WELCOME TO "UNIQUE PEDIATRICS"

DEAR PARENTS,

As your pediatrician, I request your patience & cooperation so as to give your child appropriate & timely medical care. Please feel free to discuss any concerns with my staff in order to serve your child's best interests. I will address your concerns.

1-FOR ALL ROUTINE/URGENT CONCERNS OR APPOINTMENTS CALL:

(760) 776-5620 (INCLUDING AFTER HOURS) / FAX: (760) 776-5626
HOURS: MONDAY – FRIDAY 9:00 AM – 4:30 PM
CLOSED FOR LUNCH (11:30 AM – 1:30 PM)
*Hours Subject to change seasonally
AFTER HOURS: Press "0" to transfer to Pediatrician on Call.
To leave voice message for office staff, Press 3.

CALL 911 FOR EMERGENCIES! After Hours Messages will be evaluated for the next available Same Day appointment. If urgent care is needed, your child may be triaged to the Emergency Room or Urgent Care clinic for services not available in our office. Seek urgent care if your child has pain for >2 hours or other extreme condition per our handout regarding SICK CARE.

2-ADDRESS:

39000 BOB HOPE DRIVE – KIEWIT BLDG, SUITE 211
RANCHO MIRAGE, CA 92270

ERNESTO REYES MILLAN, M.D.
MEDICAL DIRECTOR

Dr. Millan is and Indio High School, Class of 1979 Graduate. He attended the University of California, Irvine for undergraduate studies. Medical training was completed at Boston University School of Medicine in 1988. In 1984, Dr. Millan entered the Naval Medical service completing his pediatric training at Portsmouth Naval Hospital and Children's Hospital of the King's Daughters, Norfolk, Virginia. Dr. Millan, from1991-94, served as the pediatric consultant for the Family Practice Department, Newport Naval Hospital, Newport, Rhode Island. He returned with his family to the Coachella Valley in July 1994 and is currently affiliated with Eisenhower memorial Hospital. Dr. Millan is a fellow in the American Academy of Pediatrics and certified by the American Board of Pediatrics.

ANN L. PINNING, FNP- BC
FAMILY NURSE PRACTITIONER

Ann Pinning is highly qualified for assisting me in caring for your child(ren). I have worked with her at JFK Memorial Hospital since 1995 and have noted her care as thorough, friendly and thoughtful. She has demonstrated excellent well child and critical care skills. She obtained her Nursing Credentials at Pacific Lutheran University, Tacoma, WA in 1981. She completed the Nurse Practitioner Program at California State University; Dominguez Hill, CA may 1999. She has been with us since July 1999. I fully expect that you will be pleased with her care.

CONTINUED

Please review the "Sick Care" handout before calling for advice. Note which is your medical group. Notify our office if you need a follow up visit after going to the Urgent Care clinic or Emergency Room.

If you "WALK IN" without a pre-arranged appointment or "TARDY" by 15 minutes, expect to be scheduled / rescheduled for the next available "Same Day" appointment. If no appointments are available, then you will be referred to your designated urgent care clinic. The option of rescheduling for the next day may be inappropriate for issues of breathing problems, fever or extreme pain.

WE WORK BY APPOINTMENTS ONLY

Schedule for WELL CHILD VISITS / IMMUNIZATIONS:

Birth					HepB1	
2 Week	No Vaccination					
2 Month	DTaP1	HIB1	IPV1	Prevnar1	HepB2	RotaTeq1
4 Month	DTap2	HIB2	IPV2	Prevnar2		RotaTeq2
6 Month	DTaP3	HIB3	IPV3	Prevnar3		RotaTeq3
9 Month					HepB3	
12 Month				MMR1-VARIVAX1		HepA1
15 Month	DTaP4	HIB4		Prevnar4		
18 Month						HepA2
24 Month						Vaccine Catch Up
36 Month	No Vaccination					
4-6 Year	DTaP5		IPV4	MMR2-VARIVAX2		
11-14 Year	Tdap Booster		MCV1	HPV series		
16 Year			MCV2	MenB series		

HPV is offered from ages 10-18 years with the second dose 2 months after the first and the third dose 4 months after the second.
Physical exams are routinely needed annually as of 2 years of age until 18 years old.

