REGISTRATION RECORD

Member Information

Patient Name: Last Name	First Name	Middle Initial	
Address: Street	City	State	Zip
Phone: Social Security #:	Date of Birth:	[ ] Male [ ] Female	

Responsible Party Information D.O.B. S.S.#

Responsible Party Name: Last Name	First Name	Middle Initial	
Relationship to Patient: [ ] Mother [ ] Father [ ] Legal Guardian [ ] Self			
Address: Street	City	State	Zip
Phone:			

Employer Information:

Employer Name:			
Employer Address: Street	City	State	Zip
Employer Phone Number:	Occupation:		

Linguistic Service Needs

Primary Language:	Secondary Language:
Interpreter Services Offered: [ ]Yes [ ]No	Interpreter Services Accepted: [ ]Yes [ ]No (If No – indicate who will interpret for patient)
Interpreter Services Provided By: [ ] PCP [ ] Other (If Other explain here)	Is Patient Hearing Impaired: [ ]Yes [ ]No (If Yes, indicate services offered)

Emergency Contact Information

Name:	Relationship:
Phone Number:	Message Phone:

Authorization

I hereby authorize the doctor's of ______________ Medical Clinic to be attending physicians and to administer to me any examination, treatment, and medications he/she deems therapeutic to my presenting complaint. I hereby authorize ______________ Medical Clinic to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctors all payments for medical services.

Signature of Patient/Parent/Guardian: **Date:**

Rahul Grover Inc.

8733 Beverly Blvd Suite 200
Los Angeles CA 90048

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Our practice reserves the right to change this Notice in the future.

Our Commitment To Your Privacy:
Our practice is dedicated maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:
Use and Disclosure of Your Health Information in Certain Special Circumstances:
The following circumstances may require us to use or disclose your health information:

1. To the public authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrator order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or to the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an intimate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Rights Regarding Your Health Information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or to the payment for your care, such as family members and friends. We are not required to agree to your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Rahul Grover M.D.: Phone: (310) 625-3981.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Rahul Grover M.D. (310) 652-3981.You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice Of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact Rahul Grover M.D. (310) 652-3981All complaints must be submitted in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rahul Grover M.D.: (310) 652-3981 for further information.

I hereby acknowledge that I have been presented with a copy of Rahul Grover M.D.- Pediatrics Notice of Privacy Practices.

Signature Date Name of Patient (Please Print)

Rahul Grover Inc.
8733 Beverly Blvd Suite 200
Los Angeles CA 90048

MEDICAL CONSENT FORM

This is to certify that I am the parent or guardian of

____

I authorize Rahul Grover M.D., Inc. or his representative to perform all necessary medical services provided by or on the advice of Dr. Grover and Associates, on the above mentioned child. This will continue in effect unless revoked in writing. Furthermore, it includes whenever Dr. Grover or Associates see the child whether any responsible person or I brings the child in, or if the child comes in by his or herself.

Signed by: ____

Relationship to Patient: ____________________ Date: ________________

FINANCIAL POLICY AND INSURANCE AGREEMENT

It is understood that:

I am responsible for all payment due for medical services.
If covered by an insurance company, IPA, PPO, EPO, HMO or third party which has contracted with Rahul Grover M.D., Inc. then I am responsible for payment of any co-pays, deductibles, non-covered services, and for non-payment from the insurance company for any reason.
Your insurance policy is a contract between you and your insurance company. We can bill your insurance company as a courtesy to you. However, we require that you provide us with correct information. If your insurance company has not paid your account in full within 60 days, we will attempt to re-bill a second time if needed. You have final responsibility for the cost of services rendered. Past due amounts must be paid in full before further services can be provided.
Full payment is expected at the time of service.

- We accept cash, Visa/MasterCard or checks for payment on accounts. Our Agreement with our IPA and insurance companies requires that we collect all deductibles, non-covered charges and co-payments.

There will be a $25 fee for all returned checks.

I have read the Financial and Insurance agreement and understand and agree to this Financial and Insurance agreement.

____

Signature of Guarantor or Parent/Guardian **Relationship** **Date**

CHILDHOOD LEAD POISONING EVALUATION QUESTIONNAIRE

The following questions are to be answered by the parents /guardians of children under 5 years of age.

1. Does your child live in or regularly visit a house or other location built before 1960 with peeling or chipped paint? (This can include a day care center, preschool, school, barn, home of a baby-sitter, relative, friend, etc.)

   YES NO

2. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling?

   YES NO

3. Does your child have a parent, brother, sister, housemate or playmate that is being treated or followed for lead poisoning?

   YES NO

4. Does your child live with someone whose job or hobby involves exposure to Lead? (For example, painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair.)

   YES NO

5. Does your child live near an active lead smelter or battery recycling plant or other Industry likely to release lead?

   YES NO

PATIENT NAME DATE

PARENT/GUARDIAN SIGNATURE

TB (Tuberculosis) Risk Assessment

*** You (your child) may be at increased risk for TB if you answer YES to any of the following questions:**	Date / /		Date / /		Date / /		Date / /	
1. Do you have a family member or close contact with history of confirmed or suspected TB?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
3. Do you (does your child) live in an "out of home" placement facility?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
4. Do you (does your child) have a history of confirmed or suspected HIV infection?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
5. Do you (does your child) live with any individual who is HIV positive?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
6. Have you been, or do you (does your child) live with any individual who has been incarcerated in the last 5 years?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
7. Do you (does your child) live among, or are you (is he/she) frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

* A person who is at increased risk for TB should have a yearly TB test.
(All children are tested routinely for TB at 4-5 years, 13-16 years, regardless of risk)

Name:______________________________ Date:________________