

Berkeley Pediatric Medical Group

James G. Cuthbertson, M.D.
Annemary Franks, M.D.
Elaine E. Davenport, M.D.
Olivia Lang, M.D.
Benjamin N. King, M.D.
Lisa S. Kalar, M.D.

1650 Walnut Street
Berkeley, CA 94709
(510) 848-2566
(510) 848-3109
www.berkeleypediatrics.com

Welcome to Berkeley Pediatrics! We are pleased that you have chosen us to provide your child's medical care. Our goal is to give the highest quality medical care with a personal touch. We hope you find our practice to be a friendly and helpful medical home for many years to come.

Office Hours: Phone (510) 848-2566

Weekdays – 9:00 am to 5:00 pm

Saturday – 9:00 am to 12 noon Urgent care only

Sunday - Closed

Physicians will return phone calls throughout the day, scheduled appointments permitting.

After Hours Advice and Care:

If your child has an **urgent** medical need after hours, you can call the After Hours Urgent Care Line at 1-888-840-4928. This line is for urgent medical care only.

If you need non-urgent medical advice, please call the office and leave a message for your doctor. Your call will be returned during regular business hours.

For other useful medical links and general practice information, please visit our web site at: www.berkeleypediatrics.com, look under the “*Child Health Info*” link.

Vaccination Policy:

Berkeley Pediatric Medical Group does not accept families who are unwilling to vaccinate their children. This is against our philosophy of high quality, preventive medicine. Feel free to discuss immunization questions with your physician.

Appointment Policy:

Please call in advance to set up appointments, as we cannot see “drop-in” patients. In this way, we can allow plenty of time for each scheduled patient. We are happy to provide same day appointments for urgent medical problems. Be sure to make separate appointment times for each sibling who is to be seen. A longer appointment is allotted for well child visits, since this is a more thorough evaluation, so please call to schedule these appointments several weeks in advance.

We look Forward to Seeing You and Your Child!

BERKELEY PEDIATRIC MEDICAL GROUP

1650 Walnut Street, Berkeley, CA 94709
(510) 848-2566

DATE: _____ DOCTOR: _____

CHILD: _____ Gender: M F
Last First MI Birth date

PARENT: Mother _____
Father Last First DOB SS# CDL#

ADDRESS: _____
Street City/Zip Email

PHONE: () _____ () _____ () _____
Home Cell Work

PARENT: Mother _____
Father Last First DOB SS# CDL#

ADDRESS: _____
Street City/Zip Email

PHONE: () _____ () _____ () _____
Home Cell Work

Insurance Policy Holder's Name ID & Group Number Effective Date

IN CASE OF AN EMERGENCY CONTACT: (Other than parent)

NAME PHONE RELATIONSHIP

NAMES OF SIBLINGS: _____

Previous Doctor: _____
Name City/State Phone Number

The information provided is confidential and is intended only for the use of Berkeley Pediatric Medical Group.

I hereby authorize insurance payment be made directly to Berkeley Pediatric Medical Group for surgical or medical benefits. I have read and understand the Financial Policy provided to me. A 1.5% interest charge will be applied each month to the patient balance 30 days past due. **Co-payments specified by the insurance are due at each visit. Failure to pay at the visit will result in a \$10 service charge.**

Signature (Insured)

Permission for Medical Care of a Minor:

The doctors of Berkeley Pediatric Medical Group and any doctors, hospitals or agents they may designate, have our permission to provide medical and surgical care for our child in our absence.

Parent/Guardian Signature Date

Parent/Guardian Signature Date

BERKELEY PEDIATRIC MEDICAL GROUP
FINANCIAL POLICY

A "Patient Information form" is needed for all children. Please notify us of any change in phone numbers, address or insurance. If applicable, a copy of the insurance card is needed for each patient chart.

PAYMENT

Payment for our services is your responsibility. EPAY is a service provided by the office for you to leave a credit card number on file to be used, per your instruction, for any balance due, including co payments. If you are interested, please ask the office for more information

Co-payments specified by your insurance are due at each visit by the accompanying adult. Failure to pay at the visit will result in a \$10 service charge. If your child will not be accompanied by an adult, payment should be sent with the child.

If you have no insurance or if you have insurance with which we are not contracted, payment in full is due at the time of each visit. Payments for services that are not covered by your insurance carrier are due in full at the time of each visit. We have found that some insurance plans do not cover Well Care and circumcisions. You may want to contact your carrier to find out about these types of benefit under your plan.

Unless cancelled at least 24 hours in advance, there is a \$50 charge for missed appointments.

INSURANCE

Health insurance is a means to help you with your financial responsibility to pay for health care. Your coverage and benefits are a contract between you and the insurance company. If you have an insurance with which we are not contracted, **Blue Cross PPO**, we will provide you with the forms you need to be reimbursed directly by your insurance company. If you have an insurance we are contracted with, we will bill that insurance company. **You will be asked to present a current insurance card at each visit.** After billing your insurance company, the remaining balance is your responsibility. **You will receive a statement if your insurance carrier has responded and a payment is due from you.** If we do not have a current insurance card issued to the patient or the wrong primary care physician is listed, you will be asked to pay in full at the time of each visit. Insurance carriers limit the amount of time we can retroactively bill. In order for you to be reimbursed any overpayment, you must provide us with a current insurance card within 30 days of the visit. Please contact the business office prior to any insurance changes.

Newborns are usually covered by the mother's insurance and medical group for the first 30 days of life. We are members of **Alta Bates Medical Group**. If mom is **not** in Alta Bates Medical Group, you will need to contact the carrier to see if mom and baby can be in different medical groups for the first 30 days. **The baby must be added to the insurance policy as soon as possible within the first 30 days of life for coverage to continue for your child.** If you have HMO insurance, check that one of our doctors is listed as the primary care physician on the card. If you are unable to present a card for the baby at the 2 month visit, you will be asked to pay in full until we have a card. Insurance carriers limit the amount of time we can retroactively bill. In order for you to be reimbursed any overpayment, you must provide us with a current insurance card within 30 days of the visit.

Statements are sent out monthly. **Statements are sent when there is a balance due from the patient.** Payment is due upon receipt. A 1.5% Interest charge will be applied each month to all accounts 30 days past due.

It is important that you understand our Financial Policy. If you have any questions or concerns, please feel free to contact the business office, 848-4782.

Parent's Signature

Date

07/08

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorizations before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information. *
- You have the right to request an alternate means of location to receive communications regarding your health information. *
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession. *
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. *

** Conditions and limitations may apply; obtain additional information from front desk.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

Acknowledgment of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, _____ (Patient), acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient's Signature

Date

If the patient is a minor, a parent of legal guardian must sign.

Name of patient/minor _____

I, _____ (Parent or legal Guardian), acknowledge that I have received a copy of the Notice of Privacy Practices.

Parent or Legal Guardian's Signature

Date

Relationship to Patient/Minor _____

If the patient is not a minor, but under the care of a relative, friend, or caregiver, sign here.

Signature

Date

Relationship to Patient

Berkeley Pediatric Medical Group, Inc

Consent for Medical Care

The doctors of Berkeley Pediatric Medical Group and any doctors, hospitals or agents they may designate, have permission to provide medical or surgical care, including examination, treatment, immunizations, injections and laboratory tests.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the doctors of Berkeley Pediatric Medical Group.

This authorization to treat will remain in effect until revoked in writing.

Patient's Name

Date of Birth

Signature of Parent/Legal Guardian

Date