DTaP (Diphtheria, Tetanus, Pertussis)
HepA (Hepatitis A)
HepB (Hepatitis B)
HIB (H. Influenza vaccine)
HPV (Human Papilloma Virus vaccine)
Tdap (Tetanus, Pertussis)
MenB (Meningococcal Type B vaccine)
IPV (Polio)
MMR (Measles, Mumps, Rubella)
Prevnar (Strep Vaccine)
RotaTeq (Rotavirus vaccine)
Varivax (Chicken Pox vaccine)
MCV (Meningococcal Quad. Vaccine)

Thank you,

ERNESTO R. MILLAN, M.D. & ANN L. PINNING, C.F.N.P. (Revised October 2016)

Unique Pediatrics
39000 Bob Hope Dr.-Kiewit Suite 211-Rancho Mirage, CA 92270
Ernesto R. Millan MD-Tel: (760) 776-5620-Fax: (760) 776-5626-After Hours Urgent: (760) 776-5622
COVID-19 testing Hotline: (760) 837-8988

FEVER CARE (Temp >100.4):
Don't be afraid of fever, it is your child's method to fight an infection. Many illnesses have mild fever for 2-4days. For temperatures in armpit, add 1 degree to compare to rectal/oral/ear temperatures. Use armpit temps to screen for fever. Check rectal, oral, or ear to confirm fever. Use an ear thermometer on children >6 months of age. Normal temps in rectum/oral/ear range from 97.6-100.3 F. Start a fever reducer for temp >102.0 F.
Acetaminophen (Tylenol-Panadol) about 8mg/lb every 4-6 hours. Max of 500-650 mg/dose for adolescent.
Ibuprofen (Motrin-Advil) about 8mg/lb every 6-8 hours*Must be >6mos. age*Max of 200-400 mg. dose for adolescent.
Call Office: Child <3 mos. age with any detected fever warrants urgent care!
Child >3 mos. Age needs urgent care if fever is >104.0 F for more that 3-4 hrs. and tried acetaminophen, ibuprofen, and 15 min lukewarm bath. Schedule routine appt. for fever of 100.4-103.9 F by 3rd or 4th day or if fever >102.0 F for more than 12 hrs.with acetaminophen or ibuprofen. (Try switching meds by 8-12 hrs.)

MINOR COUGH AND COLD:
This minor viral illness usually resolves by 7-14 days. The 1st 3-4 days are the worst for cough & congestion.
Child<2yrs.-For congestion use humidifier or nasal suction with nasal aspirator 2-3 x's/day, don't overdue suctioning. Consider 1-2 saline drops (1/4 tsp salt per 8 oz. water) to loosen mucus. Remember 1 nostril at a time. For cough use warm liquids (breast milk, formula, water) to soothe irritated throat. I usually don't recommend meds as they are stimulants & can cause irritability, however, Zarbee's makes a natural cough suppressant with honey for children >12 mos. age and Agave for babies <12 mos. age.
Child>2yrs.-For congestion and cough use pseudoephedrine (Dimetapp, Sudafed, etc.) and dextromethorphan (Robitusin DM, Triaminic DM, etc.) Cough drops can be a choking hazard for those under 5 yrs. of age. Buy Children's syrup, it's the cheapest. >2yrs old give full-recommended dose every 4-6 hrs. as needed.
Call Office: Schedule an apt for nasal discharge 7-10 days/prolong or repeat onset of fevers/worsens during 2nd week of illness or ill for >2wks/severe sore throat without cough could be strep. Urgent care for rapid difficulty breathing/chest pain/prolong, intense, or frequent coughing spasms/restricted breathing with unusual sounds of wheezes (when exhales) or stridor (when inspires) cyanosis (bluish) discoloration.

