Welcome To Goldstar Pediatrics!

Dear Parent,

Thank you for choosing Goldstar Pediatrics as your child's medical home!

We are proud to follow the principles of being a patient-centered medical home. What this means is that we strive to provide easy access to the practice, by having appointments available on request, including same day appointments. Our patient portal also allows messages to be sent directly to the pediatrician and we will coordinate care with various specialists and help you identify the resources available to you.
Central to the success of this care is that we work together as a team.
Please call the office before you decide to go to the Urgent Care or Emergency Room for non-life-threatening health issues and notify the office immediately in the event that your child receives any care outside the practice. This enables us follow up with you and make necessary updates to the medical record.

Please note that Goldstar Pediatrics is dedicated to the health and safety of all our patients and will not accept any children into the practice whose parents have made the choice not to vaccinate.

For your convenience, the office is open on Monday, Wednesday and Friday from 8am to 5pm and on Tuesday and Thursday from 9am to 6pm. To enable you get in and out of the office without long delays, please fill out any paperwork necessary before the visit. If you are unable to do so, please arrive at least 30 minutes before your visit to complete your forms in time for your appointment.

Before your first visit, please complete the Authorization for Release of Medical Information and submit this to your child's previous doctor or clinic so all old medical records can be transferred to Goldstar Pediatrics.

Please allow 3 business days for the completion of any forms or letters submitted for the doctor's review.

We are glad to have you join us at Goldstar Pediatrics!

goldstar pediatrics

15290 Summit Avenue, Suite B
Fontana, CA 92336
Tel: (909) 225-1900 Fax: (909) 663-9072

Authorization for Release of Medical Information

Patient Name: _____ DOB: ___/___/_____

I, _____ hereby authorize the release of medical information TO:

Goldstar Pediatrics
15290 Summit Avenue, Suite B**,** Fontana CA 92336
Tel: (909) 225-1900 - Fax: (909) 663-9072

FROM:

Doctor/Clinic/Hospital: _____
Address: _____
_____
_____
Telephone Number: _____
Fax Number: _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports
___Other (specify): _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Tests for antibodies to HIV _____ (initial)
HIV Diagnosis and Treatment _____ (initial)
Genetic Information _____ (initial)

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Patient Name: _____ DOB: ___/___/_____

Purpose of disclosure:
___ Treatment/ Ongoing medical care
___ Coordination of care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid for 1 year from the day on which it is signed.

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective as valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature: _____ Date: ___/___/_____

Print Name: _____

Relationship to Patient: _____

Witness Name: _____Witness Signature: _____

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Consent to Treat

Patient's Name _____ Date of Birth __/__/_____

Please sign **one** of the options below.

OPTION 1

I authorize Dr. Tackie or any Goldstar Pediatrics' provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I authorize that my child may be treated in my absence. I understand that I am responsible for settling any costs arising from this care provided in my absence.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

For patients 16 years and older ONLY:
The patient listed above may present and be treated unaccompanied by an adult. Yes/No

Signature: _____ Date __/__/_____

Relationship: _____

OPTION 2

I authorize Dr. Tackie or any Goldstar Pediatrics' provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I do not authorize that my child be treated in my absence. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: _____ Date __/__/_____

Relationship: _____

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Patient and Family Information

Child 1: Last Name:_____ First Name:_____ MI: ____

DOB:_____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 2: Last Name:_____ First Name:_____ MI: ____

DOB:_____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 3: Last Name:_____ First Name:_____ MI: ____

DOB:_____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Child 4: Last Name:_____ First Name:_____ MI: ____

DOB:_____/____/_____ Sex: M / F Preferred Language: _____

Race: ☐ African American ☐ American Indian or Native Alaskan ☐ Asian

☐ Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

Pharmacy Name: _____ Pharmacy Phone #: _____

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Child(ren)'s parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widow(er) ☐ Other

Custodial Parent (Patient lives with this parent):

Name:_____ Relationship to Patient: _____

DOB:____/____/____ Home phone:_____ Cell phone: _____

Work phone:_____ Email: _____

Employer:_____ Occupation: _____

Best number to reach me is: ☐ Home ☐ Cell ☐ Work

Goldstar Pediatrics may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Portal

Goldstar Pediatrics may leave messages or lab results via: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Portal Initials_____

Home address:

_____

(Street) *(City/State/Zip)*

Guarantor (Bill this parent):

