AGAPE
FAMILY HEALTH

PEDIATRIC
PATIENT REGISTRATION

Date: ___________________

Patient

Last Name ______________________ First Name _________________________ Initial ________

Date of Birth _________________ Gender: ☐Female ☐Male UUP ________________________

Address ____

City ___________________________________ State _______________ Zip _________________

Phone – Home ____________________ Preferred Message/Contact Phone _____________________

Race (please circle) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other __________________

Preferred Language ____

Who was the patient's last provider? ____

Preferred Pharmacy____

Email:____

Health Insurance

Primary Insurance ______________________ ID#______________________ Group#______________

Policy Holder Name _______________________ Date of Birth _____________________________

Employer ________________________________ Relationship to Patient _____________________

Employer Address __________________________ City ______________ State _____ Zip _______

Secondary Insurance _____________________

Policy Holder Name _______________________ Date of Birth _____________________________

Employer ________________________________ Relationship to Patient _____________________

Employer Address __________________________ City ______________ State _____ Zip _______

Office Staff: if unable to scan card, make copy of card and attach to this form. If card unavailable, but patient has group & subscriber number, please write numbers on this form.

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Guardian/ 1st Parent	Last Name"'_______________________a______ First Name______________________________ Social Security Number _______________ Date of Birth _________________ Sex _____________ Address (if different from patient) ____ City ____________________________________ State _______________ Zip _________________ Phone – Home ____________________ Work ____________________ Cell _________________ Marital Status _________________ Email ____ Employer _________________________________ Relationship to Patient _____________________ Employer Address ___________________________ City ______________ State _____ Zip _______
Emergency Contact	Last Name _______________________ First Name______________ Phone Number _____________ Address ____________________________ City _________________ State _______ Zip _______ Relationship to Patient ____
2nd Parent	Last Name ______________________ First Name _________________________ Initial ________ Social Security Number _______________ Date of Birth _________________ Sex _____________ Address (if different from patient) ____ City ____________________________________ State _______________ Zip _________________ Phone: Home ___________________ Work ____________________ Cell __________________ Preferred Message/Contact Phone ________________________ Marital Status _________________ Employer _________________________________ Relationship to Patient _____________________ Employer Address ___________________________ City ______________ State _____ Zip _______

PEDIATRIC
PROTECTED HEALTH INFORMATION RELEASE

Parental/Guardian Consent for Medical Treatment when Parent/Guardian is not present:

Please check all applicable boxes and fill in any blank spaces where information is requested.

Only release information to me personally.

You have my permission to speak with my Spouse (Stepparent/Significant Other) about my child's medical care.

Spouse (Stepparent/Significant Other)'s Name ________________________
Phone ___________

You have my permission to leave information on my answering machine regarding my child's medical care and test results.

You have my permission to talk with these family members or caregivers about my child's care.

Name _______________________________ Phone________________________

Relationship __________________________

Name ______________________________ Phone _______________________

Relationship _________________________

Are there currently any legal proceedings concerning the custody of this child?If yes, please explain: _____________________ Yes No

Caregiver Information

The following named person(s) shall be authorized to bring my child to medical appointments **in my absence**.

Please attempt to contact me at the following telephone number:_____________ if you need any further authorizations.

____ ____

Caregiver's Name and Relation Phone Number

____ ____

Caregiver's Name and Relation Phone Number

I agree to pay for all services provided to my child in my absence.

This authorization shall be effective from______________ until______________ or up to one year from the date below**.
Month, Day, Year Month, Day, Year

By signing below I certify that I am the Legal Primary Caregiver of:

____ ____________________________________

Patient's Name Relationship to patient

____________________________________ ___________________________ ______________________

Legal Primary Caregiver Name **(Please print)** Legal Primary Caregiver Signature **(Please sign in office)** Date and Time **

Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

- We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

- You will receive at least two statements after your visit at our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

- The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

- I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Agape Family Health, LLC, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

Patient Name(printed):____

Signature:_________________________________Date:___________________

Relationship to Patient (if minor):__________________________________

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996
(HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain medication history from pharmacy.

Obtain lab history through labcorp portal.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name(printed):____

Signature:______________________________________Date:_____________________

Relationship to Patient (if minor):_______________________________________