Napa Valley Pediatrics

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

Patients Father's Name	DOB	Patients Mother's 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

Name of Closest Relative

Nearest Relative Not Living with Patient

Address City State Zip

Phone

Emergency Contact

Name	Phone
Relationship	

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 Drs. Morgese & Löffler-Barry 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**

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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 their pediatrician: Dr. Löffler-Barry or Dr. Morgese 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**

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To All Parents:

As of March 14, 2006 our office will be starting a new policy.

ALL ROUTINE CHECK UPS will be rescheduled for a later date if you are **15 minutes** late from your appointment time. This is to ensure patients scheduled after you still receive service at their appointment time. We ask for your understanding and cooperation in enforcing this policy.

ALL WIC forms, **SPORTS** forms, and any other **ADDITIONAL SCHOOL** forms **NOT filled out during routine check ups**, will need to be brought to our office at least a week in advance of date needed.

Let's work together for your Childs health!

Thank You.

_____ _____

Childs Name *Date of Birth*

_____ _____

Childs Name *Date of Birth*

_____ _____

Childs Name *Date of Birth*

_____ _____

Childs Name *Date of Birth*

_____ _____

Parent Signature *Date*

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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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 certifications.

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: