GetzWell personalized pediatrics

Patient Registration Agreement and Acknowledgement

Date: _____

If expecting:

Name (if decided): _____ Male □ Female □ Due Date: _____

Unknown □

If you already have a child:

Child's Name: _____ Male □ Female □ DOB: _____

Second Child's Name: _____ Male □ Female □ DOB: _____

(if more than 2 children, please add to Additional Information section)

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

Parent/Guardian 1 (Primary Contact)

Name: _____ DOB: _____ Male □ Female □

Cell Phone: _____ Email address: _____

Employer: _____ Occupation: _____

Parent/Guardian 2

Name: _____ DOB: _____ Male □ Female □

Cell Phone: _____ Email address: _____

Employer: _____ Occupation: _____

Additional Information

How did you first learn about GetzWell? _____

Additional children's name(s) and DOB(s): _____

Authorization for Medical, Health and/or Consulting Services: Pursuant to this Patient Registration Agreement and Acknowledgement ("Agreement"), I/we authorize the professionals and staff at GetzWell Pediatrics, a medical corporation ("GetzWell" or "you") to administer such medical, health care and/or consulting services, treatments and procedures for my/our children or me/us (parent/legal guardian) as you deem appropriate and necessary under the applicable circumstances. I/we understand that you will prescribe an integrative program that may include conventional pediatric/health care, nutritional therapies, homeopathy, functional medicine and other elements of integrative medicine. I/we agree that in connection with any births or adoptions, the doctor/patient relationship with GetzWell shall begin with the first physical examination and not at birth.

I/we understand that GetzWell does not make and there are no warranties, representations or assurances of successful outcomes for my/our children or me/us. Nevertheless, I desire to pursue integrative medical treatment, health care or consulting services for myself or my/our children after reviewing the information herein and receiving answers to my questions about this Agreement or the services. I/we will seek clarification from you before consenting to recommended treatments or services if I/we are unclear about the benefits or risks. As a patient or parent seeking medical, health care and/or consulting services, I/we understand that I/we are ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services) for my/our children or me/us. I/we acknowledge that GetzWell recommends that I/we should vaccinate my/our children and I/we have been informed of the risks of not fully vaccinating my/our children.

I/we will report to GetzWell any matters arising out of treatments or services and schedule a consultation to conduct appropriate follow-up. I/we will promptly seek medical attention from GetzWell or another medical facility if any of us experience any unanticipated effects associated with treatments and services or if I/we or my children's condition worsens. If a medical emergency arises, I/we 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.

Appointments and After Hours Coverage: To schedule appointments and consultations, call or email our Noe Valley office at 415.826.1701 Option 1 or **info@getzwell.com**; or Union Street office at 415.826.1701 Option 2 or **union@getzwell.com**. In general, appointments start on time. In connection with medical care (but not consulting services) GetzWell's medical professionals 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 the next business day, you may call **415.826.1701 (option 3)** to be promptly connected with our on call medical professional (usually in less than one hour). Our current clinical rates will apply to all after hour calls as follows: 5:00 p.m. on Monday – Thursday nights and until 9 a.m. the next morning; 5:00 p.m. on Friday night and until 9 a.m. the following Monday morning; and all 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/we understand that the professional's time is reserved exclusively for me or my/our children's care for the duration of all scheduled visits. I/we understand that I/we are expected to keep all appointments as scheduled in order to ensure maximum progress in connection with treatment and care and that if I/we are late for an appointment, the visit will end at the scheduled time and I/we will be responsible for the cost of the full visit. If I/we need to cancel/reschedule an appointment, to avoid a late or failure to show fee, I/we will call between 9 a.m. to 5 p.m. at least **two business days in advance.** As an illustration, if an appointment is on a Monday, canceling during business hours on the prior Thursday provides two business days' notice. I/we understand that if I/we cancel an appointment during business hours **only one business day** prior to the scheduled visit, I/we will be charged a fee equal to the greater of $140 or 50% of the cost of the scheduled appointment (or, for pre-natal interviews, the then

current rate). I/we understand that **if I/we cancel on the day of the appointment or fail to show, I/we will be charged a fee** representing the full cost of the scheduled appointment.

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.

