UCSF Benioff Children's Physicians

Pediatric Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	**Email Address:**
What is the family's preferred language?	**Would you like an interpreter**? ☐ Yes ☐ No
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	Is the **patient** employed? ☐ Yes ☐ No If yes**, Employer Name**:
Name of Pediatrician:	**Employment Status:** ☐ Full Time ☐ Part Time

Patient Contacts	
In **case of an emergency**, please provide the **names of individuals** (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver

UCSF Benioff Children's Physicians

Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Someone Else

If 'Someone Else' please provide their **name and address**:

Guarantor's Sex:	**SSN:**	**DOB:**

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other Relative

Email Address:

Is this person **currently employed**? ☐ Yes ☐ No

If yes, complete below:

Employer Name:	☐ Full Time ☐ Part Time ☐ Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the secondary plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy and Lab?

Parent/Legal Guardian Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

UCSF Benioff Children's Physicians

Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	

Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**

Today's Date (Date of Authorization):

Email Address: ____

UCSF Benioff Children's Physicians

Phone Number(s) Authorized for Detailed Messages		
Phone Number	**Type**	**Parent/Legal Guardian**
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2

NOTE: ***Expiration of authorization automatically occurs on the patient's 18th birthday.***

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian **Today's Date**

Signature of Parent/Legal Guardian **Today's Date**

Signature of Witness (required if patient/parent/legal guardian unable to sign) **Today's Date**

Relationship to Patient

UCSF Benioff Children's Physicians

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.UBCP.org.

You may add the names of all your children on one form.

____

Printed Patient Name Date of Birth (DOB)

____

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

____

Relationship to Patient

____

Signature of Patient or Parent/Legal Guardian Today's Date (Date Noticed Received)

UCSF Benioff Children's Physicians

Terms and Conditions of Registration, Medical Services and Financial Agreement

1. UCSF Benioff Children's Physicians (UBCP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires UBCP to provide the following information to individuals who supply information about themselves. As a patient of UBCP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UBCP is authorized to maintain this information. As required by UBCP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UBCP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see UBCP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, UBCP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UBCP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UBCP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UBCP, including emergency services, at a rate not to exceed UBCP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UBCP by me.

You may add the names of all your children on one form

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name **Today's Date**

Signature of Parent/Legal Guardian or Financial Guarantor **Today's Date**

Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign) **Today's Date**

Relationship to Patient

Signature of Interpreter (if applicable) **Today's Date**

Language Used

UCSF Benioff Children's Physicians

You may add the names of all your children on one form.

Consent to Treatment of a Minor

I,____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

____, born on _______________________________
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an UBCP clinical facility. This authorization is effective from ________________________ until
(Today's Date)
consent is withdrawn.

____
Signature of Parent/Legal Guardian **Today's Date**

Other Adult Consent to Treatment (Optional)

I,____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

____, born on _______________________________
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize _____________________________________ to act as my agent to consent to any
(Printed Name Agent/Other Adult)

x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from ________________________ until consent is
(Today's Date)
withdrawn.

____
Signature of Parent/Legal Guardian **Today's Date**

According to the Affordable Care Act (ACA), your healthcare insurance should cover a well check without you having to pay a co-pay or co-insurance or meet your deductible.

We value your time and want to make the most of each appointment for your child. This is why we will address any problem that needs attention during well-child visits so that only one trip is needed. Some services that may be provided and will be billed **in addition to** preventive services include (but are not limited to):

- The doctor's work to address more than a minor problem, which will be billed as an office visit (For example, if the doctor gives a prescription, orders tests, or changes care for a known problem)
- Medical treatments (For example, breathing treatments)
- Any surgery (For example, removing foreign bodies, freezing/treating warts)

Name ____

Signature______________________________________   Date ____________________

Immunization Policy

At Almaden Pediatrics, Inc, we strongly believe in the importance of immunizations and fully support the childhood immunization schedule established by the American Academy of Pediatrics. Therefore, **our policy requires that every patient within our group receive the vaccinations listed below:**

By 18 months of age, your child will receive the following:

Type of Immunization	
Hepatitis B	3 doses
Diptheria, Tetnus and Pertussis (DTaP)	4 doses
Inactivated Polio Vaccine (IPV)	3 doses
Haemophilus influenza (HIB)	4 doses
Pneumococcal conjugate vaccine (Prevnar)	4 doses
Varicella vaccine (Chicken Pox)	1 dose
Measles, Mumps and Rubella(MMR)	1 dose
Hepatitis A	2 doses

By the age of 5 years your child will receive these additional vaccines:

A fifth dose of **DTaP**
A fourth dose of **Polio**
A second dose of **MMR**
A second dose of **Chicken Pox**

For Preteens-To be started at 11 years old:

Tetanus, Diphtheria, Pertussis (TdaP)	1 dose (Given at 10-11 yrs)
Meningococcal Vaccine	1 dose (Given at 11 yrs)
HPV vaccine (**Gardasil)**	3 doses (First dose at 11 yrs-must be completed before 13 yrs.)

By signing, I agree to follow Almaden Pediatrics Inc s' policy.

______________________________ ______________
Name Date

408-268-1122 www.almadenpediatrics.com 408-268-5215 fax
6489 Camden Avenue, Suite 102 San Jose 95120
16130 Juan Hernanadez Dr, Ste. 102 Morgan Hill 95010

Credit and Financial Policy

In compliance with the Federal Consumer Protection Act, Almaden Pediatrics wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your household/family.

Insurance:

Co-payments are due and payable at the time of visit. Almaden Pediatrics, Inc reserves the right to charge a $10.00 fee for processing of co-pays received after your visit. To avoid this, copay must be paid by end of the business day of the day your child was seen.

As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Failure to Pay Outstanding Balance

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid for 3 months without contacting our billing department to discuss payment options, the account will be turned over to a collection agency. If your account is sent to collections a charge of 25% of the amount due will be added to the balance of your account, and your child will be dismissed from the practice.

Additional Charges:

There is a $25 returned check fee in the event a patient's personal check is returned to us for any reason.

-Records Release fee- $10- 25, based on the size of the chart

- $10 fee for simple forms, $15 for complex forms. $20 for requested letters

- $5 fee for triplicate prescriptions not picked up during a visit

Missed Appointments:

Please remember that your appointment time is reserved just for you. If your appointment is missed or canceled with less than 24 hour notice, we reserve the right to charge a $40 cancellation or 'no show' fee.

Divorced Parents

Almaden Pediatrics, Inc will not get involved in custodial, separation or financial disputes involving or related to divorced parents of a minor child. The parent who is the guarantor for the policy covering the child is the responsible party for payment of services rendered. The parent bringing the child in for an appointment is responsible for that visit's copay.

The undersigned has read and agrees to the above financial credit and payment policies of Almaden Pediatrics, Inc.

Signed: ____ **Date:** ______________________

(Parent / guardian/ responsible party)

Contact Us: 408-268-1122 www.almadenpediatrics.com 408-268-5215 fax
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