pediatric wellness group

NEW PATIENT REGISTRATION FORM

PHYSICIAN: Eileen Chan, MD Niki Saxena, MD Leslie Sue, DO Joshua Parker, MD Megan Pesyna, DO

PATIENT INFORMATION **Today's Date:** _____

Name: Last	First	Middle	Date of Birth	Social Security Number
Street Address		City	State	Zip Code
M/F	Primary Phone		Hospital of Birth	
Sibling Name			Date of Birth	M/F
Sibling Name			Date of Birth	M/F
Sibling Name			Date of Birth	M/F

PARENT #1 INFORMATION ☐ **Lives with this parent** ☐ **Send Billing to this parent**

Name: Last	First	M.I.	Male/Female	Date of Birth	Social Security Number
Street Address (If different from child)			City	State	Zip Code
Home Phone		Cell Phone		E-Mail Address	
***Employer/Occupation**				***Employer Phone Number**	

PARENT #2 INFORMATION ☐ **Lives with this parent** ☐ **Send Billing to this parent**

Name: Last	First	M.I.	Male/Female	Date of Birth	Social Security Number
Street Address (If different from child)			City	State	Zip Code
Home Phone		Cell Phone		E-Mail Address	
***Employer/Occupation**				***Employer Phone Number**	

EMERGENCY CONTACT INFORMATION *(Parents will be contacted first.)*

Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number

801 Brewster Avenue, Suite 175
Redwood City, CA 94063
650-216-7794

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Patient's Name:_____

Patient's Ethnicity:

Please circle the appropriate answer

Hispanic or Latino

Not Hispanic or Latino

Prefers not to answer

Patient's Race:

Please circle the appropriate answer

Am. Indian / AK Native

Asian

Black or African American

Native HI / Pacific IS

Prefers not to answer

White

Preferred Language:_____

Primary contact e-mail for confidential Communication / appointment reminders

_____

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PWG POLICIES

Upon registration: Please provide the following information & items: insurance card (if you are a member of one of the plans that we participate with), the name, date of birth, and address of the person who is the plan member; photo ID, address, patient's date of birth and, contact phone numbers of both parents and/or all guardians.

Working with my Insurance

I authorize PWG to submit each visit and service to my insurance company on my behalf. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize the payment of medical benefits directly to PWG.

I agree that I am financially responsible for any charges not covered by my insurance carrier for services provided by PWG including but not limited to: co-insurance, copayment and/or deductibles and agree that I am to pay any of these non-covered charges at the time of service.

I understand and agree that if my insurance company subsequently notifies PWG a rendered service is not a covered benefit for any reason on my insurance plan, I am to pay in full the amount not covered upon receipt of the patient statement ("EOB") and my credit card will be charged.

During well visits if any ADDITIONAL concerns or conditions arise, these will have additional codes and charges and therefore may require a CO-PAY at your child's well visit. Some insurance companies have changed how they process preventative services. I understand it is my responsibility to check with my insurance company for well visit coverage.

You will be required to present your insurance card at each visit. If we are unable to verify your coverage, you will be asked to fill out an unable to confirm insurance form. We participate with many different plans and simply cannot know the provisions of every patient's policy. We strongly recommend that you make every effort to understand your insurance coverage and if necessary, contact your carrier prior to receiving services in order to verify your coverage levels (such as coverage for preventative care) and copay, deductible and coinsurance responsibilities.

Non-Contracted Insurance Plans: If we are not participating with your insurance, payment is due at the time of the visit. We do not submit claims to insurance plans we are not contracted with.

Coordination of Benefits: It is your responsibility to respond to your insurance when they request information. They may request more than once a year.

Dual Insurance Copayments: Dual insurance patients are required to pay the primary insurance co-payment at the time service is rendered since we cannot always determine which secondary insurance companies will cover the primary co-payment. As a courtesy we will file the claim with the secondary insurance provided, however any follow up for payment will be the responsibility of the insured. If secondary insurance remits payment to PWG for copayment paid by patient, we will issue a prompt refund.

Initial for Working with my Insurance _____

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Credit Card Policy

PWG requires a credit card on file, which can be an HSA card or credit card for services that are not covered by your insurance, such as coinsurances and or increases in your copayment or amounts applied to your deductible.

I understand it is my responsibility to update my credit card on file when it expires or is replaced. I understand that having a credit card on file ensures payment and allows me additional time to settle my account and that credit cards are stored electronically and are encrypted.

Initial for Credit Card Policy _____

Office Hours

Business hours M-F 9:00am – 5:00pm. Services rendered outside of these times are considered after

hours and CPT codes 99050 and 99051 may apply. If my insurance does not cover these, I may be responsible.

Initial for Office Hours Policy _____

Administrative

Returned Checks: If your payment by check is returned by the bank for insufficient funds (NSF), you will remain responsible for the amount of the check plus an additional fee of $35. If more than one check is returned in any given period, we reserve the right to require all future payment by credit card or cash to prevent this situation from recurring.

