Jane M. Meill, M.D.
Kara S. Ornstein, M.D
Nancy L. Schwartzman, M.D.
Amy Stenback, M.D.
Shelley A. Palfy, M.D.
Diplomates, American Board of Pediatrics

1100 South Eliseo Dr. Ste 106
Greenbrae, CA 94904
(415) 461-8828
Fax (415) 461-3772

Acknowledgement and Receipt of Registration Documents 7/18

Patient(s) Name(s):_____

_____

Notice of Privacy Practices (HIPPA):
Marin Pediatric Associates, Inc. Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.
Copies of the current notice are available upon request from MPA and are posted on our website at MarinPediatricAssociates.com
I acknowledge that I have been given access to the Notice of Privacy Practices by signing my name in the spaces below.

✎ _____
Signature of Patient or Patient's Representative Date

_____
Print Name Relationship to Patient(s)

Please initial forms you have completed/received and sign below:
_____**Registration Forms**
Page 2: Demographic information and treatment authorization
Page 3: Financial/Billing information and assignment of benefits payable to MPA
_____**Notice of Financial Policy** (pg 4)
_____**Notice of Immunization Cost Waiver to Preferred Provider Agreements** (pg 5)
_____**Notice of Well Care Exam Policies and Charges** (pg 6)
_____**Credit Card on File Form** (pg 7-recommended)
_____**Initial History Questionnaire**
_____**Medical Records Request Form** (when applicable)

I acknowledge that I have received or completed the registration and policy forms (listed above) by signing my name in the spaces below.

✎ _____
Signature of Patient or Patient's Representative Date

_____
Print Name Relationship to Patient(s)

Patient Information DEMOGRAPHIC INFORMATION

*required for teens

Patient #1 Full Name (first, middle, last)	Gender M / F	Date of Birth	*Cell #
Patient #2 Full Name	Gender M / F	Date of Birth	*Cell #
Patient #3 Full Name	Gender M / F	Date of Birth	*Cell #
Patient #4 Full Name	Gender M / F	Date of Birth	*Cell #

Address: Street | Telephone:

City Zip | primary language(s) spoken

Mailing Address (if different)

Parent/Guardian Information

Parent #1 Full Name | Gender M / F | Date of Birth | Social Security Number

Address: Street (if different) | Telephone

City Zip | Cell phone

Employer/Occupation | Work phone

other contact info:

Fax: E-mail:

Parent #2 Full Name | Gender M / F | Date of Birth | Social Security Number

Address: Street (if different) | Telephone

City Zip | Cell phone

Employer/Occupation | Work phone

other contact info:

Fax: E-mail:

Step Parent(s):

Adults (other than parents) authorized to seek medical care for patient(s):

Primary Care Physician (please circle one)

Jane Meill, M.D. **Kara Ornstein, M.D.** **Nancy Schwartzman, M.D.** **Amy Stenback, M.D.** **Shelley Palfy, M.D.**

Consent for Treatment: **By signing below**, I authorize provision of medical care for myself (>18yr) or the above named minor patient(s) by the physicians of MPA, or their designates.

✎

relationship to patient(s): Date:

Additional helpful information:

Who referred you to our practice, or how did you hear about us?

Preferred Pharmacy:

Financial/Billing Information:

Who is financially responsible for payment of services provided by Marin Pediatric Associates?*

Name: relationship to patient(s) Social Security Number: _

Address(if different): Telephone: _

✎_____ Date: _

By my signature above, I authorize release of required information, direct payment of benefits to MPA, **AND** I acknowledge my financial responsibility for all charges incurred at MPA. 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 id no not have insurance that covers the service, I agree to pay MPA for the professional and clinic services.

Please read and sign the MPA Financial Policy that follows for a detailed listing of our policies.

***In matters of separation or divorce: By law the parent bringing the child in for care is financially responsible for the balance due. Any court order regarding responsibility for such costs are to be enforced by the courts and do not determine who we bill for a child's care.**

Insurance Information:

While we are happy to file insurance claims for our patients and assist them in resolving any disputes with their insurance companies regarding benefits, parents/guardians remain responsible for payment for services provided by MPA regardless of insurance.

If you would like us to file claims with your insurance on your behalf, ***we require ALL of the following information:***
A ***current, VERIFIABLE copy*** of your insurance card must be on file with every visit. (a $25 re-filing fee applies to any claim if information is not brought up to date at the time of the visit)

Name of the main policy holder (i.e: the subscriber or employee): Subscriber's Date of Birth:

_____

Address (if different) Subscriber's Social Security Number

_____

Insurance Company Copay (if any) Effective Date of Coverage:

_____

Summary of fees and finance charges:

To cover the administrative costs of additional billing this office will assess finance charges for the following:

Co-payments are required at the time of service: billing for co-payments ($10)

Overdue balances: ($10) rebilling/finance charge for payments not made within thirty (30) days of billing)

Insurance re-filing fee: ($25), and **Bounced (NSF) checks fee:** ($25).