VOMITING ILLNESS CARE:
Do not start diet change unless noted recurrent or persistent vomiting. For example 4-6 episodes over 4 hours observation. Most vomiting illness resolves by 1-2 days. I don't recommend meds to inhibit vomiting as care may be delayed for emergencies. Most meds for vomiting have side effects of drowsiness, dizziness, and abnormal facial movements.
If needed: Restrict all liquids and solids for 1 hour. Then reintroduce clear liquids (water, juice, Gatorade, pedialyte, Jell-O water, and gelatin) at 1oz serving per 15 min of observation for vomiting. If tolerated for 1 hour advance to 2oz servings. By 3rd hour advance top 3oz servings. If tolerated, may reintroduce **BRATT diet** (banana, rice, applesauce, tea, toast, cooked egg white, soy milk/formula, cereal, noodles, soft cooked veggies or fruit) again at 15 min intervals about 4-8 bites/serving. Resume regular diet if not vomiting for 24 hours.
For strictly breastfed infants, offer 10 mins of breastfeeding or breastfeed 1 side for 15 mins then wait 15 mins to see if tolerated. Strictly formula fed infants can be bottle-fed clear liquids for 4-8 hours.
Call Office: Urgent appts for intense abdominal pain>2hrs/green vomitus. Not tolerating above plan by 2-3 hours/ dehydration noted by dry mouth, no tears, sunken eye sockets, not urination by 12 hour intervals/lethargic-extreme sleepy behavior/vomiting >2days.

DIARRHEA ILLNESS CARE:
It's normal for infants to have frequent soiling at 2-3 hr. intervals. Older children can have 1-2 stools per day. Diarrhea (loose-watery stools) can last up to 2 wks. starting with frequency of 1 per 2 hrs. The rate of diarrhea diminishes by half every 3 days till resolved. Diarrhea of 1 per 3 hrs. (8BM's/day) warrants diet treatment similar to the above treatment for vomiting. Resume regular diet if having 1 diarrhea stool per 6 hrs. (<5BM's/day). Medicine for diarrhea? Not recommended as diet changes should be sufficient, not effective, or carry risk of hives.
Call Office: Same as vomiting instructions/bloody diarrhea/diarrhea past 2 wks. duration.

ANY CHILD WITH >2HOURS OF SEVERE PAIN NEEDS URGENT-EMERGENCY CARE!!!
ANY CHILD WITH >4HOURS OF MILD PAIN NEEDS TO BE SEEN IN 24 HOURS!!!

(revised March 2020)

Tylenol Dosing Chart:

Weight	Age	Children's Liquid 160mg In 5mL (1tsp)	Children's Tylenol 80mg In each Tab	Jr Tylenol 160 mg in Each Tablet
6-11 lbs	0-3 mos	¼ tsp / 40 mg	----------	----------
12-17 lbs	4-11 mos	½ tsp / 80 mg	----------	----------
18-23 lbs	12-23 mos	1 tsp / 160 mg	----------	----------
24-35 lbs	2-3 years	1 ¼ tsp or 200 mg	2 tablets	----------
36-47 lbs	4-5 years	1 ½ tsp or 7.25 mL	3 tablets	----------
48-59 lbs	6-8 years	2 tsp or 10 mL	4 tablets	2 tablets
60-71 lbs	9-10 years	2 ½ tsp or 12.5 mL	5 tablets	2 ½ tablets
72-95 lbs	11 years	3tsp or 15 mL	6 tablets	3 tablets
96 lbs & over	12 years	----------	----------	4 tablets

Children's Tylenol Cold, Flu & Allergy Dosing Chart:

Weight	Age	Plu Multi Symptom Cold	Plus Flu	Plus Cold	Plus Cold & Allergy	Plus Cough & Runny Nose	Plus Cough & Sore Throat
6-11 lbs	0-3 mos	----------	----------	----------	----------	----------	----------
12-17 lbs	4-11 mos	----------	----------	----------	----------	----------	----------
18-23 lbs	12-23 mos	----------	----------	----------	----------	----------	----------
24-35 lbs	2-3 yrs	1 tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL	1tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL
36-47 lbs	4-5 yrs	1 tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL	1 tsp or 5 mL
48-59 lbs	6-8 yrs	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL
60-71 lbs	9-10 yrs	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL
72-95 lbs	11 yrs	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL	2 tsp or 10 mL
96 lbs & over	12 yrs	----------	----------	----------	----------	----------	----------

