Goshen Pediatrics, PC

PATIENT REGISTRATION FORM

Patient Information (*Full legal name must be used, no nicknames*)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Gender (*please circle one*): Male / Female

Mailing Address: _____ Apt # _____

City _____ State _____ Zip _____

Person Responsible for Account: _____ Phone: _____

**Signature at bottom will certify all information on this form is true. If any expenses are incurred due to lack of coverage for any reason (i.e.-no insurance, not covered by insurance, insurance not updated, etc.) guarantor is financially responsible for ALL charges.*

Parent Information (*or Legal Guardian*)

Last Name: _____

If married, Maiden Name: _____

First Name: _____

Date of Birth: _____

SSN: _____

Relationship to Patient: _____

Mailing Address: _____

_____

_____

Phone: (Home) _____

(Cell) _____

Email: _____

Parent Information (*or Legal Guardian*)

Last Name: _____

If married, Maiden Name: _____

First Name: _____

Date of Birth: _____

SSN: _____

Relationship to Patient: _____

Mailing Address: _____

_____

_____

Phone: (Home) _____

(Cell) _____

Email: _____

Insurance Information (*Receptionist will need to take a copy of your insurance card)*

Primary Insurance	Secondary Insurance
Plan Name: _____	Plan Name: _____
Policy/ID # _____	Policy/ID # _____
Group # _____	Group # _____
Policy Holder: _____	Policy Holder: _____
Effective Date: _____	Effective Date: _____
Claims Address: _____	Claims Address: _____
_____	_____
Claims Phone: _____	Claims Phone: _____

_____

Responsible Party Signature* Relationship to Patient Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my child's protected health information by Goshen Pediatrics, PC for the purpose of diagnosing or providing treatment to him/her, obtaining payment for my health care bills or to conduct healthcare operations of Goshen Pediatrics, PC. I understand that diagnosis or treatment of my child by Goshen Pediatrics, PC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Goshen Pediatrics, PC is not required to agree to the restrictions that I may request. However, if Goshen Pediatrics, PC agrees to a restriction that I request, the restriction is binding on Goshen Pediatrics, PC and the office staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Goshen Pediatrics, PC, has taken action in reliance on this consent.

My Child's "protected health information" or PHI means health information, including my child's demographic information, collected from me and created or received by his/her physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my child's past, present or future physical or mental health or condition and identifies him/her, or there is a reasonable basis to believe the information may identify my child.

I understand I have a right to review Goshen Pediatrics, PC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that will occur in his/her treatment, payment of my child's bills or in the performance of healthcare operations of Goshen Pediatrics, PC. The Notice of Privacy Practices for Goshen Pediatrics, PC is also provided at their front office. This Notice of Privacy Practices also describes my child's rights and Goshen Pediatrics, PC duties with respect his/her protected health information.

Goshen Pediatrics, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by asking for one at the time of my child's next appointment.

I, the parent/legal guardian of _____, hereby authorize the Practice listed above to release my child's medical information* to the person(s) listed:

Name:_____ Relationship to Patient:_____

Information he/she may obtain:_____

Name:_____ Relationship to Patient:_____

Information he/she may obtain:_____

Name:_____ Relationship to Patient:_____

Information he/she may obtain:_____

Name:_____ Relationship to Patient:_____

Information he/she may obtain:_____

*Must specify: Appointments Only, Labs/X-ray Results Only, Diagnoses Only, Treatments Only, Medications Only, Surgeries Only, Immunizations Only, or Access to Entire Record. If there are restrictions, please be specific.

Phone Number: (_____)_____
May we leave messages on the phone number we have on file? YES/NO

_____

Signature of Parent/Legal Guardian Print Name Relationship to Patient

Date Signed:_____

PATIENT HISTORY

Patient Name_____ DOB: ____/____/____

PATIENT'S MEDICAL HISTORY

Present Health Concerns:_____

Allergies (Please List - Name of Allergy, Severity, and Reaction):

_____

_____

Ear Infections (Dates):_____

Hospitalizations (Reason & Dates):_____

Injuries (Dates):_____

Procedures (Name & Dates):

_____

_____

Chickenpox (Circle one): **Yes** / **No** Date Diagnosed:____/____/____ Asthma (Circle one): **Yes / No**

Other Relevant Health History or Diagnosis (Dates of Onset):

_____

_____

Current Medications (Name and Dosing Information):

_____

_____

Vitamins: **Yes** / **No** _____ Religious Preference:_____

DEVELOPMENTAL CONCERNS? (i.e.-Fine motor skills, gross motor skills, communication, adaptive behavior, etc.)

