Golden Gate Pediatrics

1 Daniel Burnham Court #330C, San Francisco, CA 94109 (415)668-0888 61 Camino Alto #107, Mill Valley, CA 94941 (415)388-6303

Child's Name _____ Birthdate _____ Today's Date _____

Gender: M F Mother's Maiden Name_____

Ethnicity: (Please Circle) White Black Hispanic Asian Other _____

Parent _____ Female Male
Last First

Legal Parent: Yes No

If Legal Parent, Birthdate _____/_____/_____

Parent _____ Female Male
Last First

Legal Parent: Yes No

If Legal Parent, Birthdate _____/_____/_____

Home address

Street _____

City _____ Zip _____

Phone_____ _____
Home Cellular

e-mail address _____

Home address

Street _____

City _____ Zip_____

Phone _____ _____
Home Cellular

e-mail address_____

Employer Information

Employer_____

Street _____

City _____ Zip _____

Phone _____

Occupation _____

Employer Information

Employer _____

Street _____

City _____ Zip _____

Phone _____

Occupation _____

Who referred you to our office? _____

Relative or friend to contact in an emergency: Name_____ Relationship_____

Address _____ Phone (_____)_____

Birth History

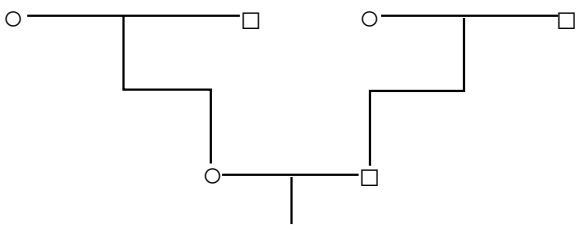
Birthplace: _____ Birth Weight _____ Normal Pregnancy? _____ Full Term? _____

Type of Delivery: _____ Apgars: _____ Problems in Nursery? _____ Breast or Bottle? _____

Family History (Circle)

- Diabetes
- Heart Disease
- Allergies
- High Cholesterol
- T.B.
- Strokes
- Deafness
- Other
- Cancer
- Mental Illness
- Kidney Disease
- Asthma
- Thyroid Disease
- Epilepsy
- High Blood Pressure

M.D. to complete



Siblings Names Age Health

1)_____ _____ _____

2)_____ _____ _____

3)_____ _____ _____

Is your child allergic to any medication? Y N

Which Medication? _____

What kind of reaction?_____

Does anyone in your family smoke? Y N

Signature of person completing form

Relationship to Patient

Completion of this side of the form is not applicable to newborn patients

Your child's developmental / behavioral history

Do you have any concerns about your child's behavior / development? ○No ○Yes _____

Sleep Problems? _____ School Performance? _____

Problems with toilet training? _____ Habits? _____

Other concerns? _____

Your Child's Medical History

Does you child have allergies to food or medication? _____

	Yes	No		Yes	No
Hospitalizations	☐	☐	Chicken Pox	☐	☐
Surgeries	☐	☐	Urinary Infections	☐	☐
Serious Illnesses	☐	☐	Chronic Ear Infections	☐	☐
Serious Injuries	☐	☐	Recurrent Strep Throat	☐	☐
Broken Bones	☐	☐	Asthma	☐	☐
Poisonings	☐	☐	Pneumonia	☐	☐
School Problems	☐	☐	Emotional/Behavioral Problems	☐	☐

Is your child on any medications?	Yes ☐	No ☐	If yes, which medications and dosages:

Are there any other problems that concern you? _____

Insurance Claim Submission

For your convenience, we will submit claims to your insurance company on your behalf. If we are not contracted with your insurance carrier or medical group, we will ask for payment at the time of service. **If you are unable to provide proof of insurance, you will be responsible for the services charged on the date of service.**

Please complete this form in its entirety. Missing information could lead to non-payment from your insurance plan and the charges for services rendered will be your responsibility.

Please note, we do not bill secondary insurance plans.

Any co-pays specified on your insurance card are due at the time of service. Failure to pay at the time of service will incur a $10.00 billing charge in addition to your co-pay. You will also be responsible for any co-insurance or deductible portions (if applicable) once the insurance plan processes the claim.

We require 24-hour advance notification for cancelled appointments. Appointments not cancelled 24 hours in advance will incur a $75.00 "late-cancellation/no show" fee.

