TORRANCE MEMORIAL PHYSICIAN NETWORK

FOR USE BY PATIENTS 12 -17 YEARS OF AGE

PATIENT REGISTRATION FORM

Patient Information

Patient Last Name	Patient First	M.I.	Patient Date of Birth

Primary Language	Preferred Name	Sex Assigned at Birth ☐ Male ☐ Female

Race: (check all that apply)
☐ White ☐ Black / African American ☐ Asian
☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander
☐ Decline to Answer ☐ Other_____

Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Patient's Street Address	City	State	Zip Code

Patient Phone #	Primary Care Physician

Authorized phone # for voicemail

Is there any other information you would like your physician to know? (e.g. language translator needed, preferred pronoun, blind or visually impaired, hard of hearing, etc.)

EMERGENCY CONTACT if parents cannot be reached ***(signed authorization required)***

Name:	**Relationship:**	**Preferred phone #:**

Parent Information & Guarantor person responsible for the bill

Parent 1 & Guarantor	Date of Birth	**Parent 2**	Date of Birth
Last Name First Middle Initial		Last Name First Middle Initial	
Relationship other than parent:		Relationship other than parent:	
Street Address		Street Address	
City State Zip		City State Zip	
Primary Phone Number		Primary Phone Number	
Email	SSN	Email	SSN

Insurance Information

Primary Insurance Company	Member ID	Group#	Date of Birth

Subscriber's Full Name	SSN	Relationship to Patient

Subscriber's Address

Subscriber's Employer Name	Subscriber's Employment Status ☐ Full Time ☐ Part Time ☐ Retired Date: _____

Subscriber's Employer Address	City	State	Zip Code	Employer Phone ( )

Secondary Insurance Company	Member ID	Group#	Date of Birth

Subscriber's Full Name	SSN	Relationship to Patient

Subscriber's Employer Name	Subscriber's Employment Status ☐ Full Time ☐ Part Time ☐ Retired Date: _____

Acknowledgement: By signing below, I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Torrance Health Association DBA Torrance Memorial Physician Network to provide any and all medical treatment to myself or my dependent.

_____	_____	_____
Parent/Guardian (Please Print)	Signature of Parent/Guardian	Today's Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge you have been provided our Notice of Privacy Practices.Our Notice of Privacy Practices tells you how we may use and disclose your protected health information. Signing this form does not mean you agree or disagree with our Privacy Practices.It simply means we have provided information about our Privacy Practices to you.

We may change our Notice of Privacy Practices from time to time. If we change our Notice, you canfind a copy of the new Notice on our website at tmphysiciannetwork.org or by contacting us. We will also keep a copy of the current Notice posted in our facilities.

If you have questions, please contact the Privacy Office:

Torrance Memorial Physician Network
23326 Hawthorne Boulevard, Suite 200
Torrance, CA 90505
Phone: 310-517-1165 ext. 71165

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and that I am authorized to attest to this as the individual or legal representative by my signature recorded electronically on the signature notepad.

Patient name (please print) _____ Patient / Patient Representative signature _____

If Representative, give relationship _____

Date (MM/DD/YYYY) _____ Time _____

STAFF ONLY:

If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain their acknowledgement, and the reasons why it was not obtained:

- ☐ Patient is unresponsive
- ☐ Patient is injured
- ☐ Patient refused
- ☐ Patient unable to sign/no family at bedside
- ☐ Other

(specify)_____

Staff name (please print) _____ Staff signature _____

Date (MM/DD/YYYY) _____ Time _____

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FINANCIAL & ASSIGNMENT OF BENEFITS POLICY

We would like to thank you for choosing Torrance Memorial Physician Network for your healthcare. Please ask for clarification if needed, and sign in the space provided. A copy of this agreement will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the physician/provider.

Regarding Insurance Billing

You are responsible to provide accurate insurance information for covered healthcare services. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for payment in full. We will bill your insurance company as a courtesy. It is your responsibility to know your benefits and how they will apply to your treatment by the physician/provider. We do not have access to the details of your insurance policy.

Your co-insurance and/or unmet deductible is your financial responsibility. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or co-insurance, and service amounts. All co-pays will be collected at the time of service. If you are scheduled to have a surgical procedure you may be required to pay a deposit. Any deposits will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You may forfeit part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the physician's care team for further details regarding this deposit.

Form Fees

There is a fee (per form) for completing disability, insurance, and/or medical imaging copies. Payment is due when the form is completed. Please allow 5 business days to complete the form(s). For a full list of fees, please see receptionist.

Assignment of Benefits

I hereby assign and convey Torrance Health Association, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Torrance Health Association (THA), DBA Torrance Memorial Physician Network (TMPN) for any equipment or services (i.e., provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to THA/TMPN any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from THA or its attorneys in order to claim such medical benefits.

I understand that by signing this form, I am accepting financial responsibility for all services that I receive.

Patient's Name (Please print) _____ Date of Birth _____

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

Relationship to Patient _____

TORRANCE MEMORIAL
PHYSICIAN NETWORK

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION & CONSENT TO TREAT

Completion of this document authorizes the disclosure and/or use of your medical information. Failure to provide all information requested may invalidate this Authorization.