Name:_____ Relationship to Patient: _____

DOB:____/____/____ Home phone:_____ Cell phone: _____

Work phone:_____ Email: _____

Employer:_____ Occupation: _____

Best number to reach me is: ☐ Home ☐ Cell ☐ Work

Goldstar Pediatrics may contact me via: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Portal

Goldstar Pediatrics may leave messages or lab results via: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Portal Initials_____

If you do not live with the patient, please provide the address (please disregard if same as Custodial Parent):

_____

(Street) *(City/State/Zip)*

Would you like to sign up for My Kid's Chart, our patient portal, so you can securely view and print your child's medical record online? We will email you the link so you can sign up. ☐ Yes ☐ No

If yes, please provide email address and write legibly: _____

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Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records? Yes / No

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

Emergency Contacts, other than parents. Name & Relationship:

Name: _____ Phone: _____

Name: _____ Phone: _____

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Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

HE0328

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Financial Policy

Goldstar Pediatrics participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what your particular benefits may be. Therefore it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be due at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Credit Card on File[i]

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Rev 02/23/2016

Administrative Fee[i]

At Goldstar Pediatrics, coordination of care is central to making sure that children get good quality healthcare. This means several hours are spent providing services that insurance does not pay for. Some of these services include processing various administrative requests, handling refill requests outside of office visits, providing after hours calls to parents, performing phone consultation with other pediatric specialists, securing medical records from other providers, providing a patient portal and filling any forms needed for school or camp without charging a fee for each form. To cover that administration, we charge a small annual fee of $40 per child up to a maximum of $100 per family.

You may choose to opt out of the annual administrative fee and pay a-la-carte for these requests instead. A $50 fee will need to be charged for each request, including any school entry, annual school physical, sports and camp physical forms and prescription refill requests made when the patient is not in the office.

Medical Record Release Fees

Requests for copies of medical records must be made in writing to the clinic. Records will be made available upon request and will be charged a nominal fee based on the number of sheets involved.

No-Show Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of $25. Repeated no-shows will result in the family being advised to transfer care out of the practice.

I have read and understood the above policy and agree to it.

Signature _____ Date ___/___/_____

Name _____

Relationship to patient _____

[i] **This policy does not apply to patients with Medicaid and Medicaid HMO insurance**

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goldstar pediatrics

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Credit Card On File Policy

At Goldstar Pediatrics, we require that a valid credit card be kept on file for all patients with commercial insurance. We understand that this may be a new concept to you and you may have questions regarding how this policy works.

Why leave a credit card on file with the practice?
We are familiar with the idea of giving our credit card information when we check into a hotel or rent a car. However, not many of us have ever had to give that information at the doctor's office. With all the changes in healthcare today, your insurance company may not always pay 100% of your medical bill to the doctor. A portion of the bill may be assigned to you as 'Patient Responsibility'. This is especially true if you have a high deductible plan in which case your insurance company does not begin to pay until you have met your deductible. Having credit card information on file allows the practice to collect payments that may become due after a patient has already left the doctor's office.

How will I know how much you are going to charge me?
Following your visit with us, your insurance company will send you a letter called the Explanation of Benefits (EOB) either by regular mail or by email.
We will also be sent a similar letter and usually receive this after you have received yours. Once we determine what part of the bill has been assigned to 'Patient Responsibility', this amount will be charged to the card on file.

For your convenience, payment may be made in cash, by card, or on the website payment portal once you receive your EOB.

If you would prefer to settle the bill in installments, please contact the office to set up a payment plan as soon as you receive the EOB to avoid having the entire deduction made at once.

Is my credit card information safe with you?
We do not store any of your sensitive card information on our servers. All information is securely housed with a secure gateway called BluePay. They are PCI-DSSI compliant and certified by all the major credit card companies. BluePay will only be used to process your payment and email you a receipt once payment is processed.

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When do I give you my credit card information?
Once you have read and signed the Credit Card Authorization Form in the office, we can then go ahead to swipe your card on an encrypted reader and return it to you immediately. With the encrypted reader, we will never be able to see all the numbers on your card. You may choose to give us your card information over the phone. We however advise that you do it in person since this is more secure.

What if I have questions?
Please speak to our staff if you have any questions regarding this policy. We will work with you if you feel there has been an error made in your bill and will refund the amount to your credit card if this is found to be the case. We will only bill what we are instructed to bill based on the EOB your insurance company sends us.

