

Client Registration Agreement and Acknowledgement

Date: _____

Requesting Appointment With:

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

Emily Waight, 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/we authorize the professionals and staff at GetzWell Pediatrics (“GetzWell”) to administer such medical, health care and/or nutrition services, treatments and procedures for my/our children or me as they deem appropriate and necessary under the applicable circumstances. I/we understand that they 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 acknowledge and agree that in connection with any births or adoptions, the doctor/patient relationship shall begin with the first physical examination and not at birth.

I/we understand that if any explanations as to benefits and/or risks and dangers of the prescribed treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. I/we understand that there have been and can be no warranties, representations or assurances of successful outcomes for my/our children or me. Nevertheless, I desire to pursue integrative medical treatment or nutrition services for myself or my children after reviewing the information herein and receiving answers to any questions related to this Agreement. As a patient or parent seeking medical, health care and/or nutrition 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.

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 an appointment, call reception at **415.826.1701** or send an email to **reception@getzwell.com**. In general, appointments start on time. In connection with medical care (but not nutrition services) Dr. Getzelman and our other 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 **415.826.1703** 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: 7:00 p.m. on Monday – Thursday nights and until 9 a.m. the next morning; 6:00 p.m. on Friday night and until 9 a.m. the following Monday morning; 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/we understand that the professional’s time is reserved exclusively for 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 or reschedule an appointment, I/we will call during business hours at least **two business days in advance**. No charge will apply in this situation. 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 \$120 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.

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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 extended telephone consultations of 10 or more minutes that occur at any time, I/we will be billed at the same consultation rate as in-person visits, which I/we authorize to be charged to the credit card on file. Email and telephone consultations are not provided for nutrition services. In general, GetzWell members will not be charged for brief and uncomplicated email questions. However, I/we 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/we will be billed at the current in-person consultation rate, which I/we authorize to be charged to the credit card on file. By sending an email, I/we acknowledge and agree that a prompt reply is NOT required or expected and acknowledge that I/we will not use email communications to deal with emergencies or other time sensitive issues. I/we also understand and agree that email communications may not be secure and the confidentiality of emails cannot be assured or guaranteed, but agree that this is my/our risk with respect to all email communications. GetzWell may keep copies of email communications and such messages may be included in my/our children's or my health record. When any medical, health or non-nutrition related matter requires an urgent response, I/we agree to call GetzWell during business hours or the after hours telephone number (415.826.1703). For all emergencies, I/we will call 911 or go directly to the nearest hospital emergency room.

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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 employers or insurers. 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 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/we understand that the annual open access membership fee paid for each child will not be reimbursed by my/our children's or my insurer.

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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 indicated below. I/we authorize this credit card (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 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.

Additionally, 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 (unless the child is enrolled solely for nutrition services) based on the then applicable fee schedule and understand that the current 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 or 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 become applicable. I/we authorize GetzWell to charge the initial annual fee to my/our credit card when I/we are admitted to the practice and renew the open access membership annually by charging the then applicable annual membership fee to the credit card on file unless I/we withdraw from the practice. I/we understand and agree that the open access fee is nonrefundable. If my/our membership in GetzWell Pediatrics expires or I/we cancel membership, GetzWell is authorized to charge my/our credit card on file for any unpaid balances. My/our signature(s) below verify that I/we 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 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/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 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/we agree to comply fully with this policy. This is my/our sole and exclusive remedy in connection with any complaint or 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 available or accessible forum, newspaper, magazine, electronic publication, blog, web site, on-line users group or similar device, 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 without GetzWell's prior written consent. I/we acknowledge and agree that these terms are reasonable and that any breach or violation of this paragraph will cause significant damage and expense to GetzWell that would be impossible or highly impractical to quantify and establish. Consequently, I/we agree that upon each breach or violation of this paragraph, I/we will be obligated, jointly or severally, to pay liquidated damages to GetzWell in the amount of \$200.00 per day per violation until the breach or violation has been cured to GetzWell's satisfaction.

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 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/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 **Client 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

[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.]