Motrin Dosing Chart:

Weight	Age	Infant Drops	Children's Suspension	Junior Strength Caplets	Junior Strength Chewables	Children's Cold Suspension
6-11 lbs	0-3 mos	----------	----------	----------	----------	----------
12-17 lbs	4-11 mos	1.25 mL	----------	----------	----------	----------
18-23 lbs	12-23 mos	1.875 mL	----------	----------	----------	----------
24-35 lbs	2-3 yrs	----------	1 tsp or 5 mL	----------	----------	1 tsp or 5 mL
36-47 lbs	4-5 yrs	----------	1 ½ tsp or 7.5 mL	----------	----------	1 tsp or 5 mL
48-59 lbs	6-8 yrs	----------	2 tsp or 10 mL	2 caplets	2 tablets	2 tsp or 10 mL
60-71 lbs	9-10 yrs	----------	2 ½ tsp or 12.5 mL	2 ½ caplets	2 ½ tablets	2 tsp or 10 mL
72-95 lbs	11 yrs	----------	3 tsp or 15 mL	3 caplets	3 tablets	2 tsp or 10 mL
96 lbs & over	12 yrs	----------	----------	----------	----------	----------

Ernest R. Millan, M.D.
39000 Bob Hope Dr Suite K-211, Rancho Mirage, CA 92270
Phone (760) 776-5620 Fax (760) 776-5626

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, be kept confidential. HIPAA gives the patient significant new rights to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for the following purposes:

- **Treatment.** Providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment.** Obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health Care Operations.** Conducting quality assessment and improvement activities, auditing, cost-management analysis, and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services, which might be of interest to you.

Any other uses and disclosures may be made only with written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights, which you can exercise by presenting a written request to our office.

- To request restrictions on certain uses and disclosures of protected health information. This includes disclosures to family members, other relatives, personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or at alternative locations.
- To inspect and copy your protected health information.
- To amend your protected health information.
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this notice upon request.

This notice is effective as of January 1st, 2008 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised *Notice of Privacy Practices* from this office.

Should you feel your privacy protections have been violated, you may file a written complaint, about violations of the provisions of this notice or of the policies and procedures of our office, with this office or with the Department of Health & Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

Please contact us for more information. For more information about HIPAA contact:
The U.S. Dept. of Health & Human Services, Office of Civil Rights
200 Independence Ave. SW, Washington, D.C. 20201
Phone (202) 619-0257 or toll free (877) 696-6775.

WELCOME TO UNIQUE PEDIATRICS !

General Pediatrics—39000 Bob Hope Dr—Kiewit Suite 211—Rancho Mirage, CA 92270

Ernesto R. Millan, MD—Telephone: (760) 776-5620 Fax: (760) 776-5626

FAMILY DEMOGRAPHICS FORM

TELL US ABOUT YOUR CHILD

NAME: _____ (LAST / FIRST / MI) NICKNAME: _____

HOME PHONE #: (____) ____-____ BIRTHDATE: ____-____-____ AGE: _____ SEX: ____MALE ____FEMALE

SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____ (STREET / CITY / STATE / ZIP CODE)

WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: _____ (LAST / FIRST / MI) RELATIONSHIP: _____

DO YOU HAVE LEGAL CUSTODY? ___YES ___NO IS THE CHILD ADOPTED? ___YES ___NO IN A FOSTER HOME? ___YES ___NO

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU (EMERGENCY REFERENCE)

NAME: _____ RELATION: _____ HOME PH#: (____) ____-____

ADDRESS: _____ (STREET / CITY / STATE / ZIP CODE) WORK PH#: (____) ____-____

PARENT'S INFORMATION

PARENT'S MARITAL STATUS: ___MARRIED ___DIVORCED ___SEPERATED ___WIDOWED ___REMARRIED ___SINGLE

MOTHER:

___MOTHER ___STEPMOTHER ___GUARDIAN BIRTHDATE: ____-____-____ SS#: ___-___-____

NAME: _____ (LAST / FIRST / MI) HOME PH#: (____) ____-____

ADDRESS: _____ (STREET / CITY / STATE / ZIP CODE) WORK PH#: (____) ____-____

EMPLOYER: _____ OCCUPATION: _____

FATHER:

___FATHER ___STEPFATHER ___GUARDIAN BIRTHDATE: ____-____-____ SS#: ___-___-____

NAME: _____ (LAST / FIRST / MI) HOME PH#: (____) ____-____

ADDRESS: _____ (STREET / CITY / STATE / ZIP CODE) WORK PH#: (____) ____-____

EMPLOYER: _____ OCCUPATION: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ (LAST / FIRST / MI) RELATIONSHIP: _____

BILLING ADDRESS: (____) ____-____ _____ (PHONE / STREET / CITY / STATE / ZIP CODE)

CONTINUED ON REVERSE

ID#: _____ DATE: ___-___-____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

POLICY / GROUP #: _____ / _____ PHONE#: (____) _____-_____

ADDRESS: _____
STREET CITY STATE ZIP CODE

INSURED'S NAME: _____ BIRTHDATE: ____-____-____
LAST FIRST MI

HOME ADDRESS: _____ HOME PH#: (____) _____-_____
STREET CITY STATE ZIP CODE

EMPLOYER: _____ OCCUPATION: _____

(____) _____-_____
PHONE STREET CITY STATE ZIP CODE

AGREEMENT TO PAY FOR TREATMENT

THE PATIENT AND RESPONSIBLE PARTY HEREBY AGREE TO PAY ALL CHARGES SUBMITTED BY THIS OFFICE DURING THE COURSE OF TREATMENT FOR THE PATIENT. IF THE PATIENT HAS INSURANCE COVERAGE WITH A MANAGED CARE ORGANIZATION WITH WHOM THIS OFFICE HAS A CONTRACTUAL AGREEMENT, THE PATIENT AND / OR RESPONSIBLE PARTY AGREE TO PAY ALL APPLICABLE COPAYMENTS AND DEDUCTIBLES WHICH ARISE DURING THE COURSE OF TREATMENT FOR THE PATIENT. THE PATIENT AND / OR RESPONSIBLE PARTY ALSO AGREE TO PAY FOR TREATMENT CONSIDERED NOT COVERED BY THE THIRD PARTY INSURER.

FAILURE TO KEEP THIS ACCOUNT CURRENT WILL RESULT IN BEING UNABLE TO RECEIVE ADDITIONAL SERVICES EXCEPT FOR EMERGENCIES OR WHEN THERE IS PREPAYMENT FOR ADDITIONAL SERVICES. IN THE CASE OF DEFAULT ON PAYMENT OF THIS ACCOUNT, I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS AMOUNT OR ANY FUTURE OUTSTANDING BALANCE.

SIGNATURE _____ DATE ____-____-____

*INSURANCE COPAYS ARE TO BE PAID AT THE TIME OF CHECKING IN. YOUR VISIT WILL NEED TO BE RESCHEDULED IF YOU DO NOT HAVE YOUR COPAY.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (WE) HEREBY AUTHORIZE THIS OFFICE TO RELEASE AND DISCLOSE ALL OR ANY PART OF THE PATIENT RECORD TO:

A) ANY ENTITY WHICH IS, OR MAY BE LIABLE FOR ALL OR PART OF THE PROVIDER CHARGES.

B) REFERING PHYSICIANS, HOSPITALS, OR OTHER HEALTHCARE PROVIDERS WHICH MAY ASSIST IN THE TREATMENT OF THE PATIENT.

C) ANY ENTITY THAT WILL ASSIST IN THE REIMBURSEMENT OF BENEFITS TO WHICH I MAY BE ENTITLED.