Telephone, Email and Electronic Communication Consultation Policy: In connection with telephone, text, email and other forms of electronic communication for medical and health care matters outside of GetzWell's regular business hours and extended telephone, email or text based consultations of 10 or more minutes at any time, I/we will be billed at the current clinical rate for in-person visits, which I/we authorize to be charged to my/our credit card on file. In general, GetzWell members will not be charged for non-urgent, brief and uncomplicated email or text message questions. However, I/we understand and agree that where one or a series of emails or text messages takes 10 minutes or more to read and reply or is in lieu of an in-person or phone consultation, I/we will be billed at the current in–person clinical rate, which I/we authorize to be charged to the credit card on file. By sending an email or text message, I/we acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I/we will not use email or text message communications to deal with emergencies or other time sensitive issues. I/we understand that if I/we communicate with you by email, text or other form of electronic communication, whether or not a response is specifically requested, I/we consent to you replying via email, text or other form of electronic communication even if my/our communication or GetzWell's reply contains confidential or protected health information. I/we also understand and agree that email, text and other forms of electronic communications may not be secure and the confidentiality of emails or text messages cannot be assured or guaranteed, but agree that this is my/our risk with respect to all email, text and other forms of electronic communications. I/we understand and agree that Getzwell will not, under any circumstances, be responsible for maintaining the security and confidentiality of electronic communications, including emails or text messages. GetzWell may keep copies of email, text and other forms of electronic communications and such messages may be included in my/our children's or my health record. When any medical, health or consulting related matter requires an urgent response, I/we agree to call GetzWell during business hours or the after-hours telephone number (415.826.1701 (option 3)). For all emergencies, I/we will call 911 or go directly to 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.

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

I/we understand that GetzWell does not participate in insurance plans or accept assignment from any other payer including insurers or other third parties (unless GetzWell consents in writing in advance). I/we will be responsible for all charges and fees incurred for treatments or services rendered to my/our children or me, even if my/our insurance company determines that any services are non-covered or excluded. I/we understand that insurance reimbursement may not be available for some services. My/our insurer and my/our children's insurer may not pay for office visits, telephone consultations, emails and other forms of electronic communications 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/we understand that GetzWell's annual open access membership fee(s) will not be reimbursed by my/our children's or my insurer.

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.

Financial Responsibility and Authorization for Payment: I/we understand that payment for all services, treatments, products and other fees will be required at each visit and after each other service related matter and authorize GetzWell to charge all outstanding balances to my/our credit card or bank account on file. I/we authorize this credit card or bank account (and all substituted credit cards) to be used to guarantee and pay for late cancellations and missed appointments and unpaid balances including those related to office visits, telephone/e-mail/text consultations, vaccines, charges for products and supplements and miscellaneous costs. I/we agree that if the credit card on file does not accept the charge, I/we will immediately make payment to GetzWell for the amount due and will provide an alternative Visa/MC account number upon request if my/our current credit card account is over limit, canceled or expired. GetzWell may assess a late payment fee equal to one percent (1%) per month for any amount not paid when due or because a credit card charge or check is rejected for any reason.

When I/we join GetzWell for medical and health care services, I/we agree that GetzWell has the right to assess an annual open access membership fee for each child who is a patient based on the then applicable fee schedule and have reviewed GetzWell's website to determine the current annual fee for one child and two or more children per family. The annual membership fee also applies to adults who join without children or for adult services or consultations. For parents enrolled solely for pre-natal services, if I/we subsequently enroll a child for medical and health care services, the current annual open access membership fee policy shall be applicable.

I/we authorize GetzWell to charge the initial annual fee to my/our credit card or bank account when I/we are admitted to the practice and renew the annual open access membership fee by charging the then applicable membership fee to the credit card or bank account on file unless I/we withdraw from the practice prior to the applicable anniversary date of joining the practice. I/we understand and agree that the open access fee is nonrefundable and that the renewal fee will increase periodically based on cost of living or other factors considered relevant by GetzWell. If my/our membership in GetzWell expires or I/we cancel membership, GetzWell is authorized to charge my/our credit card or bank account on file for any unpaid balances. My/our signature(s) below verify that I/we have reviewed and consent to the financial terms set forth herein.

