GetzWell personalized pediatrics

Patient Registration Agreement and Acknowledgment

Patient's Name: _____

DOB: _____ Male _____ Female _____

Primary Residence Address: _____

Home Telephone: ( ) _____ Mobile Phone: ( ) _____

If expecting: Name (if known) _____ Due date: _____ Sex (if known) _____

If you already have children (as applicable):

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

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

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

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?

□ Google □ Yelp □ Spotify □ Instagram
□ Friend/member _____ □ Other _____

GetzWell
personalized
pediatrics

Financial Responsibility and Authorization for Payment:

I/we understand that payment for all services, products, vaccines and other amounts incurred will be required for each visit and after each other service related matter and authorize GetzWell Pediatrics to charge all outstanding balances to the credit card or bank account indicated below. I/we authorize this credit card (and all substituted credit cards) to be used to guarantee and pay for late cancellations, missed appointments and unpaid balances including those related to office visits, telephone/e-mail/text consultations, vaccines, products, supplements and miscellaneous costs. I/we agree that if the payment information on file does not accept the charge, I/we will immediately make payment to GetzWell for the amount due and will provide updated payment information upon request. 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, debit or check is rejected for any reason.

To become a member of GetzWell, I/we agree to remit an annual open access membership fee for each child who is a patient based on the current 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, for adult services and consultations. For adults enrolled solely for pre-natal services, if I/we subsequently enroll a child for medical and health services, the 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 upon admission 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. 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.

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 all unpaid balances. My/our signature(s) below verify that I/we have reviewed and consent to the financial terms set forth herein.

Payment Information

ACH Debit Authorization: I authorize GetzWell Pediatrics to initiate electronic debit entries for payment of my medical, health, membership and other charges to my bank account:

Type of Bank Account: ____ Checking account ____ Savings account

Financial Institution Name: _____ Routing # _____ Account # _____

Financial Institution Address: _____

Authorized Signature: _____

Credit Card Authorization: I hereby authorize GetzWell Pediatrics to charge my then current credit card on file for any unpaid balance(s).

Visa/MC (circle type) Account #: _____

Name on credit card: _____

Expiration Date: _____ Security Code: _____

_____

Authorized signature: _____

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 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 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.

Appointments and After Hours Coverage: To schedule appointments and consultations, call or email our: Noe Valley office at 415.826.1701 or info@getzwell.com; or Union Street office at 415.969.6670 or union@getzwell.com.

In connection with medical care (but not consulting services) GetzWell's 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: After 5:00 p.m. on Monday – Thursday and until 9 a.m. the next morning; After 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 cancellation or no show fee, I/we will call between 9 a.m. to 5 p.m. at least **two business days in advance.** This policy applies to all Well Child, Complex, and Consult appointments. For clarity, if an appointment is on a Monday, to make a change, contact us during business hours on the prior Thursday.

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 50% of the cost of the scheduled appointment. 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.

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 all extended telephone, email, skype 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. I/we authorize such charges to my/our credit card or bank account 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 when 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 or bank account 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 afterhours 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.

Insurance Responsibility and Claims Management: I/we acknowledge that GetzWell strongly encourages all of its patients to 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. 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 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 and charges. 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, herbal medicine, etc. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or kits sent to labs using innovative 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.

Health Information Release Authorization and Privacy Practices: GetzWell is permitted by applicable federal and state privacy laws to use and disclose my child's or my own 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), 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.

GetzWell
personalized
pediatrics

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 the ___ day of_____, 20__.

_____ _____

Parent/Guardian Signature Parent/Guardian Signature

_____ _____

Printed Name Printed Name