BERKELEY PEDIATRIC MEDICAL GROUP

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

DATE:_____ DOCTOR: _____ Primary Spoken Language: _____

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

ADDRESS: _____ _____
Street City/Zip Primary Email (Activate Patient Portal Y or N)

PARENT: Mother_____ _____ _____ _____
(Circle one) Father Last First Date of Birth SS# Driver License #

PHONE: ( ) _____ ( )_____ _____
(Circle one) Primary: Cell or Home Secondary: Cell or Home Employer Name & Contact Number

ADDRESS: _____
(If different) Street City/Zip

PARENT: Mother _____ _____ _____ _____
(Circle one) Father Last First Date of Birth SS# Driver License #

PHONE: ( ) _____ ( )_____ _____
(Circle one) Primary: Cell or Home Secondary: Cell or Home Employer Name & Contact Number

ADDRESS: _____
(If different) Street City/Zip

INSURANCE: Please present insurance card for copying. Primary Insurance is through the parent whose birthday occurs first in the calendar year.

Primary: _____
Name of Insurance Name of Insured & relationship to patient Policy ID/Group number

Secondary:_____ _____
Name of Insurance Name of Insured & relationship to patient Policy ID/Group number

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

_____
NAME PHONE RELATIONSHIP

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

I acknowledge receipt of Berkeley Pediatric Medical Group Financial Policy.
I hereby authorize insurance payment be made directly to Berkeley Pediatric Medical Group for surgical or medical benefits.
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.

_____ _____ _____
Date Signature Print name

BERKELEY PEDIATRIC MEDICAL GROUP

FINANCIAL POLICY

A "Patient Information form" is needed for every patient. 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. Co-payments specified by your insurance are due at each visit by the accompanying adult. 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. Payment 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. Please contact your carrier regarding coverage for these services.

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 any insurance with which we are not contracted, you will need to pay in full at each visit. 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.

Newborn Health Insurance Coverage. Coverage is not automatic. The parents must add the baby to the insurance policy as soon as possible within the first 30 days of life in order for the baby to be covered on the policy. Newborn health insurance coverage is usually through the mother's insurance and medical group for the first 30 days of life. We are members of **Hill Physicians Medical Group**. If mom is **not** in Brown and Toland 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 when there is a balance due from the patient. Payment is due upon receipt. You can pay your statement online thru your MyChart account or on a Guest Account. The link is available on our website.

It is important that you understand our Financial Policy. If you have any questions or concerns, please feel free to contact the business office, 510-848-4782.

8/2023

_____

Parent's Signature Date

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

_____ _____
Patient's Name Date of Birth

_____ _____
Patient's Name Date of Birth

_____ _____
Signature of Parent/Legal Guardian Date

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. *
- Your 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.

11/2008

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.

Name of patient _____Date of Birth_____

Name of patient _____Date of Birth_____

Name of patient _____Date of Birth_____

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

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

If the patient is not a minor, sign here.

_____
Signature Date

Berkeley Pediatrics

1650 Walnut Street, Berkeley, CA 94709
Phone: 510-848-2566 Fax: 510-848-3109
www.berkeleypediatrics.com

REQUEST FOR RECORDS

I hereby authorize:

_____
Physician's Name (Print)

_____
Address

_____
City State Zip Phone Number Fax Number

to release medical records, including immunizations, concerning:

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

(Our office is on EPIC EHR through UCSF. Please contact our office if we can request the records electronically through EPIC.)

To: _____
Berkeley Peds Physician's Name

By signing this authorization. I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

_____
Signature Date

_____
Parent/Guardian's Name Relationship to Patient

UCSF Benioff Children's Physicians

UCSF Medical Center — MyChart Proxy Authorization Form
Granting Proxy Access to Parent/Guardian on behalf of a

CHILD (0-11 years)

CHILD'S NAME_____ **CHILD'S BIRTHDATE**_____

CHILD'S MEDICAL RECORD #: _ _ _ _ _ _ _ _ ***(optional)*** **Last 4 of Social Security:** _ _ _ _ ***(optional)***

Important Reminder: UCSF MyChart displays certain information from your medical records, but **it does not display all health information** in your medical records.

Parent/Legal Guardian of Child: This authorization form is used for minors under the age of 12, in which, Attorney for Health Care, Advance Health Care Directive, or legal guardianship papers may be requested. A renewal of this authorization may be requested as well. Expiration of pediatric proxy access automatically occurs on the patient's 12th birthday.

