PT ACCT#_____ DATE _____

GOSHEN PEDIATRICS, PC

PATIENT REGISTRATION FORM

PATIENT INFORMATION (*Full legal name must be used for according to Insurance/Birth certificate*)

NAME

Last:_____ First:_____ Middle Initial:_____

Preferred Name (if other than legal):_____ DOB:_____

Gender: Male / Female Alaskan/Native American: Y / N - If yes, do you have documents supporting heritage? Y / N

Address Street _____ Apt #_____ City_____

State_____ Zip_____ Primary Phone Contact:_____

Email to Set Up Patient Portal: _____

PARENT/LEGAL GUARDIAN

Last Name:_____

*If married, Maiden Name:*_____

First Name:_____

Date of Birth:_____/_____/_____

SSN:_____-_____-_____

Relationship to Patient:_____

Mailing Address:_____

_____

_____

Phone: (Home)_____

(Cell)_____

INITIAL FOR CONSENT TO RECEIVE:

VOICEMAIL MESSAGES/REMINDERS_____

TEXT CONFIRMATIONS/REMINDERS_____

PARENT/LEGAL GUARDIAN

Last Name:_____

*If married, Maiden Name:*_____

First Name:_____

Date of Birth:_____/_____/_____

SSN:_____-_____-_____

Relationship to Patient:_____

Mailing Address:_____

_____

_____

Phone: (Home)_____

(Cell)_____

INITIAL FOR CONSENT TO RECEIVE:

VOICEMAIL MESSAGES/REMINDERS_____

TEXT CONFIRMATIONS/REMINDERS_____

INSURANCE INFORMATION

☐ Self-Pay/No Insurance for Patient (check box if this applies)

Primary Insurance

Plan Name:_____ Policy/ID #_____

Policy Holder:_____ Group #_____

Claims Phone:_____ Effective Date:_____

Claims Address:_____

Secondary Insurance

Plan Name:_____ Policy/ID #_____

Policy Holder:_____ Group #_____

Claims Phone:_____ Effective Date:_____

Claims Address:_____

SEE FINANCIAL RESPONSIBILITY FORM (*Receptionist also will need to take a copy of your insurance card)*

_____ _____ _____

PARENT/GUARDIAN Signature* PRINT NAME RELATIONSHIP TO PATIENT

Person Responsible for Account:_____ Daytime 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.*

PT ACCT#_____ DATE _____

GOSHEN PEDIATRICS, PC

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 GOSHEN PEDIATRICS to release my child's medical information* to the person(s) listed below.

*Parents/Legal Guardians have consent for all information below unless we receive a court order stating otherwise. This consent is null once patient turns 18 years old and must give permission personally and fill out consent forms at that time.

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

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:_____

Signature of Parent/Legal Guardian:_____ Date:_____

Print Name:_____ Relationship to Patient:_____

PT ACCT#_____ DATE _____

GOSHEN PEDIATRICS, PC

PATIENT HEALTH HISTORY

Patient Name *(last, first):*_____ **DOB**: ____/____/____

*We recommend following state guidelines for vaccinations and always discussing with the physician. If not current, please explain why patient is delayed or unvaccinated in the reason indication below.

Vaccination Status: *Current / Delayed / Unvaccinated* *Reason:_____

RELIGIOUS PREFERENCE:_____

PHARMACY

Name:_____Phone:_____Fax:_____

Address:_____City_____State_____Zip_____

Current Medications *(if you need more space, please submit separate list)*

Name and Strength	Frequency/Daily Dosage	Reason for Medication	Prescribing Doctor

*Always notify all physicians of medications at time of visits and discuss any changes. **Vitamins: Yes / No**

Addition Supplements and Reason_____

_____

PATIENT'S MEDICAL HISTORY (*can skip to * below if newborn*)

Allergies *(Lis - Name of Allergy, Severity, and Reaction. Always mention to Physician when medication is being prescribed)*

_____ _____

_____ _____

_____ _____

Hospitalizations *(Reason and Dates)* Surgeries/Procedures *(Name & Dates)*

_____ _____

_____ _____

Asthma: **Yes / No** Chickenpox: **Yes** / **No** Date Diagnosed by Physician:____/____/____

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

_____ _____

_____ _____

DEVELOPMENTAL CONCERNS? Yes / No - If yes, Please list and specify what stage/age you notice for your child. (i.e.-Fine motor skills, gross motor skills, communication, adaptive behavior, etc.)

