Evergreen Pediatric Associates

Linda Ha, M.D. & Christopher Vu, M.D.

Registration Form

Please provide us with the following information and give this form to the receptionist so a chart can be prepared for you.

Patient Name-- Last:_____ First: _____ MI:____
Gender: M/F
Birthdate (m/d/y): _____/____/_____ SS#: _____-_____-_____
Name of parents-- Mother: _____ Father: _____
or Guardian: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone-- home: (____)_____-_____ work: (____)_____-_____
Cellular mom : (____)_____-_____ Cellular dad: (____)_____-_____
E-mail address mom: _____
E-mail address dad: _____

Emergency Contact--Name: _____ Relationship: _____
Phone-- home: (____)_____-_____ cellular: (____)_____-_____

Primary Insurance Info-- Insured Name: _____
Insured Driver's License #: _____ Insured Date of Birth: _____
Insured SS#: _____-_____-_____ Relationship to Patient: _____
Insured Address: _____ City: _____ State: ___ Zip: ____
Insured Employer: _____ Insured Occupation: _____
Employer Address: _____
City: _____ State: ___ Zip: _____
Insurance Company Name: _____
Insured ID#: _____ Group#: _____ Effective Date: _____

In order to submit a claim form for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance company. Please sign below.

1. I authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor indicated on the claim.
2. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature is valid as the original.

X: _____ Date: _____

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Practice Financial Policy

Welcome to our office. Thank you for choosing us as your healthcare provider.

We are dedicated to providing the best possible care and service to you and your family. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. Please carefully read and initial each of the following points, indicating that you **ACCEPT FINANCIAL RESPONSIBILITY** in the following situations:

___ WHEN YOU PROVIDE US WITH AN INSURANCE CARD, you understand and accept that you will be liable in the following situations...if…

a. at the time of the visit, you are not covered by your insurance company.
b. at the time of your visit, your dependents (child/children) are not covered by your insurance.
c. your insurance does not cover tests deemed necessary by the physician or requested by you.
d. your insurance does not cover vaccinations (shots) recommended by the physician or requested by you.
e. your insurance does not cover annual health exams or well child exams.
f. your insurance is an HMO and your dependents are not signed up with our physicians at the time of the visit.

___ If a co-payment is indicated either on the insurance card or subsequent evaluation of "Explanation of Benefits" by your insurance company, this fee will be paid at the time of your appointment.

___ After evaluation of the "Explanation of Benefits" from your insurance company, if a co-insurance of deductible is indicated, you will be responsible for the specified amount.

___ For those patients enrolled in an HMO, please confirm with your insurance company that you have signed up with one of our physicians at the time of the visit. Please provide us with a copy of the insurance card with our physician's name as soon as you have a copy (if applicable).

___ Please provide us with any changes in insurance information, address, or phone numbers.

___ For those patients under 30 days old, the child is usually covered under the mother's insurance in the first 30 days of life. However, after that, the child is required to be enrolled separately. It is recommended that you call the "Human Resources" department at your company to enroll your child as soon as possible. We also recommend that you confirm the child's enrollment with your insurance company after the first month. Failure to do so may result in unnecessary bills for subsequent visits.

___ IF YOU DO NOT PROVIDE US WITH AN INSURANCE CARD at the time of the visit, we ask that you make payment for the full amount of the visit. If in the future, you can provide us with an insurance card in a timely manner and your insurance company covers the visit, you will be reimbursed the full amount (minus any co-payment required).

___ Please note that you will be charged $25.00 in addition to any bank charges for returned checks.

___ **Missed appointments:** Unless canceled 24 hours in advance, you may be charged $25.00. Please help us to serve you better by keeping scheduled appointments.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

X_____ X_____ _____

Signature of Parent or Guardian Name of Patient (please print) Date

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Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice--Evergreen Pediatric Associates) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate of under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure or your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to:
   Evergreen Pediatric Associates-- 1569 Lexann Ave. Suite 232, San Jose, CA 95121
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to above address. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our front desk receptionist. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

I hereby acknowledge that I have been presented with a copy of Evergreen Pediatric Associates' Notice of Privacy Practices.

X_____ _____ _____

Signature Patient's Name (please print) Date