

Client Registration Agreement and Acknowledgement

Date: _____

Requesting Appointment With:

Dr. Julia Getzelman Dr. Aarti Nasta Dr. Marcella Spera

Janis Mandac, PNP Other: _____

Patient's Name: _____ DOB: _____ Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone #: (_____) _____ Mobile #: (_____) _____

Work #: (_____) _____ Email address: _____

Employer: _____ Occupation: _____

Insurance Company: _____

Insured Name: _____ Relation to Patient: _____

Insurance ID #: _____ Group #: _____

If patient is a minor, please fill out the following:

Parent's Name: _____ DOB: _____ Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

(if different from above)

Home Telephone #: (_____) _____ Mobile #: (_____) _____

Work #: (_____) _____ Email address: _____

Employer: _____ Occupation: _____

Parent's Name: _____ DOB: _____ Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

(if different from above)

Home Telephone #: (_____) _____ Mobile #: (_____) _____

Work #: (_____) _____ Email address: _____

Employer: _____ Occupation: _____

Siblings seen in this office: _____

Who may we thank for your referral? _____

Authorization for Medical, Health and/or Nutrition Services: Pursuant to this Client Registration Agreement (“Agreement”), I authorize the professionals and staff at GetzWell Pediatrics to administer such medical, health care and/or nutrition services, treatments and procedures for myself or my children as they deem appropriate and necessary. I understand that they will prescribe an integrative program for me or my children that may include conventional pediatric/health care, nutritional therapies, acupuncture, functional medicine and other aspects of integrative medicine. As a patient or parent seeking medical, health care and/or nutrition services, I understand that I must decide, in conjunction with my or my children’s professional, the course of treatment and services that will best benefit me or my children.

I understand that if any explanations as to the benefits and/or the risks and dangers of the prescribed treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. While I understand that there have been and can be no warranties, representations or assurances of successful outcome for myself or my children, I nevertheless desire to pursue integrative medical treatment or nutrition services for myself or my children after having considered all factors, including the information contained herein.

It is my responsibility to report to GetzWell Pediatrics any matters that I or my children may have with treatments or services and to schedule a consultation to conduct appropriate follow-up. I am responsible for seeking professional medical attention from GetzWell Pediatrics or another medical facility if I or my children experience any unanticipated effects associated with treatments and services or if my or my children’s condition worsens. If a medical emergency arises, I will call 911 or visit the nearest hospital emergency room.

Initials: _____. Please initial here and sign the last page to indicate you have read and accept the terms of this section. If patient is a minor, at least one parent and/or authorized legal guardian must initial and sign.

Scheduling Appointments and After Hours Coverage: To schedule an appointment, you may either call reception at 415.826.1701 or send an e-mail to reception@getzwell.com. In general, appointments start on time. In connection with medical care (but not nutrition services) Dr. Getzelman and our other MDs share after hours call for our practice. We check telephone messages during business hours and respond to them on a regular basis throughout the week. Outside of regular business hours, if you feel that any medical matter is too urgent to wait for us to call you back on the next business day, you may call 415.826.1703 to be promptly connected with a physician (usually in less than one hour). Our current clinical rates will apply to all calls that occur between the hours of 7:00 p.m. and 9:00 a.m. Monday through Friday, during the weekend and holidays. Of course, if you or your children are experiencing a medical emergency, please call 911 or go directly to an emergency room.

Cancellation Policy: I understand that the professional’s time is reserved exclusively for my or my children’s care for the duration of all scheduled visits. I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my or my children’s treatment and that if I am late for an appointment, the visit will end at the scheduled time and I will still be charged for the full visit. If for some reason I cannot make an appointment, I will call at least **two business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than two business days** prior to the scheduled time, I will be charged a fee that represents the greater of \$115 or 50% of the cost of my scheduled appointment (or, for pre-natal or other interviews, the then current rate). I understand that if I cancel on the day of my scheduled visit or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment. As an illustration, if an appointment is on a Monday, I must cancel by the prior Thursday to provide two business days notice.