Missed Appointments: Life happens, and we understand that sometimes you cannot make your appointment. Please call us at least one day in advance to cancel or change your scheduled appointment. No call to our office equals a 'No Show' and we reserve the right to charge a $50 fee to cover some of the cost of that unfilled appointment slot.

Payment by Check: Checks accepted up to $100.00. For payments larger than $100.00 we accept credit cards and cash.

Forms: The cost of researching, filling out and signing forms is not covered by health insurance. We charge a nominal $5 fee to cover the costs of completing these forms and require four (4) business days to fill them out. For forms that need to be filled out on the same day there will be a $30.00 charge. These fees may change from time-to-time.

Health insurance non-payment: We cannot carry open claims for more than 90 days, except in the most extenuating circumstances. For the plans in which we participate, services that have not been paid for by your health insurance carrier within 90 days of claim submission will be billed to you (without an invoice charge) and become your responsibility to pay in full. Should your health insurance carrier later pay us for those services, we will immediately reimburse you.

Guarantor: The parent or guardian who signs the patient's paperwork is the party responsible for all charges and payments. Due to confidentiality rules we can only bill the person who signs the practice paperwork; therefore, if the person responsible for the medical bill changes, the new guarantor must complete a new set of paperwork. Please inform us as soon as circumstances change.

Self-pay patients: If you do not have health insurance, if we are out-of-network for your insurance plan, or if you are receiving a non-covered service, payment at the time of the visit is required. We are happy to provide you with a bill after your visit is complete. You can submit to your insurance plan or keep for your records.

Divorce and Separation Decrees: Pediatric Wellness Group is not a party in divorce or separation decrees or in child support arrangements. We bill one guarantor, at one address, and expect prompt payment. We do not handle billing or insurance coverage disputes between parents.

Initial for Administrative Policy_____

Acknowledgement of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that PWG works very hard to

protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that PWG may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

PWG has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods or to an alternative location. This Notice of Privacy Practices may be updated periodically.

Initial for Privacy Practices _____

Acknowledgement of Vaccine Administration Policy

I understand that PWG will administer vaccines in accordance to the American Academy of Pediatrics Guidelines. I also understand that I will be given information about these vaccines and the opportunity to discuss them prior to administration. PWG does not accept families who do not vaccinate their children.

Initial for Vaccine Policy _____

Consent to Treat: I authorize Pediatric Wellness Group to which to provide medical care to my child and authorize treatment or care in my absence if my child is accompanied by the following care giver (check all that apply):

Grandparent(s)/Sibling:_____ Nanny/Babysitter:_____

Other:_____

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Acknowledgement of PWG Policies

Signature of Parent/Guardian: _____ **Date** _____

NAME of Parent/Guardian: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Guarantor E-Mail address_____

Name:_____

Custodial E-Mail address_____

Name:_____

PHONE NUMBER FOR FAMILY ACCOUNT:_____

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to PWG for any services furnished to my dependent or ward. I acknowledge that I am financially responsible for the accuracy of all information provided.

Parent/ Guardian Signature:_____ Date: _____

Parent/ Guardian name (Print): _____

Relationship to patient: _____

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INSURANCE INFORMATION

GUARANTOR/INSURANCE POLICY HOLDER

Name: Last	First	Date of Birth
Relationship to Patient		Social Security Number

INSURANCE INFORMATION

Name of Company:		
P.O. Box/ Address:		
City:	State:	Zip Code:
Policy Number:		Group Number:
Effective Date:		Employer:

CONSENT

CONSENT TO RELEASE:
I hereby authorize the physicians of Pediatric Wellness Group to release any and all (including dental) information to the above named insurance carrier (or to a designated attorney) for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until it is revoked in writing.

CONSENT TO ASSIGNMENT:
I hereby assign payment of medical service to Pediatric Wellness Group to which I am entitled or have incurred for medical and/or surgical services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of nonpayment to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

PLEASE NOTE: Unless accompanied by a note from a guardian, vaccinations will NOT be administered to minors.

Signature of Parent/Legal Guardian: _____ Date: _____

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PATIENT'S FAMILY MEDICAL HISTORY

Do any of the child's immediate family members - grandparents, parents, aunts/uncles, siblings - have the following or have had a history of any of the following conditions?

Please check all that apply Patient:_____

CONDITION	DON'T KNOW	NO	YES	FAMILY MEMBER
CHRONIC EAR INFECTION				
ALLERGIES: ENVIROMENTAL				
ALLERGIES: MEDICATION				
ASTHMA				
ADHD				
DEPRESSION				
ANXIETY				
LEARNING/DEVELOPMENTAL DISABILITIES				
HEART DISEASE/HEART MURMURS				
HIGH CHOLESTEROL				
KIDNEY DISEASE				
BLOOD DISORDERS(example: leukemia)				
DIABETES				
HIGH BLOOD PRESSURE				
THYROID DISEASE				
SEIZURES				
CANCER:				
SMOKING				
ALCOHOL/DRUG USE				
OTHER:				

Were you referred to our group? ☐ Y ☐ N

If so, by whom? _____

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