AGREEMENT—
The *UCSF Medical Center (UCSFMC) Terms and Conditions for UCSF MyChart, and the UCSF MyChart Proxy/Disclaimer* for access to My Family's Record UCSF MyChart section control this agreement between the child's parent/legal guardian and UCSF Medical Center. Please refer to these documents when you signup online.

YOUR RIGHTS
This Authorization to release health information is voluntary. You may revoke proxy access at any time to your family member's UCSF MyChart account. For revocation, please contact your family member's practice. The Revocation will take effect within 2 business days upon notification of your request except to the extent UCSF Medical Center or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, or ended by revocation, authorization for UCSF MyChart proxy access will expire automatically when the patient turns 18 years old. In order for revocation to be effective, it must be executed in writing.

Print Name of Child's Parent/Legal Guardian:_____

Relationship to Child: (parent/legal guardian): ____ Parent ____ Legal Guardian

Address: _____ **Child's parent/legal guardian birthdate:** _____/_____/_____

_____ **Contact Phone Number: (__ __ __) __ __ __ - __ __ __ __**

Email Address:_____

☐ **Check** if the parent/guardian is a **UCSF patient**
MRN #: __ __ __ __ __ __ __ __ (optional) Last 4 of Social Security: __ __ __ __ (optional)

☐ **Check** if the parent/guardian is **NOT a UCSF patient**
Full Social Security #: _ _ _ - _ _ - _ _ _ _ (optional) Gender: Male ___ Female ___

Primary Language: _____ Marital Status:_____

Employer: _____ (optional)

I attest that the above information is true and correct.

Signature of Child's Parent/Legal Guardian:

_____ Date:_____ **Practice**

Representative who witnessed this proxy:

_____ Date:_____

A copy is as valid as the original

ADMINISTRATION ONLY: ____ Scanned to Child's Record (Document Type UCSF Clinical Outpatient Documentation — 200122) - 11_07_2012

UCSF Benioff Children's Physicians

UBCP MyChart Proxy Authorization Form

Granting Proxy Access to Parent/Guardian on behalf of an

ADOLESCENT (12-17 years)

PATIENT'S NAME_____ **PATIENT'S BIRTHDATE**_____

PATIENT'S MEDICAL RECORD #: __ __ __ __ __ __ __ __ ***(optional)*** **Last 4 of Social Security:** __ __ __ __ ***(optional)***

Important Reminder: UCSF MyChart displays certain information from your medical records, but **it does not display all health information** in your medical records. **To secure all health information, contact Health Information Management 415-476-9000**

Parent/Legal Guardian of Adolescent: This authorization form is used to establish UCSF MyCart accounts for both the Parent/Legal Guardian and the adolescent patient. This authorization form serves as acknowledgement and permission for my adolescent to have a UCSF MyChart account. Legal papers establishing parental or guardian relationship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 18th birthday.

AGREEMENT—

The *UCSF Medical Center (UCSFMC) Terms and Conditions for UCSF MyChart, and the UCSF MyChart Proxy/Disclaimer* for access to My *Family's Record* UCSF MyChart section control this agreement between the child's parent/legal guardian and UCSF Medical Center. Please refer to these documents when you signup online.

YOUR RIGHTS

This Authorization to release health information is voluntary. You may revoke proxy access at any time. For revocation, please contact the patient's practice. The Revocation will take effect within 2 business days upon notification of your request except to the extent UCSF Medical Center or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, or ended by revocation, authorization for UCSF MyChart proxy access will not expire unless the relationship between the legal guardian and the patient changes.

Print Name of Parent/Legal Guardian:_____

Address: _____ **Patient's parent/legal guardian birthdate:** _____/_____/_____

_____ **Contact Phone Number: (__ __ __) __ __ __ - __ __ __ __**

Email Address: _____

☐ **Check** if the parent/guardian is a **UCSF patient**
MRN #: __ __ __ __ __ __ __ __ (optional) Last 4 of Social Security: __ __ __ __ (optional)

☐ **Check** if the parent/guardian is **NOT a UCSF patient**
Full Social Security #: _ _ _ - _ _ - _ _ _ _ (optional) Gender: Male ___ Female ___

Primary Language: _____ Marital Status:_____

Employer: _____ (optional)

I attest that the above information is true and correct.

Signature of Patient's Parent/Legal Guardian:

_____ Date:_____ **Practice**

Representative who witnessed this proxy:

_____ Date:_____

A copy is as valid as the original

ADMINISTRATION ONLY: ____ Scanned to Child's Record (Document Type UCSF Clinical Outpatient Documentation — 200122) - 11_07_2012