NO SHOW fees: *Patients who fail to notify us of cancelled appointments at least 24 hrs in advance will be charged **a no-show fee** ($25/visit or $50/well care or extended visits).*

Bills unpaid for more than 120 days may be turned over to a collections agency unless other arrangements have been made. Accounts that are turned over to collections will result in dismissal from the practice. *If special circumstances make prompt payment impossible, payment arrangements must be approved **in advance** by our Business Office staff.*

Medical Records: Our office charges ($35-$45) for the copying and transfer of all medical records. The higher fee applies to charts with more than 25 pages of material or "rush" requests. We will continue to provide copies of immunization and growth charts at no cost.

Forms and letters: Camp/school/athletic release/prescription medication forms: $10 fee. Please allow 72 hrs for completion – we assess well care exam and immunization needs before we sign any of these forms. (fee waived if forms presented when your child is being seen for an appointment). $15 fee for letters.

Labs and other testing fees are billed separately by the individual lab or testing facility.

I have read the above summary of fees and finance charges and agree to these terms.

✎_____

Signature of Parent/Guardian Print Name of Parent/Guardian / Relationship to patient Date

Financial Policy7//18

We are committed to providing you with the best possible care. If you have medical insurance, we are happy to work with you to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and you understanding of our financial policies as described below:

Important changes impacting our insurance provider status, and billing: Effective 9/18/18 we will be a UCSF- Benioff Children's Hospital Partnership practice, and as such, providers under the umbrella of UCSF Benioff Children's Physicians (UBCP). Our status as preferred providers for all the various insurance providers should remain unchanged but the contracted relationship will be under UBCP and their Tax ID number. Any services provided prior to that date will be billed directly through MPA and our Tax ID. For a period of time, you may receive billing statements from both.

Marin Pediatric Associates, A Medical Corp. (MPA) accepts most PPO and Private Health Insurance Plans, HMO* Plans *affiliated with Meritage Medical Network (formerly the Marin IPA)*, as well as cash paying patients. While we are happy to file insurance claims for our patients and assist them in resolving any disputes with their insurance companies regarding benefits, parents/guardians remain responsible for payment for services provided by MPA regardless of insurance. It is the parents'/ guardians' responsibility to confirm with the insurance company that we are participating providers. ***All charges not covered by your insurance company are your responsibility.***

Not all services are a covered benefit in all insurance contracts. We will not always know whether a service is covered by your insurance company. Some insurance companies do not pay for well care, preventive care, exams for sports or camp, or excluded diagnoses or conditions, or immunizations (see separate Immunization waiver form). Only your insurance company can confirm your benefits with you. Please fee free to ask about the costs of these services when the appointment is made. Disputes between you and your insurance company do not affect your responsibility to pay for medical services for your child. As health care providers, our relationship is with you, not your insurance company. We follow AAP guidelines regarding routine physicals and immunizations.

*HMO patients **must** list one of our MPA physicians, or our Practice as your Primary Care Provider (PCP). Only the Primary Care Provider listed on your card will be paid for services. It is the parents' responsibility to confirm that we are listed as your PCP. *If you wish to have your child seen in our office prior to correcting the PCP assigned to your child, we will provide care on a fee-for-service (cash) basis only.*

Parents/Guardians must provide this office with current, VERIFIABLE insurance information AT THE TIME OF SERVICE if you would like us to bill the insurance for you. Most insurance companies will now DENY PAYMENT for services if they do not receive the claim within 30 days of the visit. A **$25 re-filing fee** applies any time we must resubmit a claim. **If we are unable to verify current insurance coverage at the time of your visit, payment for services is expected at the time of the visit.**

We do not bill secondary insurance (except for patients with MediCal).

Parents/Guardians are responsible for any co-payments, co-insurances, deductibles, and non-covered services. Non-covered services may include recommended vaccines, or portion of vaccine costs not covered by insurance.

This office considers the parent/guardian bringing the child in for medical attention financially responsible for any charges arising for that date of service, regardless of any custody issues. Any court orders regarding responsibility for such costs are to be enforced by the courts and do not determine who we bill for a child's care.

Payment is required for copays and services not covered by insurance AT THE TIME OF SERVICE. Failure to pay your copay at time of service will result in a **$10 finance** charge. We encourage you to complete a "credit card on file/auto-pay authorization" to avoid unpleasant finance charges. We also accept deposits to your account that we will debit automatically for copays and co-insurance charges.

We accept cash, Visa, MasterCard and personal, local checks.