This Authorization is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

I acknowledge and understand that Torrance Memorial Physicians will not accept patients whose parents refuse immunizations for their children. If it is NOT my intent to vaccinate my child, I agree to seek a pediatrician outside of the Torrance Memorial Physician Network for care. Initials _____

I, _____ as the parent/guardian of the minor patient, _____ (the "Patient"), and hereby authorize the individual identified below to (check all that apply):

- ☐ To act as my agent to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, Torrance Memorial licensed physician(s) and/or midlevel provider(s) to the Patient, whether such diagnosis or treatment is rendered at the doctor's office or at the hospital.

- ☐ To receive any and all of the Patient's Protected Health Information (PHI) to which I am entitled to as the Patient's parent/guardian pursuant to all applicable state and federal laws and regulations.

Name: **Relationship:**

_____ _____

PLEASE USE ONE AUTHORIZATION PER INDIVIDUAL DESIGNEE

I understand that this Authorization is given in advance of any specific diagnosis, treatment, or hospital bare being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a Torrance Memorial licensed physician and/or midlevel provider recommends.

This Authorization is given pursuant to the provision of Family Code Section 6910.

_____ _____
Patient's Name (Please print) Patient's Date of Birth

_____ _____
Parent/Guardian (Please print) Today's Date

_____
Signature of Parent/Guardian

This Authorization shall remain in effect unless and until which time I it is revoked. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Torrance Memorial Physician Network
ATTN: Privacy Officer
23326 Hawthorne Boulevard, Suite 200
Torrance, CA 90505

Revocation. You have the right to revoke this Authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this Authorization, before the time you revoke it. The Revocation Form is available upon request.

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PRIVACY QUESTIONNAIRE – PEDIATRICS

Patient's Last Name	First	Middle Initial	Date of Birth ___/___/___ mm dd yyyy

1. Please list any persons other than your child's biological parents, members or other persons, if any, who may accompany your child and consent for treatment, and whom we may inform about your child's general medical condition or diagnosis (including treatment and healthcare operations):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. Please list the family members or other persons whom we may inform about your child's medical condition ONLY IN AN EMERGENCY:

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

3. Please list the name(s) of persons who are specifically **NOT** allowed to consent for treatment or be informed about your child's general medical condition or diagnosis. **If a child's parent is listed please provide us with a copy of legal documents regarding custody or specific restrictions.**

   Name: _____ Name: _____

_____ _____

Signature of Patient ≥18 years of Age/Parent/Legal Guardian Today's Date

_____ _____

Name of Parent 1/Legal Guardian 1 (Please Print) Relationship to Patient

_____ _____

Name of Parent 2/Legal Guardian 2 (Please Print) Relationship to Patient

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COMMUNICATION PREFERENCES & CONSENTS

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

This form shall explain the different methods of communication a patient may choose from. It is important to note that not all communication preferences perform in the same manner.

Important to note: Statement of Adolescent Patient Rights. Confidential health care means certain information from the 12 -17 year old patient's (the "Adolescent Patient") Torrance Memorial visit will be discussed only between the Adolescent Patient and the Adolescent Patient's care team. However, someone must give consent for the Adolescent Patient to receive health care at Torrance Memorial.

The Adolescent Patient can receive health care ***without*** a parent/guardian's consent for:

- Sexually transmitted infections
- Contraception
- Pregnancy-related issues
- Substance abuse treatment
- Mental health concerns

These services do not require a parent/guardian to be present at the medical visit, and Torrance Memorial will keep these visits confidential, except if the Adolescent Patient is going to self-harm or harm others.

General health care for ***all patients under the age of 18 years***, including sports physicals and illness treatment, require the consent of a parent/guardian and the parent/guardian must be present.

MyTorranceMemorial Patient Portal provides teens with full access to their own electronic health records**.** Teens may also appoint parents or legal guardians as their proxy, granting access to **certain** information on their account. MyTorranceMemorial Patient Portal provides access to online appointment requests, the ability to send messages to the office and online access to vaccine records and messaging. PLEASE SEE FRONT DESK FOR MORE INFORMATION ON OUR PATIENT PORTAL.

Texting. This authorization allows us to communicate through our Automated Appointment Reminder, Messaging and Survey System. By providing a cell phone number we will automatically enroll you in these systems.

☐ Yes – Please communicate with me by text message for reminders and surveys. My cell phone number is _____. I will let you know right away if my cell phone number changes.

☐ No – Please do not communicate with me or my parent/guardian by text message.

Voicemail. This authorization allows Torrance Memorial to leave voicemail messages at a designated phone number. To protect your confidentiality, we will not leave detailed messages or messages with any other individual unless you specifically give your permission in writing to do so, using the "Authorization for Use or Disclosure of Medical Information" form.

☐ Yes – Please communicate with me by private phone number. My phone number is _____. I will let you know right away if my phone number changes.

☐ No – Please do not communicate with me or my parent/guardian by private phone number.

Consent to Photography I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purposes of my diagnosis or treatment or for Torrance Memorial operations, including security, peer review, education, or training programs.

☐ Yes, I consent. ☐ No, I do not consent.

Disease Registries and California Immunization (CAIR) Registries are computer-based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals to assess needs and avoid redundant immunizations and control disease outbreaks. Torrance Memorial shares information with CAIR Registries. Additional information can be found at https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-updates-disclosure.aspx

Open Payments Database Notice. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov .

Revocation. You have the right to revoke authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this authorization, before the time you revoke it. A Revocation Form is available upon request.

Patient Name (Please Print)	Date of Birth
Parent/Guardian Name (Please Print)	Today's Date
Parent/Guardian Signature	