_____

_____

_____

*If the patient is a newborn: Birth Weight _____ Birth Length _____

HABITS

Sleep:_____hours per night Naps: **Yes** / **No** _____Bed Wetting: **Yes** / **No**

Eating:_____

School:_____

Other:_____

Patient's Other Healthcare Providers:

Name	**Specialty**	**Phone #**

PATIENT FAMILY HISTORY

Patient Name_____ DOB: ____/____/____

Immediate Family:

Mother_____ DOB_____ Health History_____
Father_____ DOB_____ Health History_____
Siblings :
1._____ DOB_____ **M / F** Health History_____
2._____ DOB_____ **M / F** Health History_____
3._____ DOB_____ **M / F** Health History_____
4._____ DOB_____ **M / F** Health History_____
5._____ DOB_____ **M / F** Health History_____

Please note any family history (Parents, Grandparents, Siblings, Aunts, Uncles) for the following conditions:

	Circle one	Relationship to Patient
1. Alcohol/Substance Abuse	**Yes / No**	
2. Allergies	**Yes / No**	
3. Anemia	**Yes / No**	
4. Anxiety Disorder	**Yes / No**	
5. Autoimmune Disease	**Yes / No**	
6. Asthma	**Yes / No**	
7. Bleeding disorder	**Yes / No**	
8. Cancer	**Yes / No**	
9. Depression	**Yes / No**	
10. Developmental Disorder	**Yes / No**	
11. Diabetes	**Yes / No**	
12. Epilepsy/seizures	**Yes / No**	
13. Headaches/Migraines	**Yes / No**	
14. Heart Problems	**Yes / No**	
15. High Cholesterol	**Yes / No**	
16. Hypertension	**Yes / No**	
17. Immune problems	**Yes / No**	
18. Kidney Disease	**Yes / No**	
19. Liver Problem	**Yes / No**	
20. Mental Illness	**Yes / No**	
21. Thyroid Problems	**Yes / No**	
22. Tuberculosis	**Yes / No**	
23. Other	_____	
24. Other	_____	

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

Co-payments are due at time of service.

If my plan requires a referral, I must obtain it prior to my visit.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Goshen Pediatrics on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Goshen Pediatrics to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

*Please note: Person signing this form must be the parent and legal guardian of patient's that are minor's (under 18 year of age) or are their legal Power of Attorney. For patient's that are 18 years of age or older, you are the responsible party unless there is a power of attorney responsible for your healthcare services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorize Representative or Responsible Party Relationship to Patient

Goshen Pediatrics
Cancellation, No-show and Late arrival policy

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show, Cancellation, and Late Arrival Policies as follows:

No-Show Policy and Cancellation Policy

Effective January 1, 2017, we will implement a "no-show" policy, which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

- First occurrence – Patient will receive a warning letter advising of our policy.
- Second occurrence – Patient will receive a 2nd letter and a $25.00 no show fee
- Third and subsequent occurrences – May result in dismissal from practice and additional $25 no show fee

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. It is the patient's responsibility to remember their scheduled appointment; reminders for appointments are done as a courtesy.

Late Arrival Policy

Patients arriving more than 20 minutes late for a scheduled visit or new patient visit appointment will be rescheduled for another day.

We understand that certain circumstances may cause you to cancel in less than 24 hours. If this is the case, please contact our office as soon as possible. Fees in this instance may be waived but only with management approval. Our practice firmly believes a good physician-patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to management.

Please sign below that you have read, understand, and agree to this policy.

Patient Name:_____ **Date of Birth:**_____

Signature of Patient or Patient Representative:_____

Name of person signing in behalf of patient:_____

Today's Date:_____