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Patient Financial Responsibility

I hereby authorize Goldstar Pediatrics to apply for benefits on my behalf for covered services rendered by the practice. I also assign my benefits and request that all payments from _____ *(insert insurance company)* be made directly to Goldstar Pediatrics. The foregoing insurance company is the *(circle one)* primary / secondary insurance for me. If the foregoing insurance company is the secondary insurance, the primary insurance company is _____ *(insert insurance)* company. I agree to assume responsibility of full payment as allowed by applicable law, in the event that:

- My insurer or self-funded employer does not pay the claim in a timely and accurate manner; or
- The insurer or payer deems the service to be either not medically necessary or to be an excluded or non-covered service; or
- The payer or insurer denies the claim for lack of timely filing or adherence to utilization or payment policies; or
- A claim is prospectively or retroactively denied due to lack of eligibility for benefits.

I certify that the information I have reported with regard to my coverage is correct. I further authorize Goldstar Pediatrics to release to said insurance company and its agents any information related to any claim.

_____ **DATE** _____

Signature

Relationship to patient_____

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Administrative Fee Form

Patient's Name _____ Date of Birth ___/___/_____

□ Please charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family).

□ Please do NOT charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family). I prefer to pay a-la-carte for services covered by the fee and understand that a $50 fee will need to be charged for **each** request, including any school entry, annual school physical, sports and camp physical forms and prescription refill requests made when the patient is not in the office.

I understand that I may switch my preference to the annual fee prior to incurring the first charge.

Signature: _____ Date: ____/____/_____

Print Name: _____

Relationship to Patient: _____

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Well Child Visit or Sick Visit?

There are many reasons a child might be brought in to see the pediatrician. In general however, these visits are either for a full physical examination in an otherwise healthy child or because the poor child is feeling unwell. And sometimes we are already scheduled for our physical, but little Johnnie wakes up not feeling well.

The Well Child Visit is exactly that – a visit for a child who is well. It is also what we usually call a physical. This is a time to follow up on normal growth, check things like hearing, vision and blood pressure, make sure development is on track and get a full head-to-toe examination. These visits are scheduled at intervals that allow the pediatrician to address age-specific issues for each child. Infants and toddlers do a lot of growing and changing in their first couple of years of life and so are seen more frequently to make sure everything is alright and if not, to address problems and treat them as early as possible.

With a Sick Visit, the pediatrician limits the visit to the problem(s) that brought the child to the office.

What then happens if your child is scheduled for a physical but is ill on the day of the visit?
When this happens, we may offer you the option to reschedule the physical for a day when the child feels better or go ahead and do both the well visit and a sick visit on the same day.

Sometimes a child being seen for a regular visit is found to have a problem that requires treatment at the time of the Well Visit. This problem is no longer considered part of the Well Visit and is treated as a Sick Visit on the same day.

Please note that while the Well Visit is covered by insurance with no co-pay, a visit that addresses a problem outside the scope of a well visit requires a co-pay. This is a requirement from the commercial insurance companies and the practice has to collect the appropriate amount at the time care is given.

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Welcome to My Kid's Chart!

Our patient portal will allow you to:

- view upcoming appointments for your child
- review a visit summary for your child's appointments, including
  - diagnoses
  - vitals (height, weight, etc.)
  - screening results (vision, hearing)
- receive lab results
- download and print a copy of your child's immunization record

In addition, you will be able to send secure messages to the office to request

- non-urgent medical advice (from the nurse)
- non-same day appointments (check-ups, follow-up appointments)
- prescription refills

These messages are responded to during normal business hours, and it may take 24 hours for a reply. You will receive a notification at the email address you provided that a new message is waiting for you in the patient portal. You can retrieve the message by visiting **mykidschart.com/goldstarpeds**.

To request an appointment . . .

You will need to provide as much specific information as possible, such as

- Patient name and date of birth
- Type of appointment needed
- Doctor you would like to be scheduled with
- Office location
- When
  - specific date or day of the week
  - time of day

Please call the office directly if you need to schedule a same day appointment or reschedule an existing appointment

To request a prescription refill . . .

You will need to provide the following information

- Patient name and date of birth
- Name of medication, including if it brand-name or generic, and dose
- Pharmacy to send refill to OR office location for pick-up

Prescription refills can take up to 72 hours before they are complete and cannot be expedited

Do not send a message if you wish to request a different medication or dose—these type of requests typically require an appointment with the Doctor who usually prescribes the medication

For more information
http://learn.pcc.com/help/my-kids-chart-users-guide/

Rev 04/08/16

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My Kid's Chart Registration

MyKidsChart.com/goldstarpeds

PLEASE PRINT CLEARLY!!!

