Golden Gate Pediatrics

3641 California St. San Francisco, CA 94118 (415)668-0888 61 Camino Alto #107, Mill Valley, CA 94941 (415)388-6303

Child's Name ______________________________ Birthdate ______________ Today's Date ___________

Gender M F Child's Social Sec. # ______-____-________ 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 ______________________________

Employer Information

Employer____________________________________
Street ______________________________________
City ___________________________ Zip ________
Phone ________________________
Occupation ________________________________

Home address

Street ______________________________________
City ___________________________ Zip_________
Phone ________________ ___________________
Home Cellular
e-mail address______________________________

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

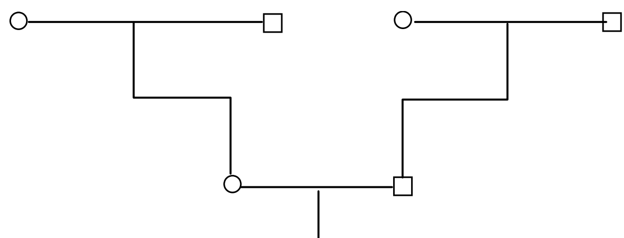
Birthplace: ______________________ Birth Weight _______________ Normal Pregnancy__________ Full Term? __________

Type of Delivery: ___________________ Apgars ___________ Problems in Nursery ?_____________ Breast or Bottle _______

Family History (Circle)

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

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 Problem	☐	☐

Is your child on any medications? ☐ ☐ If yes, which medications and dosages:

Are there any other problems that concern you? ________________________________

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____

Insurance Claim Submission

For your convenience, we can 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 entire bill on the date of service.**

Please fill out this form in its entirety, as all fields are required for proper claim submission. The form must be signed and returned to the business office or the front desk. **Make sure this form is filled out in its entirety. If not, you will receive a bill for the services rendered and the charges will be your responsibility. WE DO NOT BILL SECONDARY INSURANCE.**

If your insurance company fails to acknowledge receipt of the claim within 90 days, you are responsible for payment of the charges in full. Please be aware that you will need to carefully monitor your claims.

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

Primary Insurance Coverage Information

Patient: ______________________ ______________________ ______ ____________________
(Last Name) (First Name) (MI) (Date of Birth)

Siblings: ______________________ ______________________ ______ ____________________

Siblings: ______________________ ______________________ ______ ____________________

Policy Holder's Name: ______________________________

Policy Holder's Employer: ____

Insurance Company Name: ____

Claim Address: ____

____

Group #: __________________________ Identification Number: __________________________

Effective Date of Coverage: ____

Parent's Name & DOB: ______________________
Gender: M or F

Parent's Name & DOB: ______________________
Gender: M or F

Child's Primary Care Physician: ______________________________________

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 medical 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.

Patient Balance

Payment of the bill is the patient's responsibility and not that of the insurance company. A service charge of 1 1/2% per month will be made on balances due beyond 60 days. This represents an annual rate of 18%.

I have read and understand the policies above.

Signature: ______________________________________ Date: ____________________

Please Do Not Write Below This Line - For Office Use Only

Status	Date	Initials
Received		
Verified & Entered		
Returned for:		Date returned

Golden Gate Pediatrics – A Medical Corporation

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Golden Gate Pediatrics – A Medical Corporation to use and/or disclose certain protected health information (PHI) about my child or myself to:

(Initials)

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

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, origin of information, etc.

(Initials)

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

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. 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:

- o Until revoked
- o 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 redisclosure 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:
3641 California Street, San Francisco, CA 94118

Signed by:________________________________ ___________________________ __________
Signature of Patient, Parent or Legal Guardian — Relationship to Patient — Date

________________________________ ____________________________________
Patient's Name — Print Name of Patient, Parent or Legal Guardian

Patient/Guardian to Be Provided With a Signed Copy of Authorization

(Please Complete Other Side of Form as Well)

Golden Gate Pediatrics – A Medical Corporation

To our patients. This notice describes how health information about you (as a patient of this practice) 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 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:

Use and disclosure of your health information in certain special circumstances. The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. 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 able to prevent the threat. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
5. To federal officials for intelligence and national security activities authorized by law.
6. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
7. For Workers Compensation and similar programs.

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.

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. You must submit a request in writing to: Medical Records – Golden Gate Pediatrics, A Medical Corporation, 3641 California Street, San Francisco, CA 94118.

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.

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, Kathy Chebib, at (415)668-0137. 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.

If you have any questions regarding this notice or our health information privacy policies, please contact: Kathy Chebib, Office Administrator – Golden Gate Pediatrics. A Medical Corporation, 3641 California Street, San Francisco, CA 94118

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

If the patient is a minor:

______________________________________ __________________________________
Print Patient Name Date

______________________________________ __________________________________
Parent or Guardian signature Print Parent or Guardian Name

Golden Gate Pediatrics
A Medical Corporation

Eileen G. Aicardi, M.D.
William S. Gonda, M.D.
Martin F. Ernster, M.D.
Mary D. Piel, M.D.

Laurel J. Schultz, M.D.
Lisa G. Dana, M.D.
Dawn Rosenberg, M.D.

Our office has been dealing with numerous issues in regards to managed care. We ask for your cooperation in helping us remedy these problems.

We have been receiving a large number of claims denials because of incomplete or incorrect insurance information. Other problem areas include failure to make co-payments at the time of service and "no shows" for scheduled check-ups.

Because of these ongoing issues we have instituted the following measures effective January 1, 2001. Please read the following statements carefully, then sign and date where appropriate. Thank you for your cooperation in helping resolve these matters.

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1. I understand that all patients must have their own 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 Pediatrician other than the 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 the change. We cannot bill to your insurance HMO or Managed Care 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 check-up appointment, I will need to notify your office to cancel the appointment. If the office is **not notified** at least **24 hours** prior to the scheduled check-up there will be a **$75.00 "no-show" fee assessed**.

Signed: ______________________________________ Date: ___________________

Patient Name: _____________________________________ (Please Print)
Last First

3641 California Street, San Francisco, CA 94118
(415)668-0888 fax (415)752-5391

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