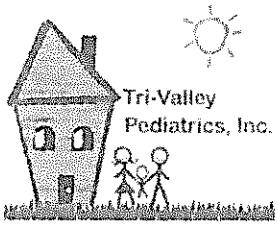
UCSF Benioff Children's Physicians



Tri-Valley Pediatrics, Inc.

Patient Demographic Form

Patient's name | Date of birth | Male/Female

Patient's name | Date of birth | Male/Female

Patient's name | Date of birth | Male/Female

Parent/Guardian Information

Mother's name | Date of birth

Home phone | Cell phone

Address

City, state, and zip code

Email address

Employer

Father's name | Date of birth

Home phone | Cell phone

Address

City, state, and zip code

Email address

Employer

Insurance Information

Primary insurance

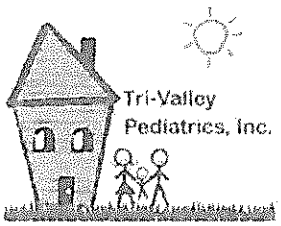
Policy or identification number | Group number (if applicable)

Subscriber's name | Subscriber's date of birth

Emergency Contact

Emergency contact (name and relationship) | Phone number

UCSF Benioff Children's Physicians



INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other patient information.

I have read the above and accept financial responsibility in full for this account.

Signature: _____ Date: _____

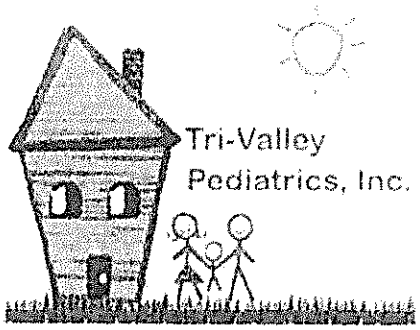
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used to any of the following purposes: diagnostic, insurance, legal, and at times when the doctor deems necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) the receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of the information.

I authorize the release of any medical information necessary to process and claim. I permit a copy of the authorization to be used in place of original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

We may also share Health Information about you with other non-UCSF Health System providers. The disclosure of your Health Information to non-UCSF Health System providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your UCSF Health system records to coordinate services for you. If you wish to opt out of this non-UCSF Health System provider exchange, please let our front office staff know.



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 does not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.trivalleypediatrics.com.

Patient's name (printed) Date of birth

If patient representative, name (printed)

Relationship to patient (patient)

Signature (parent or guardian)

Date notice received

UCSF Benioff Children's Physicians Policy and Procedure	Tri-Valley Pediatrics, Inc.
Missed Appointments, No-Show, and Form Completion Policy & Charges	**Effective: January 1, 2016**

Cancellation Policy:
If you must cancel an appointment, please notify us as soon as possible so that we can make room in our schedule for another child to be seen. We require 24 hours notice to consider an appointment cancelled. Our Receptionists and/or automated reminder system confirm all appointments 24-48 hours in advance, so please make sure that we have a current phone number, and E-mail. We will apply a charge of $25 for a missed appointment (1st time). This fee can not be billed to your insurance company. **Initial**_____

Multiple missed/no show policy:
Missed appointment (or appointments cancelled with less than 24 hour notice) are a cost to us, to you, and to other patients who could have used the time set aside for your child. Please make every effort to call us as soon as possible to cancel your appointment.
For the second appointment missed, we will apply a $50 fee. **After the third appointment missed, we will apply a $75 fee and we have the option of dismissing your family from our practice.** We do realize that sometimes there are emergencies and we will take these into consideration. We will send you a warning letter after your family has missed 2 or more appointments. This letter serves as a warning that you may be dismissed from our practice if you continue to have missed appointments.
Initial_____

Charges for form completion:
Our office gladly provides a completed school and immunization form at the time of a well appointment/physical exam. Our office charges to complete forms outside of the well appointment visit. Below are our form turnaround times and charges:

3 business day = $10 <3 business day = $20

These charges are not billed or reimbursable by your insurance. They are your responsibility. All fees for forms must be paid at the time form is dropped off. The form will not be completed until payment is made. **Initial**_____

I understand that I am responsible for any fees for missed/no show or appointment cancelled with less than 24 hour notice, and for any form need completed. I understand these charges will not be billed to my insurance. I agree to pay these fees and understand I may be dismissed from this practice for multiple missed/no-shows as outlined above.

Signed_____Date_____

Parent/Legal Guardian Name (print):