I, (WE) AUTHORIZE AND REQUEST THAT PAYMENT OF ANY THIRD PARTY OR INSURANCE COMPANY BENEFITS BE MADE TO THIS OFFICE FOR ANY SERVICES FURNISHED TO THE PATIENT. THE SIGNATURES FURNISHED BELOW SHALL SUFFICE FOR ALL INSURANCE FORMS ON A CONTINUING BASIS.

SIGNATURE _____ DATE ____-____-____

SIGNATURE _____ DATE ____-____-____

WE ALL WISH TO PROVIDE GOOD, QUALITY AND TIMELY VISITS. PLEASE REVIEW THE FOLLOWING RECOMMENDATIONS.

PLEASE NOTE THAT THE ASSIGNED TIME FOR AN OFFICE VISIT IS "CHECK IN TIME". DEPENDENT UPON THE TIMELINESS OF INSURANCE CERTIFICATIONS, PATIENTS' TARDINESS, AND PRECEDING PATIENT NEEDS, YOUR OFFICE WAITING TIME MAY TAKE LONGER THAN EXPECTED. IF YOU WAIT MORE THAN 15 MINUTES TO ENTER A CLINIC ROOM, PLEASE NOTIFY THE FRONT OFFICE. IF YOU WAIT 15 MINUTES IN THE CLINIC ROOM, PLEASE NOTIFY THE MEDICAL ASSISTANT. AN EXPLINATION WILL BE GIVEN OR THE DOCTOR WILL BE NOTIFIED OF YOUR WAITING TIME.-- WE DO NOT PROVIDE "DRIVE IN PEDIATRIC CARE".

IF THERE IS A PROBLEM WAITING FURTHER, DUE TO CHILD'S BEHAVIOR OR OTHER PRESSING APPOINTMENTS, PLEASE NOTIFY THE OFFICE STAFF. IF ANOTHER VISIT IS NOT INCONVIENCED WE MIGHT BE ABLE TO ACCOMMODATE AN ARRANGEMENT.

THOSE WHO ARE LATE FOR CHECK IN WILL BE RESHEDULED. UNSCHEDULED WALK-INS ARE NOT APPRECIATED AND WILL BE GIVEN THE NEXT APPROPRIATE APPOINTMENT.

FAILURE TO RESCHEDULE OR CANCEL OFFICE VISITS CURTAIL OUR DELIVERY OF CARE. YOU WILL BE NOTIFIED ABOUT REPEATED "NO SHOWS" AND IF UNRESOLVED, CAN JEOPARDIZE OUR RELATIONSHIP.

UNCIVIL OR RUDE BEHAVIOR WILL NOT NE TOLERATED BY ANYONE. INITIAL: _____

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

I Understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I consent to this information being used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly or indirectly in that treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and professional certifications.

I have access to your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that you have the right to change the *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a copy of the current *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____/_____/_____

I.D.#: _____

UNIQUE PEDIATRICS
GENERAL PEDIATRICS—39000 BOB HOPE DRIVE-KIEWIT SUITE 211-RANCHO MIRAGE, CA 92270
ERNESTO R. MILLAN—MEDICAL DIRECTOR—TEL: (760) 776-5620—FAX: (760) 776-5626

NEW NO SHOW POLICY

Beginning July 1st, 2014 if you do not show for your appointment and do not call before Noon on the day before the scheduled appointment, it will be documented as a NO SHOW.

NO SHOW appointments will be handled in the following manner.

First offense:

You will have 2 weeks to reschedule a make-up Well Child Appointment.

Second offense:

Make up Well Child appointment needed for office services (Rx, SDA & Special Problem Appointments) as well as disenrollment for subsequent No Shows.

Third offense:

Three NO SHOW appointments in any 12 month period will constitute a Forced Transfer of Care. We will notify your insurance that we wish to divorce you as patients and you will need to find a new Physician.

We pride ourselves on being able to schedule and see our patients in a timely manner, however, if we have patients that habitually do not show up for their appointments, it makes it difficult for the office to run efficiently.

We thank you for your cooperation and look forward to treating your child to the best possible care we can offer.

Sign:_____ **Date:**_____