pediatric wellness group

NEW PATIENT REGISTRATION FORM

PHYSICIAN: **Eileen Chan, MD** **Niki Saxena, MD** **Leslie Sue, DO** **Roma Shah, 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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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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PWG POLICIES

Team PWG is here to provide the highest level of pediatric care and support to our patients and their families. We have implemented these policies to help us achieve those goals while being financially sustainable. Your understanding and cooperation are greatly appreciated!

- You will need to present your current insurance card at each visit for us to verify coverage. If we are unable to verify coverage you will be responsible for payment of all services provided at that visit and will be asked to complete a separate form.
- The Subscriber/Guarantor is defined as the person whose insurance covers the PWG patient for medical care. The Subscriber/Guarantor is responsible for any balance(s) on the account.
- **It is your responsibility to understand the coverage provisions of your insurance policy, we do not have that information.** We strongly encourage you to review your insurance coverage prior to receiving services at PWG and contact your carrier with any specific coverage questions.
- We are required to add the following statement per Assembly Bill (AB) 1278 that took effect 1/1/2023:

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.

Billing Policies:

I authorize Pediatric Wellness Group [PWG] to submit a bill for 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 understand that I am financially responsible for any charges not covered by my insurance carrier for services provided by PWG.

If any ADDITIONAL concerns or conditions arise during a preventative care visit/well child visit these will have additional codes and charges. We may be required by our contract with your insurance company to collect a COPAY/COINSURANCE PAYMENT for these services which needs to be paid at the time of service.

Non-Contracted Insurance Plans: Payment is due at the time of service if we are not contracted with your insurance plan. We cannot submit claims to your insurance plans if we are not contracted with that plan.

Health insurance non-payment: We make every effort to submit claims and obtain payment from your insurance carrier in a timely manner. Services that have not been paid for by your health insurance carrier within 90 days of claim submission will be billed to you and become your responsibility to pay in full. If your health insurance carrier submits payment to us after your payment, we will reimburse you.

Coordination of Benefits: It is your responsibility to complete this if requested to do so by your insurance carrier. They may request this more than once a year. **Failure to complete this may result in a denial of insurance payment for our services and you will become financially responsible for payment of all services.**

Dual Insurance Copayments*:* Dual insurance patients [patients covered by a primary and secondary insurance] will need to pay any co-payments required by the primary insurance

company at the time of service. We will submit a claim to the secondary insurance on file as a courtesy. If the secondary insurance company denies payment, then the Subscriber/Guarantor will need to work with them directly. If the secondary insurance remits payment to PWG for copayment already paid by the patient/guarantor, we will issue a prompt refund to the Subscriber/Guarantor.

Credit Card Policy:

PWG requires a credit card on file [CCOF] for services that are not covered by your insurance plan such as coinsurances, increases in your copayment, or amounts applied to your deductible. HSA cards and/or credit cards are accepted. We only accept debit cards that also have a MasterCard or Visa logo.

I understand it is my responsibility to update my credit card on file when it expires or is replaced. Credit card information is securely stored electronically and encrypted in accordance with industry standards.

Financial Policies:

I understand that once my insurance company processes my claim, I am responsible for any remaining patient balance and the credit card on file will be charged for that amount. The credit card on file may be charged prior to receiving a statement. I also agree to pay in full at the time of service for any non-covered services.

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

Self-pay patients: Payment is required at the time of service. We will provide you with a bill after your visit is complete, this can be submitted to your insurance plan or kept for your records. You may be considered self-pay if we are out-of-network for your insurance plan, if you are receiving a service that is not covered by your insurance plan, or if you do not have health insurance.

Administrative Policies:

Missed Appointments: We understand that sometimes you may not be able to keep your scheduled appointment. **It is your responsibility to notify us at least 24 hours in advance that you need to cancel/reschedule.** We will send you an appointment reminder as a courtesy using the contact information you have provided to us. It is your responsibility to ensure that information is correct**. If you do not notify us at least 24 hours in advance to cancel your appointment, you will be charged $50** for every reserved appointment time missed on that day. The $50 fee is the sole responsibility of the Subscriber/Guarantor, it is not billed to insurance, and your CCOF will be charged the day of the missed appointment.

Completing forms: This service is not covered by health insurance. Form fees are as follows:

- Standard: $10 and forms will be completed within 4 business days.
- Expedited: $40 and forms will be completed within 1 business day

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

Acknowledgement of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that PWG has implemented policies and procedures 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 healthcare 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.

The Notice of Privacy Practices contains 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.

Acknowledgement of Vaccine Administration Policy

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

Consent to Treat

For patients under 18 years of age, I authorize Pediatric Wellness Group to provide medical care to my child/children and authorize treatment or care in my absence if my child/children is accompanied by the following caregiver (please fill out all that apply). **Please note that PWG will not administer vaccines without written or verbal consent from a parent/legal guardian.**

Patient Name/DOB: _____

Patient Name/DOB: _____

Patient Name/DOB: _____

Caregiver(s)

Grandparent(s): _____Sibling(s) _____

Nanny/Babysitter: _____Other: _____

Acknowledgement of PWG Policies

I have read 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 verify that the information I have provided is accurate, and that I will be held financially responsible if I provide inaccurate information.

Patient or Parent/Guardian Signature: _____Date:_____

Patient or Parent/Guardian name (Print) : _____

Email: _____ Phone:_____

Relationship to patient(s): _____

Guarantor/Subscriber Name:_____

Guarantor/Subscriber Email Address:_____

Guarantor/Subscriber Phone: _____