection agency, additional fees (up to 30% additional fee and 1.8% interest daily) will incur, that are separate and are in addition to charges for services rendered by our office.

Patient Name (print) _____ Date _____

Patient/Legal Guardian signature X _____ Date _____

Authorization to Use Emails to Communicate

I authorize Ying Peng, MD Ph.D Inc. to Email me regarding my protected health information (PHI).

Patient Name (print) _____Date _____

Patient/Legal Guardian signature X _____ Date _____

Authorization to Leave Messages

I authorize Ying Peng, MD Ph.D Inc. to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party.

Patient Name (print) _____Date _____

Patient/Legal Guardian signature X _____ Date _____

Notice of Privacy Practices Acknowledgement

HIPAA regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of the information.

Patient Name (print) _____ Date _____

Patient/Legal Guardian signature X _____ Date _____

Notice of Privacy Practices

This notice is to inform you of our privacy practices and how we maintain the confidentiality of your "protected health information" (PHI). We understand that this information is personal and completely confidential so this policy is designed to explain to you how we handle your information.

Your confidentiality is maintained by restricting access only to employees who need access to your PHI in order to process services. Also we have implemented appropriate physical electronic and procedural safeguards to protect your PHI against any unauthorized use of disclosure. Our staff is required to complete and annually review a training program designed to protect your PHI.

Although there are many safeguards to protect your PHI, there are some instances where Federal and State laws allow us to use/disclose your information without your consent. They are:

1. To provide your health care services
2. To bill and collect payments for the health care services provided
3. To provide you with treatment alternatives
4. To inform you about health benefits and services
5. To remind you about your appointments
6. To complete health care operations such as to resolve an appeal or grievance
7. When required by law
8. For public health activities
9. For reports about child and other types of abuse or neglect or domestic violence
10. For health oversight activities
11. For lawsuits and other legal disputes
12. For law enforcement purposes
13. To report to coroners, medical examiners, or funeral director
14. For tissue or organ donations
15. For research
16. To avert a serious threat to the health and safety of you or others
17. For national security and intelligence/military activities
18. In connection with services provided under worker's compensation laws
19. To family members or other persons who are involved in your care or payment of care
20. To create a directory that includes your name, your location at the facility, your general condition and your religious preference when you are in an Affiliated Hospital

You may agree or object to this disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgment.

If you are a parent, you may control your minor child's PHI. There are some cases where we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even this PHI may be used or disclosed without your written authorization if required or permitted by law. All other uses and disclosures of your PHI require your written authorization.

If you need an authorization form, we will provide one for you or your personal representative to complete.

When you receive the form, please fill it out and return it to Ying Peng, MD.PHD A Medical Corporation.

You may revoke or modify your authorization at any time by notifying us in writing. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

You also have the right to review and copy any of your PHI that we possess. If you wish to see your PHI, please write to us and we will tell you when and where you can review your PHI in our possessions within our normal business hours. If you would like a copy of the information we have, please notify us in writing. If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted by applicable law. If we deny your request for review or copy of your PHI, we will explain the reason. If we do not have your PHI, but know who does, we will tell you whom to contact. If you wish to have your PHI corrected or updated, please notify us in writing as to what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also provide us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

You have the right to request an accounting of certain disclosures that we make of your PHI. Please note that certain disclosures, such as those made for treatment, payment, or health care operations, need not be included in the accounting we provide to you. We will respond to your request within a reasonable period of time, but no later than 60 days after we receive your written request. You have the right to request and receive a paper copy of this Notice.

You have the right to request restrictions on how we use and disclose your PHI for our treatment, payment, and health care operations. All requests must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality health care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI, and that additional restrictions may be harmful to your care.

You have the right to request that we provide your PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternate means (e.g., sending by a sealed envelope, rather than post card) or to an alternate address (e.g., calling you at a different telephone number, or sending a letter to you at your office address rather than your home address). We will accommodate any reasonable requests, unless they are administratively too burdensome, or prohibited by law.

We must follow the privacy practices set forth in this Notice while in effect. If you have any questions about this Notice, wish to exercise your rights, or file a complaint; please direct your inquiries to: Attention: Dr. Ying Peng.

You may contact your Health Plan with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.

We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in the Notice. We reserve the right to revise our privacy practices consistent with the law and make them applicable to your entire PHI we possess, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Unless law requires the changes, we will not implement material changes to our privacy practices before we revise our Notice. You may request updates to this Notice at any time. This Notice is effective: October 1, 2013.