Welcome to the Practice

Casa Verde Pediatrics, Inc.

Lisa M. Asta, MD

We strive to provide the best medical care for infants, children, teens and young adults. We value getting to know your family and working together to combine the medical arts and technology for the most up-to-date information on health, development and illness.

To partner with us for health care, we request that parents and patients

- Schedule regular wellness checks
- Participate actively in health care
- Immunize against vaccine-preventable diseases
- Follow care plans
- Communicate with us if you are uncomfortable with the proposed care plan
- Contact us if you interrupt or discontinue treatment plans
- Provide us with updated contact and insurance information
- Provide caregivers with written permission to obtain treatment for your child in your absence
- Educate yourself about your health insurance

Ins and Outs

Appointments

We are available Monday through Friday from 9 a.m. until 5:30 p.m. Drop-in visits for brief, urgent care illness are available without appointment at 9 a.m., Monday through Friday. During the cold and cough season, you may be asked to reschedule for later during the day if patient demand exceeds drop-in capacity. **Please refer to our Financial Policies below for further details.**

After hours and weekends are described on the last page of this handout.

Help us make the office run smoothly

- Notify us of any change of address, telephone numbers and insurance information.
- Arrive on time. If you are running late, please call ahead.
- Patients who arrive late will be seen as the schedule permits and may be asked to reschedule.
- Present all forms to office staff for their completion.
- Please refrain from using your cell phone while we are working with your family.
- Help us to maintain a clean office by supervising your children and helping to keep books, magazines and toys tidy. We regret that we cannot be responsible for personal items.

Sibling Appointments

To enhance the attention that each individual patient receives, we prefer to schedule only two well visits at a time per family. If this is a hardship for you, please let the receptionist know and we will do our best to accommodate your needs.

We ask you to call ahead if you wish to consult us on a child other than the one who has the appointment. We will make every effort to accommodate your family's health care needs, but given scheduling constraints, it may not always be possible to add certain appointments onto the doctor's schedule once it fills. Help us keep patient wait times down for everyone by scheduling the doctor appropriately.

Telephone Advice
Our nurse practitioner is available for telephone advice during our normal business hours. Calls are triaged and returned based on urgency. Please provide us with the best time and number to reach you. For advice outside of our regular business hours, see the last page of this handout.

Prescription Refills

1) For medication refills, call your pharmacy. We require 48 hours' notice, during regular business hours. Please plan accordingly. We regret that prescriptions for controlled substances, including most ADHD medications, cannot be refilled by phone.

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued. Many insurances require an office evaluation for referrals.

After Hours and Weekend Care

As parents and pediatricians know, children don't always get sick during business hours. For after hours advice and visits, Dr. Asta belongs to the Children's After Hours Care Service in Walnut Creek. This group provides after hours phone advice service and an after hours pediatric urgent care clinic. When you call the nurse, or have your child seen in the clinic, our doctors receive a fax notification so that we can follow-up with you if needed. Please note: if you take your child to any other after hours facility, Dr. Asta will not know about this visit.

Routine, non urgent visits and advice should be directed to our office during our regular hours.

Children's After Hours Care Services
1450 Treat Blvd.
Walnut Creek, CA 94597
(925) 296-9001

Office Hours
Monday through Friday 5 pm to 9 pm*
Sat. and Sun. 9 am to 5 pm*
Holidays 9 am to 3 pm*

*Office hours may vary due to seasonal needs

Pediatric Nurse Advice Line
(925) 296-9001
Monday through Friday 5 pm to 8:30 am the following morning
Sat, Sun, and holidays 24 hours

Please note: If you forget the after hours phone number just call our office (925)939-7334 (PEDI) and listen to the recording.

PATIENT REGISTRATION

Lisa M. Asta M.D.
301 Lennon Lane, Suite 203
Walnut Creek, CA 94598

PATIENT INFORMATION

CHILD'S LAST NAME:_____ FIRST NAME:_____ M.I._____
CHILD'S STREET ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
HOME PHONE:_____ SEX:___MALE ___FEMALE BIRTHDATE:_____
SOCIAL SECURITY #_____-_____-_____
EMERGENCY CONTACT:_____RELATIONSHIP:_____ PHONE: _____

PREFERRED PHARMACY

PHARMACY:_____ADDRESS:_____CITY:_____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN #1:_____ ADDRESS(If different):_____
HOME PHONE:_____ WORK PHONE:_____
CELL PHONE:_____ RELATION:_____ SS#_____
EMAIL:_____

PARENT/GUARDIAN #2:_____ ADDRESS(If different):_____
HOME PHONE:_____ WORK PHONE:_____
CELL PHONE:_____ RELATION:_____SS#_____
EMAIL:_____