_____
Parent/Guardian Signature

Health Information Release Authorization and Privacy Practices: GetzWell 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, or by mail upon request or in person at our office. I/we authorize GetzWell to release my/our 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/we understand that the Notice may be modified or amended by GetzWell on the basis described in the Notice. I/we also authorize any physician or health care provider that my/our 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 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 person has a complaint, problem or unsatisfactory or negative experience related to GetzWell's 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/we agree to comply fully with this policy. This is my/our sole and exclusive remedy in connection with any complaint, problem or unsatisfactory or negative experience that I/we may have with GetzWell's business, services or products (other than remedies available in a court of law or pursuant to arbitration). I/we further agree not to publish, post, transmit, disclose or distribute (directly or indirectly), in or on any publicly accessible forum, newspaper, magazine, electronic publication, blog, website, on-line users group or similar document or medium, any negative, false or disparaging comment, belief, opinion, experience or information (or that could reasonably be so construed) related to GetzWell, its professionals, officers, employees, services or practices unless I/we have first brought the matter to GetzWell's attention privately, by email, phone or in person, and provided GetzWell with at least thirty (30) days to investigate and attempt in good faith to reasonably resolve the matter in accordance with this section.

Duration of Agreement, Revocations of Authorizations and Amendments: I/we may revoke the PHI release authorization in writing at any time and GetzWell will attempt to accommodate all reasonable requests, however, I understand that in some circumstances related to treatment, payment or health care operations, GetzWell 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 and, except for rights 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/we also certify that my/our children are enrolled in this practice to receive medical and 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 and each of the undersigned.

I/we have reviewed this Agreement and accept the above terms. I/we are authorized to sign this **Patient Registration Agreement and Acknowledgment** for my/our children and individually and have executed it in San Francisco, California as of (date) _____.

_____ _____

Parent/Guardian Signature **Printed Name**

_____ _____

Parent/Guardian Signature **Printed Name**

GETZWELL PEDIATRICS,
A Medical Corporation

Notice of Privacy Practices
Effective April 1, 2015

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction: At GetzWell Pediatrics, a medical corporation, we are committed to treating and using protected health information ("PHI") about you responsibly and in the manner required by law. This Notice of Privacy Practices ("Notice") describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. You have the right to receive a copy of this Notice upon request. This Notice is effective as of April 1, 2015 and supersedes all prior versions. Note: For the purpose of this Notice, "you" or "your" refers to the patient and, as applicable, to the parent or guardian of all patients that are minors.

Understanding Your Protected Health Information: We are permitted by applicable federal and state privacy laws to use and disclose your PHI for treatment, payment and health care operations and for other purposes that are permitted by law. PHI is the information we receive from you, create and obtain in providing our services to you. Such information may include information and images sent by you electronically, including by email or text message, or other means of documenting your symptoms, examination, test results, diagnoses, vaccinations, treatment, or requesting treatment and applying for future care or treatment as well as documents related to billing for these services. This Notice also describes your rights to access and control your PHI.

Changes to this Notice: We may change, amend or eliminate provisions related to our privacy practices and make any new provisions effective for all PHI we maintain, at any time. This Notice covers all PHI that we maintain at the time of effectiveness, and until an amendment is made, we are required by law to comply with this Notice. Upon your request, we will provide you with any revised Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain, regardless of when it was created or received. You may call our office during business hours to request that a revised copy be sent to you in the mail or you may ask for one when you next visit our office. A copy of this Notice will also be posted on our website.

How We Use and Disclose Medical Information about You: The categories set forth below describe the different ways that we may use and disclose your PHI and include a few examples of what we mean. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that may be made by our office. Other uses and disclosures of your PHI that are not listed or described below will be made only with your written authorization or in the manner permitted by law. You may revoke your prior authorizations, at any time, in writing, but it will not apply to any actions we have already taken.

For your treatment: Your PHI may be used by us for the purpose of providing health care services to you and such information may be disclosed to the health care professionals and staff within our office. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, your PHI may be provided to a physician or other licensed professional to whom you have been referred by us or are otherwise seeing. If a lab or other similar test is required outside our office, a laboratory technician will also have access to some of your PHI. By transmitting information or images to our staff electronically, including by email or text message, whether or not a response is expressly requested, your PHI may be used by us to respond to your electronic communication and we may maintain copies of that electronic communication and our response, if any, in our electronic medical record system.

