PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY) DATE: _____

OFFICE:_____

PATIENT INFORMATION

Name_____ Date of Birth_____

Address_____ Home Phone ( )_____

City_____ Cell Phone ( )_____

State_____ Zip Code_____ Work Phone ( )_____

Employer Name_____ E-mail Address _____

Primary Care Physician_____

EMERGENCY CONTACTS

Name_____ Relationship_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

ACCESS TO MEDICAL RECORDS

I give access to my medical records and account information for personal inspection and/or discussion to:

_____ **Relationship**_____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial I _____ authorize PHA to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives PHA permission to leave this information on my cell phone or with a member of my household.

Phone number to call with information: ( )_____

_____ Initial I authorize PHA or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. PHA has my permission to release any diagnostic studies, reports, etc. to a specialist involved in my care.

PAYMENT POLICIES

_____ Initial **Insurance Information**: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances**: When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. <u>You are responsible for payment of services unpaid by your insurance company and for timely payment of your account.</u> We accept cash, checks or credit cards. PHA reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $10 fee. All returned checks will be subject to a service charge of $15.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

_____ Initial **Referrals:** If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows:** A $50 no show fee will be assessed for all well and specialty consult visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

<u>PLEASE COMPLETE BOTH SIDES OF THIS FORM</u>

PEDIATRIC HEALTHCARE ASSOCIATES PATIENT REGISTRATION FORM (18 YEARS OR OLDER)

In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE:

- ☐ Caucasian
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Asian Pacific American
- ☐ Pacific Islander
- ☐ Subcontinent Asian American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian
- ☐ Black Non-Hispanic
- ☐ Other Race or Ethnicity
- ☐ White Non-Hispanic
- ☐ Race Not Reported – Refusal
- ☐ Race Not Reported – Don't Know
- ☐ Race Not Reported – Not Ascertained

ETHNICITY: ☐ Latino/Hispanic ☐ Not Latino or Hispanic ☐ Other ☐ Refused

Language predominantly spoken _____

COMPLETION OF THIS SECTION IS <u>OPTIONAL</u>

GENDER IDENTITY

- ☐ (M)ale – person specifies gender identity as male.
- ☐ (F)emale – person specifies gender as female.
- ☐ (FTM) Transgender Male / Female-to-Male – person specifies gender identity as transgender male.
- ☐ (MTF) Transgender Female / Male-to-Female – person specifies gender identity as transgender female.
- ☐ (G) Genderqueer – neither exclusively Male nor Female.
- ☐ (O)ther – person specifies a gender identity that is other than the options of Male, Female, Transgender Male, Transgender Female, or Genderqueer.
- ☐ (D)eclined

My signature below indicates I am the patient listed on the front page and that I have provided accurate information to the best of my knowledge and I understand and agree to all the provisions as stated.

Patient Signature _____ Date _____