INSURANCE INFORMATION

PRIMARY INS:___**Aetna**_____ POLICY #:_____
SUBSCRIBER NAME/DATE OF BIRTH:___**Quinn Diebel**_____
GROUP #:_____ EFFECTIVE DATE:_____
MARITAL STATUS:____Single____Married____Divorced____Widow____Other STUDENT STATUS:_____Full-Time_____Part-Time
YOUR RELATIONSHIP TO INSURED: _____Self _____Spouse _____Child _____Other

FINANCIAL AGREEMENT & RELEASE OF INFORMATION

Casa Verde Pediatrics will bill certain insurance plans in which we are a participating provider. Patients are required to pay applicable co-payments at the time of service. When we are notified by your insurance carrier(s) of any non-covered services, deductibles, or additional co-payments, we will send you a bill. You are required to pay this bill upon receipt. Please remember that this is a courtesy to you and that our billing your insurance plan does not release you of the financial responsibility of your medical services. I understand that I am financially responsible to Casa Verde Pediatrics for all charges incurred. I authorize Casa Verde Pediatrics to furnish information from my records to any insurer of mine. Further, I authorize payment to Casa Verde Pediatrics of the health insurance benefits otherwise payable to me, but not to exceed the regular charges for this period of care. I understand that I am financially responsible to Casa Verde Pediatrics for the charges not paid by my insurance plan(s).

Signature:_____ Date:_____

Patient History

Patient Name: _____ Date of Birth: _____

Parent/Guardian #1:	Parent/Guardian #2:
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Education/Training: _____	Education/Training: _____
Occupation: _____	Occupation: _____
Preferred Phone #: _____	Preferred Phone #: _____

Home Environment: Please list other family and household members:

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		

Please list any pets: _____

Are your child's parents: ___Married ___Unmarried ___Separated ___Divorced

If separated/divorced, what is the custody arrangement? _____

Child-care situation: __Parents __Others (specify who and hours per day) _____

Birth History:

Hospital where born: _____ City: _____ State: ___ Country: _____

Weight: _____Full Term or Premature (___ weeks) Complications of delivery: _____

Type of delivery: Vaginal or Cesarean If cesarean, why? _____

Complications of pregnancy: _____

Fertility/Assisted Birth___ Adoption___ Stepchild___ Other: _____

Breast Fed? Yes No How long? _____ Formula Fed? Yes No Which one(s)? _____

Medical History: (Check any that have been diagnosed and comment below)

__ Hospitalization	__ Congenital Heart Disease	__ Diabetes	__ Recurrent Ear Infections
__ Asthma	__ Prematurity	__ Vision Problems	__ Urinary Tract Infection (UTI)
__ Allergic Rhinitis	__ GE Reflux	__ Seizures	__ Vesicoureteral Reflux (VUR)
__ Eczema	__ Constipation	__ ADD/ADHD	
__ Wheezing	__ Anemia	__ Mental Illness	
__ Food Allergies	__ Murmur	__ Substance Abuse	

Other Medical History: _____

Please list current medications, vitamins, and supplements, even those used intermittently:

_____

Please list allergies or reactions to medications or foods:

Allergy:	Reaction:
_____	_____
_____	_____

Surgical History: (Check any past surgeries and complete age/date) ____No Surgeries

Procedure:	Age/Date:	Procedure:	Age/Date:	Other Surgeries:
__Adenoidectomy	_____	__Hernia Repair	_____	_____
__Appendectomy	_____	__Orthopedic Surgery	_____	_____
__Ear Tubes	_____	__Tonsillectomy	_____	_____
__Heart Surgery	_____	__Circumcision/Urological Surgery	_____	

Patient's Name: _____ Date of Birth: _____

Please flip over →

Family History: (Check any known problems in the family – please complete for parents and siblings).

MGM: Maternal Grandmother
MGF: Maternal Grandfather
PGM: Paternal Grandmother
PGF: Paternal Grandfather

Relationship to Child	Name	Alive?	No Known Problems	ADHD/ADD/Learning Disability	Alcohol/Substance Abuse	Allergies/Food Allergies	Anemia	Anxiety/Depression	Asthma	Autism	Autoimmune/Immune Disorder	Birth Defect/Congenital Anomaly	Bleeding Problem	Cancer	Diabetes	Eczema	Eye/Hearing Problems	Genetic Disorder	G.I. Problems	Heart Attack Before the Age of 55	Heart Disease/High Cholesterol	Hypertension	Kidney Disease	Mental/Psychiatric Illness	Migraines	Seizures	Thyroid Disorder	Tobacco/Vaping/Cannabis	Tuberculosis
Parents	Mom																												
	Dad																												
Siblings	Bro Sis																												
	Bro Sis																												
	Bro Sis																												
	Bro Sis																												
Grandparents	MGM																												
	MGF																												
	PGM																												
	PGF																												

Comments (including *other* responses): _____

_____

Additional Family History: (If Needed)