To obtain payment for our services: Your PHI may be used and disclosed by us to obtain payment for health care services, to assist you in obtaining payment from your insurance company for services we provide to you or to assist another health care provider in obtaining payment for their health care services to you. We may also disclose your PHI as required by your health insurance plan before it approves health care services or reimburses you for services and this may include information that identifies you.

For our health care operations: Your PHI may be used and disclosed by us to support our daily operations. Our staff will enter your information into our electronic medical record system and respond to your emails or text messages, as appropriate. We may obtain services from our business associates for quality assessment, technical support, outcome evaluation, protocol and development of clinical guidelines to assess the care and outcomes in your case and others like it. This information may also then be used by us in an effort to continually improve our services. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management.

To our business associates: We will share your PHI with third party "business associates" that perform various activities for us (e.g., bookkeeping or information technology services) related to our operations. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written agreement in place that contains terms that obligate the business associate and their subcontractors, where applicable, to protect the privacy and security of your PHI. For example, we utilize an information technology consultant to maintain and upgrade the systems and technology we use to provide services to you. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse or one of their business associates, California law prohibits all recipients of health care information from disclosing it except as specifically required or permitted by law.

For appointment reminders, lab result notifications and referrals: We may use or disclose your PHI to contact you to remind you of your appointment, by mail, text or telephone or to leave information about a referral. Our message may include the name of our practice or the name of our physician as well as the date and time for your appointment or a reminder that an appointment needs to be scheduled. We may use or disclose your PHI to contact you regarding lab tests or other similar test results, by mail, telephone, fax, email or text or to make a referral.

Others involved in your health care: Unless you object, we may disclose to a member of your family, a relative, a close friend designated by you or any other person you identify, PHI that directly relates to the involvement of such other person in your health care, your location or general condition. We may also disclose such information if we determine that it is required to prevent a serious threat to health or safety. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose information in a disaster even over your objection if we believe it is necessary to respond in emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Proof of Immunization: We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your PHI in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

As required by law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. We may also disclose your PHI to a public health authority authorized by law to receive reports of child abuse or neglect.

California Information Registry and public health agencies: We may disclose your PHI for public health activities and purposes to a local health department, the California Department of Public Health and similar public health agencies to the extent they are permitted by law to collect or receive such information including the California Immunization Registry (CAIR) pursuant to the California Health and Safety Code ("H & SC"). CAIR allows doctors, nurses, health plans and authorized public health agencies to see which shots may be needed, remind you about needed shots and helps with record keeping and safety. In connection with CAIR, as a matter of policy, we will not allow your immunization record to be shared with other health care providers, agencies or schools in the CAIR, unless you request an information sharing format. Information is recorded in a secure electronic exchange of immunization records. If you have requested information sharing, schools, child care and certain other agencies are authorized to have limited access as provided in the H & SC. All parties that have access to CAIR are required by law to protect the confidentiality of the information in the registry. This information includes patient's name, sex, and birth place; parents' or guardians' names; limited information to identify parents; and details about a patient's shots. We will not input your current address and phone number in the registry. Only your doctor's office, health plan, or public health department may obtain your address and phone number. It is your legal right to ask: (i) not to share your (or your child's) registry shot records with others besides your doctor, (ii) not to receive shot appointment reminders from your doctor's office, (iii) to look at a copy of your or your child's shot records, and (iv) who has seen the records or to request that your doctor correct any mistakes. If you want us to share your immunization information in the registry, please request a "Decline or Start Sharing/Information Request Form" or call us at (415) 826-1701. CAIR's address is California Dept. of Public Health, Immunization Branch, 850 Marina Bay Parkway, Building P, Richmond, CA 94804, and website is cairweb.org.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, our patients' health information will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

GETZWELL PEDIATRICS,
A Medical Corporation

Breach Notification: In the case of a breach of unsecured protected health information, we will notify our patients as required by law. If you have provided us with a current email address, we may use email to communication to provide information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate. We are not responsible, under any circumstances, for the security of information or images sent by you via electronic means, including by text message or email, or information or images sent by us electronically in response to your text message or email.