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Telephone and Email Consultation Policy: In connection with calls and emails for medical and non-nutrition matters that occur after hours, on weekends or holidays, or more extended telephone consultations of 10 or more minutes that occur at any time, I will be billed at the same consultation rate as in-person visits, which I authorize to be charged to my credit card on file. I understand that email and telephone consultations are not provided for nutrition services. In general, for members of our practice with brief and uncomplicated email questions, there is no fee. However, I understand and agree that where one or a series of emails takes 10 minutes or more to read and reply or is in lieu of an in-person or phone consultation, I will be billed at the current in-person consultation rate, which I authorize to be charged to my credit card on file. By sending an email, I acknowledge and agree that a prompt reply is NOT required or expected. I acknowledge that I will not use email communications to deal with emergencies or other time sensitive issues. I also understand that email communications may not be secure and the confidentiality of emails cannot be assured or guaranteed, but agree that this is my risk with respect to all email communications. I agree that GetzWell Pediatrics may keep copies of email communications and that such messages may be included in my or my children's health record. When any medical, health or non-nutrition related matter requires an urgent response, I agree to call your office during business hours or the after hours telephone number (415.826.1703). For all emergencies, I understand that I should call 911 or go directly to the nearest hospital emergency room.

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Insurance Responsibility and Claims Management: I acknowledge that GetzWell Pediatrics expects that all of its patients will maintain health insurance coverage. It is my responsibility to know my plan benefits and to obtain insurance advice from my own licensed insurance agent, broker or human resource professional. Given the uncertainty that pervades insurance decisions, I agree that GetzWell Pediatrics will not be responsible for any information that turns out to be incorrect and will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating any insurance claim. I understand I will receive a superbill or claim form showing the cost and nature of services and it will be my responsibility to submit the claim to my insurer.

I understand that GetzWell Pediatrics does not participate in insurance plans or accept assignment from any other payer including employers or insurers. I am responsible for all charges and fees incurred for treatments or services rendered to me or my children, even if my insurance company determines that any services are non-covered or excluded. I understand that insurance reimbursement may not be available for some services. My insurer and my children's insurer may not pay for office visits, telephone consultations or emails including but not limited to circumstances where the focus of the consultation is on prevention, education, wellness, nutrition advice, herbal medicine, etc. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed. Additionally, I understand that the annual open access membership fee that I pay for each child will not be reimbursed by my or my children's insurer.

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Financial Responsibility and Authorization for Payment

I understand that payment for all services, treatments and products will be required at each visit and authorize GetzWell Pediatrics to charge my account balance to the credit card indicated below. I authorize this credit card (and any replacement credit card) to be used as a guarantee against late cancellations and missed appointments and for any and all balances including those relating to office visits, telephone/e-mail consultations, missed/late appointments, miscellaneous fees and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to GetzWell Pediatrics for the amount due and will provide an alternative Visa/MC account number upon request if my then current credit card account is over limit, canceled or expired.

Additionally, when I join the practice for medical and health care services, I agree that GetzWell Pediatrics has the right to assess an annual open access membership fee for each child who is a patient (unless the child is enrolled solely for nutrition services) based on the then current fee schedule and understand that at present the initial annual fee is \$225 for one child and \$375 for two or more children. The annual membership fee will also apply to adults who join without children. For members receiving nutrition only services, if I/we subsequently enroll a child for medical and health care services, the current annual open access membership fee policy shall become applicable. I/we authorize GetzWell Pediatrics to charge the initial annual fee to my credit card when I/we are admitted to the practice and renew the open access membership annually by charging the then current annual membership fee to my credit card unless I/we withdraw from the practice. I understand and agree that the open access fee is nonrefundable. If my/our membership in GetzWell Pediatrics expires or we cancel membership, I authorize GetzWell Pediatrics to charge my credit card on file for any unpaid account balances. My signature below verifies that I have read, understand and consent to the financial responsibility terms set forth herein.

