PEDIATRIC PATIENT REGISTRATION

Story Medical CLINICS

☐ Nevada *ph* 515-382-5413 *f* 515-382-7107 ☐ Maxwell *ph* 515-387-8815 *f* 515-387-8817 ☐ Slater *ph* 515-685-3960 *f* 515-685-3961 ☐ Zearing *ph* 641-487-7779 *f* 641-487-7749

Anyone 18 years or older will be considered an adult and placed on their own account

Patient

Legal name: _____ (First) _____ (Middle) _____ (Last)

SS#: _____ DOB: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Race: _____ Enthnicity: _____ Preferred Language: _____

Mother ☐ primary contact

Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____

_____

Home phone: _____

Cell phone: _____

Work phone: _____

Employer: _____

Father ☐ primary contact

Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____

_____

Home phone: _____

Cell phone: _____

Work phone: _____

Employer: _____

EMERGENCY CONTACT (other than parent)

Name: _____ Relationship to patient: _____ Ph: _____

INSURANCE INFORMATION

Please give us all pertinent information regarding your insurance coverage and present a copy of your card to the receptionist.

Primary Insurance:

Insurance name: _____

Person carrying ins: _____

SS#: _____

DOB: _____

Relationship to patient: _____

ID No: _____ Group No: _____

Effective date: _____

Secondary Insurance:

Insurance name: _____

Person carrying ins: _____

SS#: _____

DOB: _____

Relationship to patient: _____

ID No: _____ Group No: _____

Effective date: _____

Other Info

As primary contact, I give permission to (please check all that apply):

☐ Be contacted at the following phone numbers: ☐ Home ☐ Work ☐ Cell

☐ Leave a message regarding upcoming appointments for my child.

☐ Fax information to other providers if need be.

Signature of parent/guardian: _____ Date: _____

Clinic Use Only

MR No: _____

Updated/Review Initial/Date: _____ Initial/Date: _____ Initial/Date: _____

If the patient's information has changed, please ask them to fill out a new form.

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PATIENT REGISTRATION (CONTINUED)

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INSURANCE INFORMATION

If you have insurance that covers your child, you must allow us to make a copy of your insurance card(s). If you do not have insurance, or if you fail to provide us with a card that we can copy, you will be held financially liable for the full charges. Payment is due at the time of services rendered.

PERMISSION TO TREAT MINOR CHILD IN ABSENCE OF PARENT OR GUARDIAN

Child's name: _____

Person responsible in parent's absence (ie. babysitter, grandparent): _____

Street: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

The undersigned hereby consents to and authorizes the above named clinics, their providers and surgeons to furnish medical services and treatment to the above named minor, when presented for treatment. I will pay the charges incurred.

_____ _____

Signature of parent/guardian Date

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED WHETHER OR NOT THEY ARE COVERED BY INSURANCE. ASSIGNMENT AND RELEASE OF INFORMATION (Must have parent/guardian signature)

If I, the undersigned, have insurance coverage (or gain insurance coverage) for my child during my healthcare period, assign directly to the above named clinic all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all my insurance submissions. As parent/guardian, I am responsible for the deductible, coinsurance and uncovered services.

_____ _____

Signature of parent/guardian Date

PATIENT CONSENT FORM REGARDING NOTICE OF PRIVACY PRACTICES (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child, the patient. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice you may obtain a revised copy by visiting our website or by requesting a copy from the clinic or medical center. You have the right to request that we restrict how protected health information about your child is used or disclosed for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____

Signature of parent/guardian Date

For Office Use Only

Name: _____

MR No: _____

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