_____ _____

_____ _____

_____ _____

***If the patient is a Newborn/Infant:**

Place of Birth _____Birth Weight _____Birth Length _____

Breastfed – Yes / No Formula – Yes / No If yes, type of formula?_____

Feeding Times/Bottles Per Day_____ Ounces Per Day_____ Gassy/Fussy?_____

HABITS

Sleep:_____hours per night Naps: **Yes** / **No** - How Many? _____Length of Naps:_____Bed Wetting: **Yes** / **No**

Eating:_____

School:_____

Behavior:_____

Other:_____

PT ACCT#_____ DATE _____

GOSHEN PEDIATRICS, PC

FAMILY HEALTH HISTORY

Patient Name *(last, first):*_____ **DOB**: ____/____/____

Immediate Family *(BIOLOGICAL)***:**

Mother's Name:_____ DOB ____/____/____

Father's Name:_____ DOB ____/____/____

Siblings *(List Oldest to Youngest)*:

1._____ DOB____/____/____ **M / F**

2._____ DOB____/____/____ **M / F**

3._____ DOB____/____/____ **M / F**

4._____ DOB____/____/____ **M / F**

5._____ DOB____/____/____ **M / F**

6._____ DOB____/____/____ **M / F**

Please note any biological relatives (i.e. Parents-mom or dad/Siblings-name/Grandparents/Aunts/Uncles) history for the following conditions that have been diagnosed by a physician:

Conditions	Yes	No	Relative and Year Diagnosed
ADD/ADHD (which type?)			
Alcohol/Substance Abuse			
Allergies			
Anemia			
Anxiety Disorder			
Autoimmune Disease (type?)			
Asthma			
Bleeding Disorder			
Cancer (type?)			
Depression			
Developmental Disorder			
Diabetes			
Epilepsy/seizures			
Headaches/Migraines			
Heart Problems			
High Cholesterol			
Hypertension			
Immune problems			
Kidney Disease			
Liver Problem			
Mental Illness			
Thyroid Problems			
Tuberculosis			
Other:			
Other:			
Other:			
Other:			

PT ACCT#_____ DATE _____
GOSHEN PEDIATRICS, PC

FINANCIAL RESPONSIBILITY FORM

James Wapshare, our Physician for Goshen Pediatrics, is constantly participating with a variety of insurances. This means that we accept several insurances but may not always be an "IN-NETWORK" or "Preferred Provider" for each plan under and insurer. Being such, we cannot verify the type of coverage for each individual patients' policy as to whether your specific policy considers our physician "IN-NETWORK" or "OUT-OF-NETWORK." Choosing to receive care by Dr. James Wapshare, you are agreeing to the following:

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 for this provider, 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 or underinsured, I agree to pay for the medical services rendered to me at time of service.
   - You are responsible to contact your plan to check your benefits and coverage with our provider.
   - If our provider is considered out-of-network at the time of the visit for you/your child you are responsible for any amount the insurance policy does not cover.
   - If you have health insurance through the Marketplace, you must verify that we are assigned as your/your child(ren)s PRIMARY CARE PHYSICIAN(PCP) for each visit, otherwise you will be responsible for any uncovered services rendered.

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

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

PT ACCT#_____ DATE _____
GOSHEN PEDIATRICS, PC

CANCELLATION, LATE ARRIVAL, & NO-SHOW 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 –$25.00 no-show fee per patient scheduled
- Third and Subsequent Occurrences – May result in dismissal from practice and additional $25 no-show fee per patient scheduled

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. You are responsible for updating your contact information so we may be able to reach you to remind you of your appointment.

Late Arrival Policy

Patients arriving more than 15 minutes late for a scheduled visit or new patient visit appointment will be rescheduled for another day. If you have multiple children being seen, we may not be able to complete all visits so may need to move all appointments scheduled that 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.

By choosing to have care provided by our physician, you are agreeing to this policy.

Please sign below that you have read, understand, and have been made aware of this policy.

_____ _____

Signature of Patient or Patient Representative **Print Name**

Relationship to Patient:_____

PT ACCT#_____ DATE _____

GOSHEN PEDIATRICS, PC

CONSENT TO SHARE FORM

We cannot share health information without prior consent being obtained. This goes for sending medical information to other healthcare providers for continued care, sending forms and health records to schools, daycares, and camps. This is not a transfer of records; this is granting permission to send information to the following per your request to the phone/fax/addresses you provide. This can be revoked at any time with a written request.

HEALTHCARE PROVIDERS

Physician Name:_____ Specialty:_____

Address:_____ Phone #_____

_____ Fax #_____

Physician Name:_____ Specialty:_____

Address:_____ Phone #_____

_____ Fax #_____

Physician Name:_____ Specialty:_____

Address:_____ Phone #_____

_____ Fax #_____

Physician Name:_____ Specialty:_____

Address:_____ Phone #_____

_____ Fax #_____

Physician Name:_____ Specialty:_____

Address:_____ Phone #_____

_____ Fax #_____

Other Facilities

Name of School:_____ Nurses Name:_____

Information Consented to Share:_____ Fax #_____

Day Care Name:_____ Contact Name:_____

Information Consented to Share:_____ Fax #_____

Camp Name:_____ Contact Name:_____

Information Consented to Share:_____ Fax #_____

_____

Signature of Patient, Authorized Representative or Responsible Party

_____ _____

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