I have read the above summary of financial policies and agree to these terms.

✎_____

Signature of Parent/Guardian Print Name of Parent/Guardian / Relationship to patient Date

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IMMUNIZATION COST WAIVER TO PREFERRED PROVIDER AGREEMENTS
Advance Beneficiary Notice (ABN)7/18

Note: You will need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the item(s) that are described below. Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, if your doctor recommends that you do receive this service.

Some immunizations, such as travel immunizations, new vaccines, or vaccine combinations may not be covered by your insurance company, or they may be only partially covered. In these cases, (especially with a new vaccine) insurance companies do not reimburse us for the actual cost of the vaccine. For example, on your EOB, the reimbursement listed in the "allowed amount" column may be far below our actual cost and the balance is transferred as a write-off to the "provider adjustment" column. Specifically, **Cigna and UMR's reimbursement for many vaccines (e.g.: HPV, Meningitis, Proquad, MMR, Chicken Pox) is well below our actual cost and we will bill you for your cost share to make up the difference.**

We CANNOT accept less than our cost as reimbursement for vaccinations. By agreeing to be vaccinated, you agree that you will be liable for the full cost to our office of all vaccines if that cost is not covered by your insurance. In some instances, such as for the typhoid vaccine, we WILL ask for payment in advance for the immunization.

For HMO patients, or certain PPO patients, we will provide immunizations only when reimbursement levels meet our costs (due to contractual restrictions as providers).

I have read and accept the terms for payment for vaccines given by Marin Pediatric Associates. I acknowledge that I will be responsible for the full amount of vaccination charges incurred.

✎_____ _____

Signature of responsible party date

Jane M. Meill, M.D.
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Amy Stenback, M.D.
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Routine Annual Well Care or Preventive Physical Exams 7/18

An "Annual Physical Examination", "Well Care Exam", "Routine Physical" or "Check-up" is a Preventive visit that specifically focuses on promoting health and wellness, and identifying potential health problems.

This visit is scheduled within a specific time block and will cover the following:

- Past medical, social and family history
- Personal health habits
- Complete physical exam and review of body systems
- Review of medications
- Review and update of immunizations
- Screening tests that are age/gender/personal and family history appropriate
- Review of consultations from other physicians
- Counseling, anticipatory guidance, and risk factor reduction interventions
- Completion of school, camp, daycare, or sport clearance forms

Please note: this portion of your appointment is usually covered by insurance without a copay. However, if significant time is spent during your visit addressing new or current medical problems, chronic conditions, extensive medication review and refills, or initiating new referrals or extensive lab work, your provider may bill an additional "Sick Visit" charge for this portion of the visit. This second charge for the same date of service may be subject to co-pay, co-insurance or deductible expenses.

If you have additional questions for your physician, you may prefer to schedule another appointment after your physical to allow more time to answer your questions.

I have read and understand the above policy. I acknowledge that I am responsible for any copay(s), co-insurance, deductible, and or/non-covered service(s) charges.

✎_____ _____

Signature of responsible party date

AVOID UNPLEASANT FINANCE CHARGES! KEEP CREDIT CARD INFO ON FILE!

As a convenience to our patients and to streamline billing we are offering patients the option of having a credit card on file. This card would be billed automatically for amounts determined to be "patient responsibility" by your insurance plan. It would also be used to pay your copay if your adolescent comes in alone, or another adult accompanies your child to a visit, or you forgot to pay your copay at the time of your visit. COPAYS ARE DUE AT THE TIME OF YOUR VISIT, IF NOT PAID, A $10.00 FINANCE CHARGE WILL APPLY.

Insurance companies provide you with an EOB (explanation of benefits) that should explain these charges to you. We will provide you with receipts for these payments and will continue to provide you with a statement any time, at your request.

Naturally, you can revoke this authorization for automatic payments at any time.

By completing the information below, you authorize Marin Pediatric Associates, Inc. to automatically charge your credit card as specified for the following patient(s):

Patient:_____DOB:_____
Patient:_____DOB:_____
Patient:_____DOB:_____
Patient:_____DOB:_____

We accept the following credit cards for payment: ❑Visa ❑MasterCard
Please choose one:

❑Automatically pay copays/coinsurance/deductibles/non-covered benefits
❑Automatically pay copays/coinsurance/deductibles/non-covered benefits up to a maximum of: $_____/charge

Card # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __*(* 3 digit security code on back of CC)
Expiration: _____/_____

Name on Card:_____Signature:✎_____
Billing Address:_____
(if different) City:_____State:_____Zip:_____

Date authorization received: _____ Flagged in computer: _____(date/init.)

Date authorization renewed: _____ Flagged in computer: _____(date/init.)

Date authorization REVOKED: _____ Flagged in computer: _____(date/init.)