PEDIATRIC PATIENT REGISTRATION FORM

DATE:_____

DEMOGRAPHICS:

Patient Name: _____

Sex: _____ DOB:_____ Age: _____ Social Security: _____

Address: _____

City / State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Marital Status: _____ Race: _____ Religion:_____

EMERGENCY CONTACT:

Name: _____ Phone #: ( ) _____ Relationship:_____

EMPLOYER:

Name: _____ Phone #: ( ) _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION (To whom statements are sent):

Self ☐
Guarantor's Name: _____

Relationship to Patient_____ Date of Birth: _____

Address: Same as Patient's? ☐ _____

City / State: _____ Zip: _____

Home Phone #: ( ) _____

RESPONSIBLE PARTY/GUARANTOR: ***The responsible party/guarantor will get the bill and is responsible for payment - patients 18 or older will automatically be setup as their own unless authorized by signature below.***

I authorize the above "Guarantor" to receive my medical bills:

_____
Signature

PRIMARY CARE PHYSICIAN:

Name: _____Phone #: ( ) _____

PHARMACY INFORMATION:

Name: _____ Location/City :_____

Phone #: ( ) _____

Patient Name: _____ Date: _____ DOB: _____

INSURANCE INFORMATION: *(If available, attach copy of insurance card(s) to this sheet)*

Primary Ins: _____ Primary Ins Phone #:_____

Address to Send Claims: _____

Policy ID #:_____Group #:_____ Effective Date: _____ Co-pay Amt:_____

Policy Holder's Name:_____ DOB:_____ Sex: _____

Address: _____

Social Security # _____ Relationship to Policy Holder: _____

Secondary Ins: _____ Secondary Ins Phone #:_____

Address to Send Claims: _____

Policy ID #:_____Group #:_____ Effective Date: _____ Co-pay Amt:_____

Policy Holder's Name:_____ DOB:_____ Sex: _____

Address: _____

Social Security # _____ Relationship to Policy Holder: _____

PARENT 1

Parent Name: _____

DOB:_____ Social Security: _____

Address: *(if different)* _____

City / State: _____ Zip: _____

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

PARENT 2

Parent Name: _____

DOB:_____ Social Security: _____

Address: *(if different)* _____

City / State: _____ Zip: _____

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

REGISTER ADDITIONAL FAMILY MEMBERS (under the same Guarantor):

First Name, MI, Last Name	Date of Birth	Sex: M/F
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN INFORMATION

Usual doctor at this practice: _____

List all doctors this patient has seen in the last 3 years - please estimate the month / year last seen

Doctor	**Month/Year**
1. _____	_____
2. _____	_____

OTHER IMPORTANT INFORMATION

How did you hear about us? _____

May we leave a phone message with an appointment reminder, follow up reminder and/or result of medical tests and/or procedures on your answering machine or voicemail?

Home Phone Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No

Patient Name: _____ Date: _____ DOB: _____

FINANCIAL AND MANAGED CARE POLICY STATEMENT

University Hospitals Medical Practices/Group adheres to the policies below. The patient / responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

1. Patients with an insurance co-payment are expected to make payment when checking in for the appointment.

2. Patients with **high deductible** ($1,000 or more) plans are required to pay the following fees prior to their doctor visit: $100.00 for first new patient visit, $50.00 for each subsequent visit, $100.00 for consultations, $50 for urgent care visits. Patients will be refunded or billed for additional amounts as appropriate after claim(s) are processed by their insurance company.

3. Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.

4. Not all services are covered benefits of all insurance plans. The patient / responsible party maintains the responsibility of verification of applicable coverage.

5. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.

6. Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.

7. UHPS does not bill third parties in legal situations or injuries (non-work related). We bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient's account.

We accept cash, personal checks, and credit cards (Visa, MasterCard, Discover). Returned checks and balances older than 45 days may be subject to additional collection fees. We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today's appointment. Thank you for your understanding and cooperation with this policy.

1. **I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.**

2. **I agree that this authorization is valid regardless of when I receive services at this office, that the information on pages above is accurate, and that I am the patient or authorized to sign this document.**

Patient/Responsible Party Signature:_____ Date: _____

Patient Name: _____ Date: _____ DOB: _____

GENERAL CONSENT

SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

[Patient/Patient's legal representative] agree to permit authorized personnel of University Hospitals [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may used for educational purposes.

I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.

Authorization to Release Information

The undersigned hereby permits University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or educating students, performance improvement initiatives, discharge planning, risk management and/or as required by law. The undersigned hereby permits its affiliated healthcare providers and/or their authorized personnel to access electronic prescription data.

Assignment of Benefits

In consideration of the Hospital's and/or physician(s)'s services received or to be received for medical/surgical services, I assign to the Hospital and/or my physician(s), all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and /or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

Medicare/TRICARE/Champus Payment /Notice of Privacy Practices

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Name: _____ Date: _____ DOB: _____

Record Retention Policy

The Hospital retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data

I understand that my medical records will be accessible to authorized Hospital personnel through computers and that the Hospital will comply with certain safeguards established by federal state and local law as well as Hospital policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. In understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on the form. Otherwise, subject to applicable law, this consent will expire at the same time the Hospital's record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimbursable Items

I understand that the Hospital is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe. I understand and agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorize the hospital to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

Other Uses of Medical Information

The undersigned hereby understands and recognizes that University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by UH and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations, as well as Hospital policies regarding research studies.

Additional Permitted Uses and Disclosures of Confidential Medical Information

The undersigned understands and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency; an appropriate Public Health Authority; for purposes required by State and/or Federal Law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation; to organ procurement organizations; and for any other permissible purpose as outlined in University Hospitals Notice of Privacy Practices.

Notice of Privacy Practices - Acknowledgment

PLEASE CHECK THE APPROPRIATE BOX:

☐ Yes ☐ No ☐ N/A I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").

If no, reason acknowledgement of NOPP not received:_____

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative, if patient is unavailable Date

_____ _____
Witness Date