AGAPE
FAMILY HEALTH

PEDIATRIC PATIENT REGISTRATION

Date: _____

Last Name _____ First Name_____ Initial _____

Date of Birth _____ Gender: ☐Female ☐Male SSN: _____ Marital Status_____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Preferred contact: ☐ Phone ☐ Text ☐ Email Preferred Language:_____
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ Other _____ ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other _____

Employer _____ Occupation_____

Current/Past PCP _____ Pharmacy _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group #_____

Policy Holder Name _____ DOB:_____

Relationship to Patient _____ SSN _____

Secondary Insurance _____ ID# _____ Group # _____

Policy Holder Name _____ DOB: _____

Relationship to Patient _____ SSN _____

Guardian Information

Name 1st:_____ Name 2nd:_____

Phone Number 1st:_____ Phone Number 2nd:_____

Relationship to Patient 1st:_____ Relationship to Patient 2nd:_____

SSN 1st:_____ SSN 2nd:_____

Employer 1st:_____ Employer 2nd:_____

Are there any current legal proceedings concerning the custody of this child? _____
Are the child's parents married?_____

Agape Family Health has permission to speak concerning my medical care and results with:

☐ Only release information to me personally ☐ Other_____

☐ Leave on voicemail ☐ Text ☐ Email
Agape Family Health has permission to send appointment reminders via ☐ Text ☐ Email

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HIPAA POLICY

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 the pharmacy.
-Obtain lab history through various lab portals.
-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 of my health information. I have been given the right to read and review your 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:_____ Date:_____

Signature:_____ Relationship to patient:_____

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Agape Family Health, LLC and consent to treatment of the NP or PA on duty and whomever they may designate as their assistant, associate, and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks. I acknowledge that failing to cancel an appt without 24 hour notice can result in a 25.00 no show fee.

Patient Name: _____ Date:_____

Signature:_____ Relationship to patient:_____

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Financial Policy

Agape Family Health, LLC. will file your insurance claims for you, we do request a copy of your current insurance card and valid photo ID to ensure accurate billing. Insurance benefit verification will be performed and recorded in the patient chart before each visit. We do not accept all insurances, it is your responsibility to confirm directly with your insurance company that we participate with them. If you do not have insurance or if your insurance does not cover the services rendered from our clinic, payment is your responsibility. If your insurance company/plan requires a referral, co-pay, coinsurance, or deductible it is your responsibility to have it with you at the time of service. Failure to do so may result in 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 a valid photo ID, which will be scanned into your chart. Lack of this information may result in having to reschedule your appointment.

–Minors: The parent/guardian accompanying the minor at the time of service or the guarantor of the insurance policy to whom the minor has coverage under is responsible for payment.

-We will request copay and or coinsurance payment at the time of service as our contracts require with insurance companies.

–You will receive at least two billing statements after your visit at our clinic. If payment has not been made in full or acceptable payment arrangements have not been made by the time the patient portion of the statement reaches the 91st day, the account balance will be sent to our professional credit bureau, Rapid Recovery, LLC. for collection. The credit bureau will send you 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. Calls may also be initiated by Rapid Recovery, LLC., if a response is not received in the time allotted in the letter.Once the letter of collection has been sent, any payment on this balance must be paid directly to Rapid Recovery, LLC.. If you do not respond to the letter/calls your credit record will be adversely affected.

** I understand and agree that if I or the guarantor of the insurance policy covering dependent/dependents fails to pay for services for which I am responsible, after such default and upon referral to Rapid Recovery, LLC. by Agape Family Health, LLC., I will be responsible for all costs of collecting monies owed, including court costs, and collection agency fees.

–**Appointment Cancellations**- Appointments must be canceled/rescheduled 24 hours prior to the scheduled appointment time. In the result that this kind of situation becomes habitual (more than two appointments) Agape Family Health, LLC. reserves the right to terminate the patient/provider relationship. You will be notified by letter at your last known address.

– **No Showing for appointments**: Agape Family Health, LLC. reserves the right to collect a **$25.00 “No Show” fee** after the second no show for scheduled appointments at our facility **before you will be able to be seen for future care**. In the result that you are unwilling or unable to pay this fee, Agape Family Health, LLC. reserves the right to terminate the patient/provider relationship. You will be notified by letter at your last known address.

– Debit/Credit Card Processing: If a debit/credit card is used to make payment in the office or over the phone, a 3.5% fee of the total amount due will be added to the amount the card is charged for.

–We are disclosing our policy to avoid any misunderstanding in the future.

Patient Name(Printed): _____ Date: _____

Patient/Parent/Guardian/Guarantor Signature: _____
Date: _____

Privacy Information

Agape Family Health has permission to speak concerning my child's medical care and results with

☐ Only release information to me personally ☐ Other _____

☐ Leave on voicemail ☐ Send text ☐ Send email

Agape Family Health has permission to send appointment reminders via ☐ text ☐ email

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 Phone #: _____ if you need any further authorizations.

_____	_____
Caregiver's Name and Relation	Phone Number
_____	_____
Caregiver's Name and Relation	Phone Number
_____	_____
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 document will be considered valid unless a written revocation is received.

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

_____	_____
Patient's name	Legal Primary Caregiver's Name (please print)
_____	_____
Legal Primary Caregiver's Signature	Relationship to Patient

Health History

Child's name: _____ Date of birth: _____ Age: _____

Is this your child by: ☐Birth ☐Adoption ☐Step-child ☐Other: _____

Any significant problems during pregnancy? ☐Yes ☐No Any significant problems during labor: ☐Yes ☐No

If yes to any of the above questions, please explain: _____
_____

Have you or your prior provider ever had any concerns about your child's growth or development (speech,

language, social skills, motor skills, etc...) ☐Yes ☐No If yes, please explain:_____
_____

Have you ever denied vaccines for your child? please explain: ☐Yes ☐No

If yes why:_____

Has your child:

Had any serious medical illness? ☐Yes ☐No
Had a history of asthma of wheezing? ☐Yes ☐No
Had broken bones/frequent/sever sprains?☐Yes ☐No
Had any mental or behavioral problems? ☐Yes ☐No
Ever used an inhaler or nebulizer? ☐Yes ☐No
Had surgery? ☐Yes ☐No
Been hospitalized overnight? ☐Yes ☐No

If yes to any of the above, please explain: _____
_____

Please list allergies or reactions to medications, vaccines or foods:_____
_____

Please list all medications: _____

Family History

☐ADD/ADHD_____
☐Alcoholism _____
☐Allergies _____
☐Asthma_____
☐Blood disease _____
☐Cancer _____
☐Depression _____
☐Developmental Delay_____
☐Diabetes _____
☐Hearing Disorder_____
☐Heart disease_____
☐High Cholesterol_____
☐High Blood Pressure_____
☐IBS _____
☐Mental Illness_____
☐Migraines_____
☐Renal Disease_____
☐Seizure Disorder_____
☐Stroke_____
☐Other_____

Social History

Please list all family and household members:
_____
_____

Child-care situation ☐ Parents ☐ Daycare ☐ Other _____
Concerns about your child: ☐Alcohol use ☐Tobacco ☐Sexual Activity ☐Aggressive behavior
Is violence a concern at home ☐Yes ☐No Do any family members smoke in the home ☐Yes ☐No