HIPAA PRIVACY 2016

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. (Notice of privacy is laminated and attached to clipboard, a copy can be given upon request).

(INITIALS) _____________ Effective Date: ______________________

For more information, please contact the Office of Civil Rights, 90 7th St., Suite 4-100, San Francisco, CA 94103,

Tel. No. (800) 368-1019 or our local Privacy Officer, Dr. Maria Osmena, (650) 873-3338.

NOTICE TO CONSUMERS

I understand that Dr. Maria Luisa Osmena is licensed and regulated by the Medical Board of California.

(SIGNATURE) ______________________________

CONSENT FOR TREATMENT OF MINORS

I hereby authorize LiveWell Medical Clinic, Inc. to render medical services to:

Child's Name: ____

Date of Birth: ____

The services will include examination and treatment of medical problems, physical examinations, administration of vaccines, arrangement of hospital care, and performance of laboratory testing and procedures deemed necessary in the care of the above-named patient.

This consent will be effective, unless revoked in writing, until the patient's eighteenth birthday.

INSURANCE CLAIM SUBMISSION- *(PARENTS: PLEASE READ AND **INITIAL** ALL)*

- Payment of the bill is the patient's responsibility and not that of the insurance. For your convenience, we can submit claims to your insurance company on your behalf. You are responsible to know if we are contracted/covered with your insurance carrier or medical group. For HMO's, you understand that the assigned primary care physician must be Dr. Maria Osmena. You understand that if it's a pediatrician other than Dr. Osmena, you will be responsible for full payment of the charges. If you are unable to provide proof of insurance coverage, you will be responsible for the entire bill on the date of service. ________ **(initials)**

- You are responsible for bringing the patient's **Insurance Card** and **Parent's Identification Card (I.D.)** to **EVERY** appointment and are responsible to know if patient is eligible at the time of service, what your benefits are and what is covered by your insurance (i.e. office visits, well visits, physical exams which includes hearing, vision, hemoglobin, urinalysis and TB test, immunizations, etc). _______ **(initials)**

- Co-pays are due at the time of service. You will also be responsible for any co-insurance or deductible portions (if applicable) once insurance processed the claim. ________ **(initials)**

- If your insurance company fails to acknowledge receipt of the claim within 90 days, you will be responsible for payment of the charges in full. Please be aware that you will need to carefully monitor and follow up your claims. ___________ **(initials)**

- We charge an after office hours fee for appointments after 5 pm on weekdays and on the weekend. This amount will be billed to your insurance ___________ **(initials)**

I certify that my dependents and I have medical coverage under the insurance noted on the page 1 of the registration form. I authorize the release of any medical information necessary to process my insurance claim. I authorize payment of medical benefits to LiveWell Medical Clinic, Inc., for medical services rendered. I also understand that I am fully responsible for any non-covered services, co-insurances, deductibles and co-pays per my insurance plan.

I have read and understand the policies above.

Signature: ____ Date: ______________________________

Patient Name: ______________________________________ Date of Birth: ______________________