Your Health Information Rights: You have the right to inspect or receive a copy of your PHI maintained by us or to request that we transfer it to another practice and to receive confidential communications from us related to your PHI. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect or get a copy of it, and if you want a copy, whether you want an electronic or hardcopy format. We may charge a reasonable fee for this service. Under applicable federal and state law, you may not inspect or copy certain records including psychotherapy notes; information compiled related to a civil, criminal, or administrative action; and medical information that is subject to laws that prohibits access to medical information in certain other circumstances. In some circumstances, we have the right to deny your request to see certain information; however, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your PHI.

Restriction of PHI: You have the right to request a restriction of your PHI. You also have the right to know the uses and disclosures of your PHI. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Requests for restrictions or to know how we have used and disclosed your PHI must be in writing and include enough information to allow us to reasonably respond to your request.

We are not required to agree to your request under all circumstances. For example, if we believe the information is necessary for your treatment or payment or our health care operations, we can deny your request. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is mandated by law, needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician, who may discuss your request with our Privacy Officer.

Incomplete or Inaccurate Information: You have the right to request that we amend your PHI to correct incomplete or incorrect information. You must make a request to correct or amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We will accommodate reasonable requests, but we may condition this accommodation by asking you to confirm certain requests in writing or to provide other information necessary to honor your request. We are not required to change your health information, and if we deny your request, we will provide you with information about our denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate or complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or inaccurate.

Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us, except that we do not have to account for certain types of disclosures permitted by law, including disclosures provided to you or pursuant to your written authorization.

Paper Copy of this Notice: You may obtain a paper copy of this Notice upon request to our Privacy Officer or the next time you are in the office.

Complaints or questions: If you have complaints or questions and would like additional information, please contact us directly at the following address or phone number: Privacy Officer, GetzWell Pediatrics, 1701 Church Street, San Francisco, CA 94131 or call 415.826.1701. We will make every reasonable effort to address your concerns. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington DC 20201. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Parent/Guardian Signature_____

Please sign here to indicate you have read and accept the terms of the privacy policy. If patient is a minor, at least one parent and/or authorized legal guardian must sign.

Pediatric Medicine Redefined:
Why GetzWell Pediatrics' Custom Approach Requires Being Out of Network

Since its inception, San Francisco's GetzWell Pediatrics has redefined the practice of pediatric medicine by providing truly holistic, cutting-edge care for children and families. Some wonder why GetzWell is structured as a direct pay model rather than as a traditional insurance based practice. The reason is that GetzWell's 21st century approach to health care is fundamentally at odds with the typical insurance based medical model.

In the traditional model, insurance companies set prices for physician services that require rapid turnover and high volumes of patients. Insurance companies do not reimburse based on quality or superior outcomes. This "fast food" approach has led to a quick fix culture in medicine and discourages the development of meaningful relationships between families and their care providers. GetzWell Pediatrics categorically rejects this system as it isn't the best way to care for kids, or anyone.

Our direct pay model does not mean you won't be reimbursed by your insurance. Most of our patients with PPO insurance receive some, often significant, reimbursement (subject to the specific terms of each policy). It is easy to seek reimbursement or credit from insurers following office visits. By simply mailing or faxing the provided "superbill" from each visit directly to the insurer, most families report they are reimbursed or otherwise credited within 2-4 weeks. We now offer the option of having claims submitted for you – just ask us!

By remaining out of network, GetzWell's doctors and patients collaborate to make individual health care decisions without interference from insurance companies. As a result, the quality of care at GetzWell is unsurpassed. Many unique services are available including:

- Longer visits to answer questions, get to know parents and children, and foster trusting relationships
- Virtual appointments when safe and appropriate
- Options outside of typical prescription medications including botanical and herbal medicines, homeopathy, supplements, developmental/emotional advice, and food and lifestyle interventions
- Same day appointments for urgent care
- Guidance about safe vaccination and individualized vaccine schedules
- 24/7 direct access to GetzWell pediatricians by phone and email

At GetzWell we love what we do and this is reflected in the warmth with which families are greeted upon entering the office, the undivided attention patients receive at every visit, the unparalleled access, and most importantly, the result: having a child who is unusually healthy, seldom or never requiring antibiotics or other prescription medications. We value each patient, family, and interaction and cherish the opportunity to practice medicine in a way that's consistent with our deepest held principles and beliefs.

