SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

Patient's Name_____Birth Date_____
Sex: M/F Ethnicity_____Birth Place_____

Family Medical History- please indicate any family member who has had any of the following:

Asthma_____Epilepsy_____Allergies_____Heart Problem_____
Alcoholism_____High Blood Pressure_____Birth Defects_____
Kidney Problems_____Cancer_____Lung Disease_____Diabetes_____
Smokes_____Drug Abuse_____Tuberculosis_____

Patient's Health History-

Major Illness_____Chronic Illness_____
Operations (date and reason)_____Fractures_____
Hospitalizations (date and reason)_____
Serious Accidents_____Allergies_____Medications taken daily_____

Child's Birth History-

Birth Weight_____Birth Length_____Vaginal_____Cesarean_____
Child born: Early / Term / Late
Problems during pregnancy_____
Complications of Birth_____

Mother-

No. of pregnancies_____Live Births_____Miscarriage/Abortion_____Surviving Children____
School History-
What school does you child attend?_____
What grade does you child attend?_____
Any school or learning problems?_____
Are you child's immunizations up to date? Yes No
Has you child received the Hepatitis B series Yes No
Comments:_____

Signature – Parent/Guardian:_____Date:_____

SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT'S HEALTH

Patient's Name:_____Date of Birth:_____
Address:_____Tel:_____
_____

I hereby authorize the office of Dr. Maria Abunto to use and disclose my health information for the purposes of healthcare operations, treatments and payment activities.

DURATION: This authorization is subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or other have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless another authorization is obtained from me or unless such use or disclosure is specifically requires or permitted by law.

Signature:_____Date:_____
If signed by other than the patient, indicate relationship:_____
Name of representative:_____

SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

GENERAL CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. Maria Abunto, to render medical services to:

Patient's Name:_____

Date of Birth:_____

The service will include examination and treatment of medical problems, administration of immunizations, arrangement of hospital care and performance of laboratory testing and procedures deemed necessary in the care of the above-named patient.

_____
Parent/Legal Guardian

_____
Indicate relationship, if other than above

_____
Date Signed

SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

Patient's Name:_____Date of Birth:_____
Address:_____Tel:_____
I hereby authorize:
_____(name of previous doctor/office)

_____(address and telephone number)

To transfer and disclose my health information (medical records, including immunization records, laboratory results, radiology reports, consultation reports) to Dr. Abunto for the purpose of continuity of care.

DURATION: This authorization shall become effective immediately and shall remain in effect to one year.

REVOCATION: This authorization is subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me unless such use or disclosure is specifically requires or permitted by law.

Date:_____Signature:_____

If signed other than patient, indicate relationship:_____

Name of representative:_____

SAN BRUNO PEDIATRICS, INC.

1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

Patient Information
Last Name:_____First Name:_____MI:___
Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____
Male / Female:_____DOB:_____Age:_____SSN:_____
Name of Medical Insurance:_____
Whom we may thank for referring you:_____
In case of emergency who should be notified:_____

Mother's information Guardian's Information (please circle one)
Last Name:_____First Name:_____MI:___
Address:_____
City:_____State:_____Zip Code:_____
DOB:_____SSN:_____
Home Phone:_____Mobile Phone:_____
Company Name:_____Phone:_____
Work Address:_____
Is your child covered under your insurance? Yes or No Name of the Medical Insurance:_____

Father's information Guardian's Information (please circle one)
Last Name:_____First Name:_____MI:___
Address:_____
City:_____State:_____Zip Code:_____
DOB:_____SSN:_____
Home Phone:_____Mobile Phone:_____
Company Name:_____Phone:_____Work Address:_____
Is your child covered under your insurance? Yes or No Name of the Medical Insurance:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____(name of the insurance company and assigned directly to Dr. Abunto all insurance benefits, if any, otherwise payable to me for service rendered. I understand thatI am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____Relationship:_____Date:_____

Privacy Practice Acknowledgement

I have been provided an opportunity to review the Notice of Privacy Practices.

Parent / Guardian Signature:_____Relationship to patient:_____

SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA.94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

Notice of Privacy Practices

Each time you receive treatment at our clinic, a record is made. Typically, this record contains your symptoms, examination observations, test results, diagnosis, treatment, and future care/treatment plans. Understanding your health information and how it is used helps to ensure that it is accurate, used and disclosed appropriately, and that you make informed decisions when authorizing disclosures to others.

Per HIPAA (*Health Insurance Portability & Accountability Act*) guidelines, all clinics are required to provide patients with their privacy practices. This describes how medical information about you may be used and disclosed and how you can get access to this information.

No information about your condition will be given to employers, friends, or relatives without your permission (except if required by a court of law). We want you to fully understand your condition and your treatment. If you do not understand something, please feel free to ask questions. Also, your suggestions or complaints are important to us because we are interested in ways that we might improve our services.

By my signature below, I acknowledge (please check only one):

☐ I have been notified of the availability of the *Privacy Practices*, but decline a copy at this time, knowing it will be provided to me if requested.

☐ I would like to receive a full copy of the *Privacy Practices*.

_____ _____
Patient/Guardian Signature Date

Furthermore,

I authorize the physician and/or office staff permission to discuss my health condition with the designated individual(s) below (i.e. guardian, spouse, etc.) who may request/need to be informed about my condition.
☐ Yes ☐ No

Name(s) of allowed individual(s): _____

SAN BRUNO PEDIATRICS, INC.
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA.94066
P (650)-873-4545 F (650)-873-4544
Maria Abunto, MD, FAAP

With a new year comes new laws that every physician should be aware of. One such law – Assembly Bill (AB) 1278 – requires physicians to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

Specifically, this new law requires physicians to do the following beginning **January 1, 2023:**

"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."

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

Under this law, a violation of these requirements constitutes unprofessional conduct. The requirements created by this law do not apply to a physician working in a hospital emergency room. For additional information, please see the text of AB 1278 and visit the Board's AB 1278 FAQ webpage, or email us at webmaster@mbc.ca.gov.

Signature: _____ Date: _____