pediatric wellness group

NEW PATIENT REGISTRATION FORM

PHYSICIAN: Eileen Chan, MD Niki Saxena, MD Leslie Sue, DO Joshua Parker, MD Allen Eskenazi, MD

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

pediatric wellness group

INSURANCE INFORMATION

GUARANTOR/INSURANCE POLICY HOLDER

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

INSURANCE INFORMATION

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

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.

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: _____

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

Signature of Parent/Legal Guardian: _____ Date: _____

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

pediatric wellness group

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

_____

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

pediatric wellness group

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? _____

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

FINANCIAL POLICY

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, social security number and address of the person who is the plan member; photo ID, address, patient's date of birth and social security number, contact phone numbers of both parents and/or all guardians.

Health Insurance Cards: When scheduling each appointment, our team will verify your insurance information with you. Eligibility will be verified prior to or upon check-in at each appointment. Please make sure you bring your card to every appointment, and if your insurance changes, please notify us as soon as possible.

Health Insurance Plans: 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 & if necessary contact your carrier prior to receiving services in order to verify your coverage levels (such as coverage for preventive care) and copay, deductible and coinsurance responsibilities.

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

Unable to confirm your insurance or notice of premium not paid: If we are not able to confirm your insurance at the time of the visit, or we have received a notice that you have not paid your premiums from your carrier, we require a credit card be placed on file with our billing office through our secure bill pay service. If we do not receive payment after 30 days of billing, we may place the charges on the card on file. We will attempt to contact you prior to doing so.

Copayments: It is our contractual responsibility to collect your copayment at the time of your visit and it is your responsibility to pay your copayment amount at the time of your appointment. Please have your payment ready upon check-in. If you do not pay your copayment at the time of service, there will be a fee of $10 in addition to the co-pay amount per billing cycle.

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.

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.

Balances and deductibles: It is our responsibility, as detailed by the terms of our contracts with the health insurance companies that we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns as your responsibility. It is your responsibility to pay this portion of your bill. If you do not remit full payment (or call us to set up a payment plan) on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections and subject to collection fees. If you are having difficulty meeting medical bills, please let us know and we will be happy to help you by setting up a payment plan. There will be a $10 convenience fee added each month for accounts on payment plans, subject to change. We encourage you to contact our billing office via phone at (650) 260-1600, or via email at billing@pwgrwc.com, with any questions or concerns. Failure to address your financial obligations with us may result in dismissal from our practice.

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

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.

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.

Credit Card on File: We may ask you to keep your credit card information on file with our Paysimple online payment account for one of the following reasons:

- We have received notice from the insurance carrier / exchange that you are past due on your premiums.
- Your Insurance company may not reimburse us for medical services because you have not met your deductible in the current calendar year. We have no way of knowing this until we have filed an insurance claim and have been denied by your health plan.
- If you are seen in this office on a weekend or after hours we may not be able to verify your insurance coverage at that time. We will charge your credit card ONLY after we have contacted your health insurance and have verified that you do not have coverage.
- The insurance claim may be denied if we are not listed as your child's PCP at the time of the visit.

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: _____

Lorie Thomas, Privacy Officer
801 Brewster Ave., Suite 175, Redwood City, CA 94063
650-216-7794

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy if requested of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed:_____
Date: _____

Print Name: _____

Telephone: _____

If not signed by the parent, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

Name of Patient:_____

Patient Address:_____

City, State, Zip:_____