Primary Insurance Coverage Information

Does this policy apply to all children in this practice? ◯ Yes or ◯ No

Please list below all patients in this Practice that the policy applies to:

Patient: _____ _____ _____ _____
(Last Name) (First Name) (MI) (Date of Birth)

Sibling: _____ _____ _____ _____
(Last Name) (First Name) (MI) (Date of Birth)

Sibling : _____ _____ _____ _____
(Last Name) (First Name) (MI) (Date of Birth)

Policy Holder's Name: _____ DOB: _____ Gender: M◯ or F◯

Insurance Company Name: _____

Is there a Co-Payment? _____ Co-Payment Amount: _____

Claim Address: _____

_____

Group #: _____ Identification Number: _____

Effective Date of Coverage: _____

Child's Primary Care Physician:_____

Consent to Release & Assignment:
I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Golden Gate Pediatrics, A Medical Corporation, for services rendered.
I also understand that I am fully responsible for any non-covered services, co-insurances, deductibles and co-pays per my insurance plan.

This authorization remains valid and effective from the date signed until it is revoked in writing.
I have read and understand the policies above.

Signature: _____ Date: _____

Print Name: _____ Relation to Patient(s): _____

Golden Gate Pediatrics,
A Medical Corporation

Our goal is to provide you and your family with the best care possible. In order for us to do so, we have implemented the following policies:

1. I understand that all patients must have proof of insurance by sixty days of age. For HMO's and other Managed Care plans my card **MUST** include proof that the primary care physician is a pediatrician from this office. I understand that if a Doctor other than one from this office is listed on the card I am responsible for full payment of charges until at which time I can provide proof that the Primary Care Physician has been properly changed and the effective date of that change. We cannot bill to your insurance plan if the Primary Care Physician listed is incorrect.

2. If I have no proof that my child is insured, I understand that I will have to pay in full at the time service is provided.

3. Co-payments as listed on your insurance card are required to be made at the time of service. I understand that if my co-payment is not paid at the time of service a $10.00 service charge will be assessed.

4. If I cannot keep my child's appointment, I will need to notify the office to cancel the appointment at least 24 hours prior to the appointment time. Failure to provide 24 hour notice will lead to a $75.00 "no-show/late cancellation" fee being assessed.

5. Golden Gate Pediatrics requires patients to vaccinate according to the American Academy of Pediatrics Immunization schedule. I understand that any immunization appointments that are due to a parent/patient decision to delay or split vaccines for non-medical reasons will incur a $50.00 charge. This fee is not covered nor can be billed to an insurance plan.

Signed: _____ Date: _____

Print Parent/Legal Guardian Name: _____
Last First

Print Relation to Patient: _____

Print Patient Name: _____ Patient DOB: _____
Last First

1 Daniel Burnham Court #330C, San Francisco, CA 94109
Ph. (415)668-0888 / fax (415)752-5391

61 Camino Alto #107, Mill Valley, CA 94941
Ph. (415)388-6303 / fax (415)388-7136

Effective Date: May 14, 2013

Golden Gate Pediatrics – A Medical Corporation

Patient Authorization for Use and Disclosure of Protected Health Information

Your Authorization. By providing your authorization and initials in advance, you will not need to submit written approval each time you need records (your child or yourself) as indicated below:

(Please initial those categories you would like to authorize in advance)

- o _____ **School, Camps, Sports** – any form submitted to the office for completion
- o _____ **Insurance companies** – for underwriting purposes to obtain healthcare coverage, provided signed release is attached
- o _____ **Other,** as specified: _____

What We Release. This authorization permits Golden Gate Pediatrics to use and or disclose the following individually identifiable health information about my child or myself to schools & camps; for sport participation; to insurance companies to obtain healthcare coverage, and for other purposes I specify. If "other," please describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, and origin of information.

(Please initial the type of health information we are allowed to release)

- o _____ Health information from chart notes to complete a form as indicated above
- o _____ Immunization records, to be faxed, mailed, or picked up – upon verbal request with proper ID.
- o _____ As per my request, with proper identification
- o _____ Other _____

Authorization Expiration. We will follow your instructions and complete requests to disclose PHI until authorization expires. The Practice may receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, such as record copying fees from insurance companies. This authorization will expire:

- ○ Until revoked
- ○ Other _____

I do not have to sign this authorization in order to receive treatment from Golden Gate Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 1 Daniel Burnham Court #330C, San Francisco, CA 94109.

Signed by:_____ _____ _____

Signature of Patient, Parent or Legal Guardian | Relationship to Patient | Date

_____ _____ _____

Print Name of Signer | Patient's Name | Patients DOB

Golden Gate Pediatrics, A Medical Corporation Notice of Privacy Practices

To our patients: This notice describes how health information about you 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). We will use your protected health information for treatment, payment (health plans) & operations (quality assessment, training medical students, messaging via our answering service & other operations) & other purposes permitted by law. We reserve the right to revise this Notice. Any revision will be effective for all past, present & future health information.

Our commitment to your privacy: Our practice is dedicated to 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. We will notify you if a breach of your unsecured protected health information occurs. Please contact our Privacy Officer for any questions regarding these policies.