Email address: _____

First name: _____

Last name: _____

Phone number: _____

Patients to add to account:

Name	Date of Birth

Once your account is created, you will receive an email with a temporary password that is active for 1 week. You will need to sign into the portal in order to complete your account set-up. Be sure to verify that your name appears correctly and that the names of the patients you have requested access to appear on the screen.

Please be aware that when a patient turns 18, the record for that patient automatically becomes **private**. Messages can still be sent in regards to the patient, but information in the chart cannot be viewed. After the patient is 18, he or she may grant permission to a parent or guardian to have access to the chart by completing and signing a release form. This permission can be revoked at any time at the request of the patient or at the discretion of the physician.

Signature _____ Date _____

For office use only

Date account requested	
Date account set-up	
Initials	
Temporary password	

Rev 04/08/16

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, tell your doctor or download a "*Decline or Start Sharing/Information Request Form*" from the CAIR website (http://cairweb.org/cair-forms/) and FAX or email it to the CAIR Help Desk at 1-888-436-8320 or CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

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** By law, public health officials can also look at the registry in the case of a public health emergency.*

goldstar pediatrics

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Tylenol (Acetaminophen) Doses for Children

Brand names: Tylenol and others

This medicine is used for fever and pain relief. It can be given **every 4 hours.**

Child weight and dose	Infant drops *(Use the syringe that comes with the medicine)*  *160/5 mL per teaspoon (5 mL)*	Liquid *(Use a measuring spoon or the cup that comes with the medicine. Do not use an eating teaspoon.)*  *160 mg per teaspoon (5 mL)*	Children's chewable tablets *(or child's meltaway)*  *80 mg per tablet*	Junior strength chewable tablet *(or junior meltaway)*  *160 mg per tablet*	Adult strength tablet *(Some children cannot swallow tablets.)*  *325 mg per tablet*
6 to 10 pounds (40 mg)	1.25 mL	¼ tsp	—	—	—
11 to 16 pounds (80 mg)	2.5 mL	½ tsp	—	—	—
17 to 22 pounds (120 mg)	3.75 mL	¾ tsp	1½ tablets	—	—
23 to 33 pounds (160 mg)	5 m	1 tsp	2 tablets	1 tablet	½ tablet
34 to 45 pounds (240 mg)	—	1 ½ tsp	3 tablets	1 ½ tablets	¾ tablet
46 to 56 pounds (320 – 325 mg)	—	2 tsp	4 tablets	2 tablets	1 tablet
57 to 68 pounds (400 mg)	—	2 ½ tsp	5 tablets	2 ½ tablets	1 ¼ tablets
69 to 79 pounds (480 mg)	—	3 tsp	6 tablets	3 tablets	1 ½ tablets
80 to 90 pounds (560 mg)	—	—	—	3 ½ tablets	1 ¾ tablets
91 pounds and up (640 – 650 mg)	—	—	—	4 tablets	2 tablets

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Ibuprofen Doses for Children

Brand names: Motrin, Advil, Pediaprofen and others

This medicine is used for fever and pain relief. It can be given **every 6 hours.**
Do not give to children under 6 months old.

Child's weight and dose	Infant drops *(Use the Syringe that comes with the medicine.)*  *50 mg per 1.250 mL*	Liquid *(Use a measuring spoon or the cup that comes with the medicine. Do not use an eating teaspoon.)*  *100 mg per teaspoon (5 mL)*	Children's chewable tablets *(or child's meltaway)*  *50 mg per tablet*	Junior strength chewable tablet *(or junior meltaway)*  *100 mg per tablet*	Adult strength tablet *(Some children cannot swallow tablets.)*  *200 mg per tablet*
10 to 14 pounds (50 mg)	1.250 ml	¼ tsp	—	—	—
15 to 19 pounds (75 mg)	1.875 ml	½ tsp	—	—	—
20 to 29 pounds (100 mg)	2.50 ml	1 tsp	2 tablets	1 tablet	½ tablet
30 to 39 pounds (150 mg)	—	1½ tsp	3 tablets	1½ tablets	¾ tablet
40 to 49 pounds (200 mg)	—	2 tsp	4 tablets	2 tablets	1 tablet
50 to 59 pounds (250 mg)	—	2½ tsp	5 tablets	2½ tablets	1¼ tablets
60 to 69 pounds (300 mg)	—	3 tsp	6 tablets	3 tablets	1½ tablets
70 to 79 pounds (350 mg)	—	—	—	3½ tablets	1¾ tablets
80 and up (400 mg)	—	—	—	4 tablets	2 tablets