Pediatric Center for Wellness — Family Registration Form

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT

Child's Legal Name	DOB:	Sex	Ethnicity & Race *(Meaningful Use Data)*
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ____________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ____________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ____________
Child's Legal Name Last: ____________ First: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐ Hispanic ☐ Non-Hispanic Race: ____________

PARENT/GUARDIAN INFORMATION

Parent/Guardian	Address	Phone
☐ Father ☐ Mother ☐ Other: ____________ Name: ____________ DOB: ________ Email: ____________	Address:	☐ Cell ☐ Home Primary Phone #:
☐ Father ☐ Mother ☐ Other: ____________ Name: ____________ DOB: ________ Email: ____________	Address:	☐ Cell ☐ Home Primary Phone #:

EMERGENCY CONTACTS

(LIST ADDITIONAL PERSONS WHO MAY BRING CHILDREN FOR APPOINTMENTS OR WHO WE ARE AUTHORIZED TO COMMUNICATE WITH FOR MEDICAL INFORMATION)

Name	Relationship	Phone
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home
Name:	Relationship to child:	Phone # - ☐ Cell ☐ Home

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE PATIENT COORDINATOR

Insurance	Subscriber	DOB
INSURANCE:	Subscriber:	DOB:
INSURANCE:	Subscriber:	DOB:

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

- ✓ I understand that I am financially responsible for all professional charges that my children may incur.
- ✓ All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.
- ✓ I hereby authorize payment of medical benefits direct to Advanced Pediatric Associates. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.
- ✓ Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Pediatric Center for Wellness to treat my child in their office as required by the events of that emergency situation.

______________________________ ______________________________ ____________

Parent/Guardian Signature (Patient Signature if 18 or older) Printed Name Date

FINANCIAL POLICY

Pediatric Center for Wellness is dedicated to providing excellent care and understanding overall-service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy.

Our office participates in most major health plans, but please remember:

- It is your responsibility to verify that Pediatric Center for Wellness is a participating health care provider in your health plan. This should be done prior to making an appointment.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services, you will be responsible for payment.
- Co-pays are due at the time of service.
- Insurance cards must be brought to each visit so that we can ensure that we are billing the most current insurance plan.

Cancellation/No Show Policy & Late Arrival Policy

- PCW strives to accommodate as many same day appointments as possible in order to provide the best possible care to all our patients. Therefore, if you need to cancel an appointment, please provide 24 hours notice so we can offer the time to another patient. If sufficient notice is not provided, you could be considered a "no show."
- We ask that every patient arrives 10 minutes prior to their scheduled appointment to allow time for the check-in process. If you miss your appointment, we may have to reschedule you to accommodate all other patients on the schedule.
- Repeat violators of these policies could be dismissed from our practice.

By signing this form, I acknowledge that I have read and understood the above policies.

____
Printed Name

______________________________________ __________________________
Signature *Date*

HIPAA Acknowledgment

I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Policy Practices for Pediatric Center for Wellness.

______________________________________ __________________________
Signature *Date*

This acknowledgment will be scanned into the patient's permanent electronic medical record.

Office use only. Patient MRN: _______________

CONSENT FOR TREATMENT

I give my permission for Pediatric Center for Wellness to treat my child and/or children listed below, according to the standards of care defined by the American Association of Pediatrics (AAP)
and the realm of medical necessity as deemed appropriate by the treating Provider.

(Child 1) ___________________________ (Child 2) ________________________

(Child 3) ___________________________ (Child 4) ________________________

_____________________________ (Print Name) _________________ (Date)

_____________________________ (Signature of Parent /Guardian)

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (ie. Nanny, Grandparent, Step-Parent, and/or teen by themselves)

I,____ (Please Print), do hereby consent and authorize Pediatric Center for Wellness and its Providers and Staff to examine and/or treat my child/children in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give the Providers and Staff permission to treat my child/children in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines, and the best number to reach me for this is: _____________________________.

___________________________________ ______________________________
Signature Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.