Use and disclosure of your health information in certain special circumstances: The following circumstances may require us to use or disclose your health information without your authorization or opportunity to agree or object:

- To public health authorities and health oversight agencies that are authorized by law to collect information, including communicable disease and child abuse or neglect.
- As required by law for lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official, consistent with federal & state laws, including criminal activity.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization permitted by law to collect & receive the information.
- To federal officials for intelligence and national security activities authorized by law, as well as disclosure to Armed Forces personnel under military command, the Dept. of Veteran Affairs and foreign military command.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.
- To researchers when approved by the institutional review board and protocols ensure the privacy of your protected health info.
- To the Food & Drug Administration for quality, safety and effectiveness of FDA regulated products or activities.
- To Coroners, Funeral Directors and Organ Donation for identification, cause of death and to carry out duties including organ donation, as authorized by law.
- To Business Associates as needed to assist with our operations, such as IT services or billing, upon agreement in writing to protect your PHI.

Your rights regarding your health information

Communications: You can request that our practice communicate with you about your health and related issues in a particular matter or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

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 the payment of 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. With certain limitations, you may request an accounting of non-routine disclosures. We may use demographic information to contact you regarding fundraising activities supported by our office, provided you do not opt out. You can restrict PHI to a health plan when you pay in full for the health care service out of pocket. Please request restrictions through the Privacy Officer. 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, information complied for use in criminal, civil or administrative proceedings or laboratory results when access is prohibited by law. Decisions to deny access may be reviewable. Please contact the Privacy Officer. To obtain record copies you must submit a request in writing to: Medical Records - Golden Gate Pediatrics, 1 Daniel Burnham Court #330C, San Francisco, CA 94109.

You may ask us to **amend your health information** if you believe it is incorrect or incomplete, 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 your primary care physician. You must provide us with reason that supports your request for amendment. We may deny the request, in which case you may submit a statement of disagreement. If we do not agree, we will provide you with a copy of our rebuttal. Please contact the Privacy Officer.

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.

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 our office administrator, Mike Gangel, at (415)668-0888. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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, which you may also revoke in writing.

If you have any questions regarding this notice or our health information privacy policies, please contact: Golden Gate Pediatrics. A Medical Corporation, Attn: Privacy Officer, One Daniel Burnham Court #330C, San Francisco, CA 94109.

I hereby acknowledge that I have been presented with a copy of Golden Gate Pediatrics "Notice of Privacy Practices."

Print Patient Name _____ **Date** _____

Parent or Guardian Signature _____ **Print Parent or Guardian Name** _____

We are very excited to offer two online tools to enhance the services we provide and your experience with our practice.

1.) **Patient Portal** – online access to message us, pay your bill, retrieve immunization records, vitals, upcoming scheduled appointments and school/camp forms completed by your doctor.
2.) **CHADIS** – online system that allows you to complete developmental and screening questionnaires **<u>at home before</u>** your visit.

Please select which services you would like to opt-in for and provide the information requested below.

I would like to opt-in to: *(check all that you are interested in)*

1.) ☐ Patient Portal

☐ **I want access to online bill pay**

2.) ☐ CHADIS

<u>Please Print Clearly and Complete All Fields</u>

Today's Date: _____

Name of **User** requesting access: _____
(must be legal guardian or patient them self)

Date of Birth of **User** requesting access: _____

Signature of **User** requesting access: _____

User Relation to patient(s): _____

User E-mail address for registration: _____

Patient's Name #1: _____
Patient's DOB #1: _____ *select one:* Male ○ or Female ○

Patient's Name #2: _____
Patient's DOB #2: _____ *select one:* Male ○ or Female ○

Patient's Name #3: _____
Patient's DOB #3: _____ *select one:* Male ○ or Female ○

Golden Gate Pediatrics

A Medical Corporation

I authorize Golden Gate Pediatrics to deliver or cause to be delivered the following types of messages by voice call, text messaging or e-mail using an automated telephone dialing system or an artificial or prerecorded voice:

- Appointment Reminders
- Visit Recalls
- Situational/seasonal service suggestions (such as flu vaccine clinics)

I authorize such messages to be delivered to the following phone number or email address:

Please select ONLY ONE of the options below:

1.) Phone Number for **Text Messages**: _____

2.) Phone Number for automated **Voice Call**: _____

3.) **Email** Address: _____

I understand that by signing the agreement, I am authorizing Golden Gate Pediatrics to deliver or cause to be delivered to me certain text messages, voice calls and/or e-mails and that I am not required to sign this agreement in order to receive services from Golden Gate Pediatrics.

_____

Patient's Name(s) - (List all Patients seen at Golden Gate Pediatrics)

_____ _____ _____

Signature Printed Name Date

This consent was revoked on _____

Date