PEDIATRIC ASSOCIATES

PATIENT REGISTRATION

Please complete the patient's demographic information. ***ALL ITEMS MUST BE COMPLETED.***

PATIENT INFORMATION

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	PATIENT'S MIDDLE INITIAL	DATE OF BIRTH

GENDER	PATIENT'S CELL NUMBER (16 & OLDER)	PREFERRED PRIMARY CARE PROVIDER	PREFERRED PHARMACY/ LOCATION

LANGUAGE(S) SPOKEN IN HOME:	ETHNICITY (SELECT ONE):	RACE (SELECT ONE):
☐ ENGLISH ☐ SPANISH ☐ OTHER ___________________	☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ UNKNOWN/REFUSED	☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ UNKNOW/REFUSED

PARENT/GUARDIAN INFORMATION

PARENT/LEGAL GUARDIAN'S NAME (MAIN CONTACT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER
MAILING ADDRESS	CITY, STATE, ZIP		EMPLOYER
PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE)	CITY, STATE, ZIP		EMAIL (FOR PATIENT PORTAL ACCESS)
PARENT/LEGAL GUARDIAN'S NAME (SECONDARY CONTACT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER
MAILING ADDRESS (IF DIFFERENT THAN MAIN CONTACT'S)	CITY, STATE, ZIP		EMPLOYER
PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE)	CITY, STATE, ZIP		EMAIL (FOR PATIENT PORTAL ACCESS)

WHO IS THE PRIMARY CAREGIVER OF THE PATIENT?	IF APPLICABLE, WHO HAS CUSTODY OF THE PATIENT?
☐ BOTH ☐ MOTHER ☐ FATHER ☐ OTHER ___________________	☐ BOTH ☐ MOTHER ☐ FATHER ☐ OTHER (PLEASE PROVIDE LEGAL DOCS SHOWING CUSTODY)

EMERGENCY CONTACT (NAME, PHONE, RELATION TO PATIENT)	HOW WOULD YOU LIKE TO RECEIVE REMINDERS & NOTIFICATIONS? (CHOOSE 1 OR MORE) ☐ EMAIL ☐ PHONE ☐ TEXT

SIBLING INFORMATION (LIST ONLY IF ESTABLISHED OR FUTURE PATIENTS)

PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH	PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH
PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH	PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE	MEMBER NUMBER	POLICY HOLDER'S NAME

☐ NO INSURANCE/SELF-PAY	WOULD YOU LIKE TO RECEIVE A SLIDING FEE SCALE APPLICATION? ☐ YES ☐ NO WOULD YOU LIKE INFORMATION ABOUT OUR MEMBERSHIP PROGRAM? ☐ YES ☐ NO

Please read carefully before signing below:

- I understand I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payments, deductibles, or co-insurance at the time of service or promptly when billed. I understand that insurance cards should be presented at EVERY VISIT.
- I understand that hearing, vision, developmental screenings and all other in-house labs are billed separated to insurance and it is my responsibility to know what is covered under my insurance policy and I am responsible for any charges that may incur.
- I understand I will be listed as the guarantor and will receive the financial statements. Both parents are financially responsible regardless of custody arrangements.
- I hereby authorize payment of medical benefits directly to Pediatric Associates. I further authorize the release of any medical information necessary for processing the insurance claims. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.
- In the event of an emergency and I cannot be contacted, I give my permission to Pediatric Associates to treat my minor child (under age 18) in their office as required by the events of that emergency situation.
- I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Practices for Pediatric Associates.
- I give permission for telemedicine appointments, when deemed necessary.
- I consent to receive text, voice and/or email notices as a way to contact me about appointment reminders, billing and health notifications and announcements.
- I authorize Pediatric Associates to share immunization with my child(ren)'s school and the Colorado Immunization Information System (CIIS).

SIGNATURE	RELATIONSHIP TO PATIENT	DATE

PEDIATRIC ASSOCIATES

ALTERNATIVE CAREGIVER CONSENT

Consent must be completed by a parent/legal guardian. ***ALL ITEMS MUST BE COMPLETED.***

CAREGIVER INFORMATION		
CAREGIVER	RELATIONSHIP TO PATIENT	PHONE NUMBER
CAREGIVER	RELATIONSHIP TO PATIENT	PHONE NUMBER
CAREGIVER	RELATIONSHIP TO PATIENT	PHONE NUMBER

Please read carefully before signing below:

- I attest that the above-named individuals are all 18 years of age or older as of today's date.
- I authorize the above-named individual(s) to consent to treatment for my child(ren). This may include, but is not limited to, consent for necessary medications, immunizations, procedures and hospitalizations. Pediatric Associates may relay any medical information, including protected health information, about my child(ren) that is necessary for the above-named individual(s) to provide informed consent to treatment.
- I understand the clinician will communicate his or her findings and treatment plan to the caregiver who brings the child, and under most circumstances a follow-up call to me personally should not be necessary.
- I agree to be responsible for any fees for services requested by the above-named individual(s) when permitted by my insurance carrier(s).
- I agree to hold Pediatric Associates and its staff harmless for any disagreement between the above-named individual(s) and myself regarding treatment decisions.
- I understand that I can revoke this authorization for any or all of these individual(s) at any time.
- **I attest that I am the parent or legal guardian of the following child(ren) and I have the legal authority to make this agreement.**

SIGNATURE	PRINT NAME	DATE

CHILD(REN) COVERED UNDER THIS CONSENT	
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH
CHILD'S NAME	DATE OF BIRTH