Napa Valley Medical Group

2160 Jefferson St, Ste 260

Napa, CA 94559

Patient Information

Name of Patient			Nickname
DOB:	Age:	Sex: M / F	Pharmacy

Other Children In Family	DOB	Living in same Household

Parent Information
Email:

Parent Name	DOB	Parent Name	DOB
Address		Address	
City State Zip		City State Zip	

Phone	Work	Cell	Phone	Work	Cell
Employer Name:			Employer Name:		

Insurance Information

Primary	Policy Holders Name
Secondary	Policy Holders Name

Policy Holder Information: Relationship to patient:

DOB:	SSN:		
Address	City	State	Zip
Phone			

Person Responsible for bill

Name	Phone

Verification of Insurance coverage is required on every visit to our office. Copayments and non insurance accounts must be paid in full at the time of service. If a balance should accrue, special arrangements may be made for monthly payments, usually to have accounts paid within a 3 month period. An account is considered delinquent if no payment has been received within 60 days and will be turned over to collections.

Returned checks and balances beyond 30 days are subject to additional collection fees and interest charges of 2% per month. A $50.00 **NO SHOW** fee for **Well Checkups** and a $25.00 **NO SHOW** fee for **SICK** appointments will be charged to you in the event of a broken appointment not cancelled 24 hours in advance. A family is subject to dismissal from the practice after three **NO SHOWS.**

I hereby authorization my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of the claims.

I authorize Dr. Löffler-Barry and NVP providers to examine and administer any necessary treatment to ___________________________in the event that I am unavailable.

We are committed to providing your child/children with the best possible care. In the effort to serve you better and keep our fees to a minimum, we need your assistance and understanding of our payment policy.

We are here to manage your medical care. You are responsible to know your own health plan benefits. Your insurance relationship is a contract between you, your employer and the Insurance Company. We are not a part of that contract, except in specific Health maintenance and preferred provider organization plans of which we are members.

Should a credit balance accrue on your account; this amount will be refunded to the appropriate party or left as a credit on your account upon request.

Well exams will not be billed as sick visits when a child is well. If you do not have insurance or have Medi-cal that covers well exams, and if income qualifications are met, you may be entitled to receive state funded exams. Please feel free to ask for further information.

If you have any questions regarding the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

I hereby acknowledge that I have read and agree to the above:

___________________________________ ______________________

Signature of Parent or Guardian **Date**

Napa Valley Medical Group
2160 Jefferson Street Suite 260
Napa, CA 94559

New Policy
Effective Immediately

Due to the rising cost of providing quality care, we are now collecting deductibles and co-insurances at the time of service.

We thank you for your understanding and cooperation.

Thank you,

____
(Print Name)

____________________________ __________________
Signature Date

____

OFFICE STAFF USE ONLY

Patient and sibling account numbers

_____________ _____________ ______________

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I, ________________ authorize ________________ to bring _________________ to Dr. Löffler-Barry and NVP providers for medical treatment as needed. If there are any additional adults you would like to list, please do so in the space below.

Patients under the age of 18 will have to be accompanied by a parent or adult legal guardian. Written or verbal consent can be given for the visit by parent or legal guardian.

Thank You.

____

____

____

____
(Print Name)

____
Signature

VERBAL AUTHORIZATION

____________________	_____________________	_____________________
Employee Initial	**Employee Initial**	**Date**

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Napa Valley Medical Group
2160 Jefferson St. Suite 260
Napa, CA 94559

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifica-tions.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Pt. ____

Signature: ___________________________ Date: _________________________

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____________________ _____________________ _________________________

Date: Initials: Reason:

Napa Valley Family Medical Group, Inc

Financial Agreement

To ensure the highest quality of service and care to our patients, we have established the following financial agreement. If you have any questions, please ask a staff member.

Photo ID: The Federal Law "Red Flag" regulation now requires that we confirm your identity with your photo ID and your insurance card to prevent identity theft. Please bring your ID and insurance card to each visit. A copy will be made and scanned into your chart. This is for your protection.

Changes: You are responsible for letting us know about any change to your name, address, phone number or insurance company. We'll ask you about changes each time you come in.

Co-Pays: Co-pays are required at the time of your visit. We accept cash, checks, Visa and Master card.

Non-Covered Services: As a courtesy to you, we will bill your insurance company. We do not know what is or isn't covered by your insurance company. Consider checking your policy before your visit if you are not sure about what is covered. You are responsible for payment of whatever part of the bill your insurance does not cover.

Self- Pay Patients (no insurance): You are required to pay your bill at the time of service. The front desk staff will not be able to quote exact prices in advance. The cost will be determined by the doctor based on the treatment rendered.

Cancellations/No Shows: When possible, each patient will receive a reminder call prior to his or her appointment. We require a 24-hour notice to cancel or reschedule your appointment. You will be charged a fee of $25.00 - $50.00 if you do not let us know more than 24 hours before your appointment.

Forms/Letters/Prior Authorizations: Whenever we have to complete a form, write a letter or get prior authorization, it takes time of the staff and the doctor, so we have to charge for that. The fee ranges from $10.00 - $50.00.

Delinquent Account: After 90 days, if we do not receive full payment for your portion of the bill, we may send your account to a collection agency. As a result, the patient-physician relationship will end and you and dependant family members will have to find a new doctor within 30 days.

Hardships: If you are having financial problems and have trouble paying your bill, please call our billing office to ask for help. We want to help you, but we can't help you if we do not hear from you.
Call: 707-259-2000

ACKNOWLEDGEMENT:
By signing this form, you accept the office financial agreement and have been given a copy for your records.

We thank you for choosing Napa Valley Family Medical Group, Inc. for your medical needs.

______________________________	____________________________	____________
Patient Name	Patient/Parent Signature	Date