Type of Service	Rate*	CPT Code
Newborn in-office intake	$585	99205 + 99354
Newborn house call (weekdays) starts at	$775	99345
Newborn house call (weekends) starts at	$895	99345 + 99056
New patient well-child intake	$465	99381 – 99385 or 99205
New patient complex consultation starts at	$650	99245
Established patient brief visit	$105	99212
Established patient detailed acute visit	$200	99213
Established patient comprehensive acute visit	$250	99214
Established patient well-child visit or complex acute starts at	$325	99215 or 99391
Established patient brief weekday phone consult (9am – 5pm)**	No charge	n/a
Routine non-urgent email communications**	No charge	n/a
Established patient after hours and weekend phone coverage starts at	$54-75	99441-99442
Non-member surcharge for all services	+ $130	n/a

Many PPO health plans will reimburse 50-70% of our fees after deductibles and other plan requirements are satisfied. However, we cannot guarantee reimbursement at these levels. HMOs do not reimburse for our services. All fees and other charges are due upon completion of the visit or service. Rates are adjusted annually based on changes in the CPI index and other factors. There can be no assurance that the rates set forth above have not changed.

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*Charges for vaccines, vaccine administration, diagnostics, supplements, and medications are extra. New patient intake appointments, including the newborn home visit, typically run 60-75 minutes. Newborn house calls or newborn office visits that run more than 75 minutes, other home visits involving complex or unusual cases, lengthy office visits, and special or atypical services will cost more. Fees and other charges for treatments, services, and products are subject to the terms of our Patient Registration Agreement and Acknowledgement. Fees and charges for all services, vaccines, vaccine administration, and products may be changed without notice.

**Fees will be assessed at our current in-person consultation rates for phone calls, emails, and texts during weekday business hours (9am – 5pm) if they extend more than 10 minutes, involve on-line review of photos, or are otherwise in lieu of an office visit. After hours and weekend phone coverage fees are assessed for all calls and urgent email consultations. All phone/email consults, complex consultations, and after-hours coverage are offered only to members of the practice.

Vaccine	Cost*	CPT code
DTaP (Diphtheria, Tetanus, and acellular Pertussis)	$55 + Admin Fee	90700
Hib (Haemophilus Influenzae Type B)	$54 + Admin Fee	90648
PCV-13 (Pneumococcal Virus, 13 strains)	$235 + Admin Fee	90670
Rotateq (Rotavirus)	$127 + Admin Fee	90680
IPV (Inactivated Polio Virus)	$59 + Admin Fee	90713
MMR (Measles, Mumps, Rubella)	$110 + Admin Fee	90707
Hep A (Hepatitis A)	$74 + Admin Fee	90633
Hep B (Hepatitis B)	$63 + Admin Fee	90744
Varicella (Chickenpox)	$171 + Admin Fee	90716
Pentacel (DTaP, Hib, IPV)	$158 + Admin Fee	90698

*Prices subject to change without notice

Administration fees are $39 for the first antigen (CPT 90460) and $21 for each additional antigen (CPT 90461).

Staggered Vaccine Schedule[†]

Year One

2 mo: DTaP + Rotavirus
3 mo*: PCV + Hib
4 mo: DTaP + Rotavirus
5 mo*: PCV + Hib
6 mo: DTaP + Rotavirus
7 mo*: PCV & Hib
9 mo: IPV + flu[‡]
12 mo: Hib & IPV

Year Two

13 mo*: PCV + Hep B
15 mo[§]: DTaP + IPV
18 mo: MMR
2 yr: Hep A + Varicella
2.5 yr: Hep B
3 yr: Hep B
4 yr: DTaP + Varicella
4.5 yr*: IPV + MMR

[†]This is one illustration. Our baseline is the American Academy of Pediatrics schedule, which we can tailor to meet your child's unique needs or parental request and in anticipation of travel.

*Vaccine-only appointment.

[‡]Administration of first flu vaccine is recommended between 6-12 months of age during the annual flu season. Two doses of flu vaccine are necessary at a one month interval for children receiving the vaccine for the first time and yearly thereafter.

[§]After 15 months, vaccine schedule may vary.