Visa/MC (circle type) account #: _____
Name on credit card: _____
Expiration Date: _____
Security Code: _____
Authorized signature: _____

Health Information Release Authorization and Privacy Practices: GetzWell Pediatrics is permitted by applicable federal and state privacy laws to use and disclose your protected health information (PHI) for treatment, payment and health care operations and for other purposes as required or permitted by law. Our Notice of Privacy Practices, as it may be amended from time to time (the "Notice"), is available on our website, by mail upon request or in person at our office. I authorize GetzWell Pediatrics to release my children's PHI in connection with treatment, payment for services and its health care operations and as provided in the Notice, which is incorporated into this Agreement by reference. I understand that the Notice may be modified or amended by GetzWell Pediatrics on the basis described in the Notice. I also authorize any physician or health care provider that my children are seeing or have seen, to release their protected health information records to GetzWell Pediatrics. This authorization extends to my protected health information records, if applicable.

Complaints, Comments and Questions: GetzWell Pediatrics is committed to providing quality care and resolving favorably any complaint, problem, question or unsatisfactory experience that might occur in connection with GetzWell's business or services. For all members, non-members or prospective members, it is our policy that (i) if any member or non-member has a complaint or problem or unsatisfactory or negative experience related to our business, services or products, such person must bring the matter to our attention privately, by email, phone or in person; and (ii) we will investigate any such matter and attempt in good faith, without any retaliation, to reasonably resolve the matter. By signing this Agreement, I acknowledge and agree that I will comply fully with this policy (i.e., solely to communicate privately) and this is my sole and exclusive remedy in connection with any complaint or problem or unsatisfactory or negative experience that I may have with GetzWell's business, services or products (other than remedies that may be available in a court of law or pursuant to arbitration). I further agree that I will not (nor will any of my agents) publish, post, transmit, disclose or distribute, directly or indirectly, in or on any publicly available or accessible forum, newspaper, magazine, electronic publication, web site, on-line users group or other similar device, document or medium, any negative, false or disparaging comment, belief, opinion, experience or information (or which could reasonably be construed as such) related to GetzWell Pediatrics, its professionals, staff, business, services or practices without GetzWell's prior written consent. I acknowledge and agree that these terms are reasonable and that any breach or violation of this paragraph will cause significant damage to GetzWell Pediatrics that would be impossible or highly impractical to quantify and establish. Accordingly, I agree that upon each breach or violation of this paragraph, I will be obligated to pay liquidated damages to GetzWell Pediatrics in the amount of \$200.00 per day per violation until the breach or violation has been cured to the satisfaction of GetzWell Pediatrics.

Duration of Agreement, Revocations of Authorizations and Amendments: I may revoke the PHI release authorization in writing at any time and GetzWell Pediatrics will attempt to accommodate all reasonable requests, however, I understand that in some circumstances related to treatment, payment or health care operations, GetzWell Pediatrics may not be able to accommodate such requests. I further agree that in no event will any revocation of a prior authorization affect any of my other obligations in this Agreement. The rights and obligations of the parties herein shall be fully applicable whether or not I have become a member of GetzWell Pediatrics and, except for right or obligations that by their terms do not survive expiration or termination, the respective rights and obligations of the parties shall survive expiration, cancelation or termination of this Agreement for any reason. I also certify that my children are enrolled in this practice to receive health care and for no other purpose. This Agreement and the Notice, along with any agreement to arbitrate, reflects the entire and exclusive agreement between us and supersedes any prior or other contemporaneous agreement. This Agreement may only be amended by a written document signed by GetzWell Pediatrics and each of the undersigned.

I agree to the above terms, am authorized to sign this **Client Registration Agreement and Acknowledgment** for myself and/or my children and have executed it in San Francisco, California as of the ___ day of _____, 20__:

Parent/Guardian Signature

Parent/Guardian Signature

Printed Name

Printed Name

[Instruction: The authorized signer for the above credit card must initial this agreement in each place indicated and sign directly on the line above. Thank you.]