Relationship to Child	Name	Alive?	No Known Problems	ADHD/ADD/Learning Disability	Alcohol/Substance Abuse	Allergies/Food Allergies	Anemia	Anxiety/Depression	Asthma	Autism	Autoimmune/Immune Disorder	Birth Defect/Congenital Anomaly	Bleeding Problem	Cancer	Diabetes	Eczema	Eye/Hearing Problems	Genetic Disorder	G.I. Problems	Heart Attack Before the Age of 55	Heart Disease/High Cholesterol	Hypertension	Kidney Disease	Mental/Psychiatric Illness	Migraines	Seizures	Thyroid Disorder	Tobacco/Vaping/Cannabis	Tuberculosis

Comments (including *other* responses): _____

_____

_____

_____

Tuberculosis and Lead Screening Questions

Casa Verde Pediatrics, Inc.

Name of Child _____ DOB _____ Date _____

Tuberculosis (TB) is an infection of the lungs and many other parts of the body that can cause death if undetected and untreated. It is contagious. California wants to treat and protect children who have been exposed to TB and are at risk of the infection.

The following questions help determine testing for tuberculosis. These questions and TB testing are required for childcare, school, and many jobs. These questions are used only to decide who needs TB testing.

Ask the doctor or nurse practitioner if you need more information to answer the questions.

Where was the child born? ***Please circle one***

United States
Africa
Asia
Middle East
Northern/Western Europe
Eastern Europe
New Zealand/Australia
Latin American: Central or South America

Please answer the following questions by circling **yes** or **no**

1. **Has the child traveled to or lived in a country with a high rate of TB and stayed for *one month* or more? YES/NO**

   Where did they travel or live? ***Please circle all areas below***

   Africa
   Asia
   Middle East
   Northern/Western Europe
   Eastern Europe
   New Zealand/Australia
   Latin American: Central or South America

2. **Has the child even been around anyone who has ever had TB or a positive TB test? YES/NO**

This includes anyone with a positive TB test or was treated for TB at any time in the past including family, friends, nannies, babysitters and childcare providers, especially if they were born outside of the United States.

3. **Is your child being treated for a condition that suppresses the immune system? YES/NO**
   This includes: oral steroids for more than a month, infection with HIV, an organ transplant or other medications that suppress the immune system.

For **children under 5**, please continue to the following lead screening questions:

5. Does your child live in or regularly visit a house that was built before 1950? YES NO
Is there chipped, peeling or damaged paint? YES NO
6. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the past 6 months?) YES NO
7. Does your child have a sibling or playmate who has or did have lead poisoning? YES NO

Reviewed on: _____ _____ _____ _____ _____

Acknowledgement of Receipt of Notice of Privacy Practices
Casa Verde Pediatrics
Medical Group, Inc.
301 Lennon Ln. Ste 203
Walnut Creek, CA 94598

Lisa M. Asta, MD
Privacy Officer
(925)939-7334

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

"I would like to receive a copy of any amended Notice of Privacy Practices by e-mail through our Webview (Patient Service Plan) secure online portal."

Signed: _____ **Date: _____**

Print name: _____ **Telephone: _____**

If not signed by patient, please indicate relationship:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient

Name and address of patient(s):

_____

_____

_____

Office Financial Policy
Casa Verde Pediatrics, Inc.

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we require 8 business hours' notice to cancel. There is a charge of $35 for missed appointments, and if the appointment is for 5:00 p.m. or later the missed appointment fee is $50.

2) If you are late for your appointment (15 minutes or more), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.

Initial: _____

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

2) We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. You are responsible for any balance on your account.

3) Parents are jointly responsible for payment on their children's account.

4) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

5) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example

a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

6) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

Please flip over →

2) Co-payments are due at the time of service. A $20 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6) If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $10 re-bill fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency. You will be responsible for any fees associated with collecting your outstanding balance.
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A $35 fee will be charged for any checks returned for insufficient funds. If we receive a check back from your bank, we will be unable to accept future payments for services paid by check.
11) Parents are financially responsible for the cost of the immunization(s) if their child is not cooperative or parents change their mind about the immunization(s) and the immunization(s) must be wasted. We cannot bill insurance if the immunization is not administered to the patient.

Initial: _____

Forms

1) There is no charge for school and camp forms presented for completion at the time of your child's visit. However, should you lose your forms, there will be a $25 charge per form to replace them.
2) Any additional school, camp, or sports forms are subject to a $25 per form fee. Family and Medical Leave Act forms are $25. Payment is due when the forms are dropped off. We typically require a 5 day turnaround time. If a form is needed sooner than 5 days, there is an additional $15 rush fee.

Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We require 5 business days' notice.
2) A copy of your complete record is available for a fee.
3) We provide records of your child for visits (including consultations from specialists) rendered at this location only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____ Relationship_____

Responsible Party Member's Signature _____ Date _____

Online Communication Agreement

Casa Verde Pediatrics, Inc.

Online communication is a form of communication using 'secure' web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication and it is not meant to replace other forms of communication with the office.

Please initial each item on the line provided.

_____ The details of online communication have been explained to me in terms I understand.

_____ Alternative methods of communications (i.e. telephone, fax, in-person, mail) are still available to me.

_____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- It is easier for online communication to be forwarded, intercepted or even changed without my knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. Back-up copies may exist on a computer or in cyberspace even after both of us have deleted our copies.
- I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have the right to inspect and keep online communication transmitted through their system.
- Online communications become part of my medical record.

_____ I agree to take precautions to keep online communication confidential, including but not limited to the following:

- I will keep my password confidential
- I will not store messages on an employer-provided computer
- I will not leave messages on my screen for others to read
- I will review my messages before sending them to make sure that they are clear and that all relevant information is included.
- I will update my contact information as soon as it changes.

_____ I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.

_____ I agree to follow the procedures that the doctor implements to allow her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communications

_____ **I understand that online communication cannot be used for emergencies or time sensitive matters**

_____ I understand that online communication cannot be used to communicate highly sensitive medical information such as treatment for, or information related to HIV/AIDS, sexually transmitted diseases or addiction treatment (alcohol, drugs, etc)

_____ I have informed the doctor of other treatments I do not want transmitted via online communications

_____ I understand that it is my responsibility to determine if an unanswered online communication was received

_____ I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication

_____ I understand that failure to comply with any of the previous terms may lead to me no longer being able to use the online communication tools.

_____ The doctor or office staff has answered all of my questions

Again, please note that online communication should never be used for emergency communications or urgent requests. These should occur via telephone or by using existing emergency communication tools.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature

For online communication between: Casa Verde Pediatrics, Inc. and

_____.
Patient's Name

_____ _____
Patient/ Guardian Signature Relationship

_____ _____
Patient's Name Date

_____ _____
Email Address (Only one per family please) * Contact number

*Parent/Guardian is responsible for any email address changes with Casa Verde Pediatrics, Inc. Please call us and notify us of any changes for your email address.

I certify that I have explained the nature of this agreement to the patient/ legal representative I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained

_____ _____
Physician Signature Date

Authorization for Release and/or Disclosure of Medical Information

1. **I hereby authorize:**
   - ☐ Casa Verde Pediatrics, Inc./Dr. Lisa M. Asta 301 Lennon Ln. Ste. 203 Walnut Creek, CA 94598
     Phone: (925)939-7334 Fax: (925) 939-7340

   - ☐ Other (specify):_____
     Phone: (_____) _____ Fax: (_____) _____

2. **To release and/or disclose the medical information to the person/entity I have indicated below:**

   - ☐ Person/Entity authorized to receive the information: _____
     Complete Mailing Address/Phone/Fax: _____

   - ☐ Casa Verde Pediatrics, Inc./Dr. Lisa M. Asta 301 Lennon Ln. Ste. 203 Walnut Creek, CA 94598
     Phone: (925)939-7334 Fax: (925) 939-7340

3. **This authorization applies to the following health information:**
   - ☐ All Medical Records
   - ☐ Immunization records
   - ☐ Growth charts
   - ☐ School or day care forms
   - ☐ Imaging reports (specify dates):
     _____
   - ☐ Laboratory results (specify dates):
     _____
   - ☐ Other specific records/types of health information (including dates):
     _____
     _____

4. **I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only:** ☐ Further medical care ☐ Other (please specify):_____

5. **Expiration:** This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date entered.

6. **Preferred method of delivery:** ☐ Pick up ☐ Mail (postage charged) ☐ Access to view the record above (no fee)
   Preferred format: ☐ CD ☐ Paper copies made of the record indicated ☐ Other
   ☐ Fax up to 10 pages_____ (Please Initial) Patient requests records to be faxed to another facility or physician's office. Patient is aware of the confidentiality risks involved and releases Casa Verde Pediatrics, Inc. and Lisa M. Asta, MD from responsibility for faxing to the following number: (_____) _____.

CLERICAL CHARGES

If copies or record transfer is requested, I acknowledge that the law requires me to pay reasonable clerical costs and permits copying fess of $0.25 per printed page, plus postage for mailing copies. I acknowledge that the charge for electronic copies is based on the cost of supplies for provided electronic media, the cost of skilled labor and technical skill to produce the electronic copy, plus postage.

Signature:_____ **Date**: _____ **Time**: _____**Phone**: _____
Print Patient Name:_____**Date of Birth**:_____
Print Requestor Name (if other than patient):_____
Relationship to Patient: ☐ Legal Representative ☐ Parent/Guardian