Pediatric Associates of Western CT

Patient Registration (18 and over-No Dependents)

Primary Care Provider (PCP) - _____

Patient Name: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

Ethnicity: Hispanic / Non-Hispanic / Decline to specify *Race*: White / Asian / Black / Hawaiian / American Indian

Mailing Address: _____

(Street or PO Box) *(City)* *(State & Zip Code)*

Home Phone: (____) _____ - _____ ***Cell Phone:*** (_____) _____ - _____ *Please check preferred number to call **

Email*: _____ *Necessary for patient portal (please write legibly)

Employer: _____ *Occupation:* _____

Parent 1: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* _____ - _____ - _____

Home Phone: (____) _____ - _____ *Work Phone*: (___) _____ - _____ *Cell Phone*: (___) _____ - _____

Address: _____

***Email*: _____ (*Necessary for patient portal - please write legibly)**

Employer: _____ *Occupation:* _____

Do you live with Parent 1? Yes No

Parent 2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* _____ - _____ - _____

Home Phone: (____) _____ - _____ *Work Phone*: (___) _____ - _____ *Cell Phone*: (___) _____ - _____

Address: _____

***Email*: _____ (*Necessary for patient portal - please write legibly)**

Employer: _____ *Occupation:* _____

Do you live with Parent 2? Yes No

If parents are divorced or separated please fill out this section:

Who has legal custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

PHARMACY INFORMATION

Name and Address of Pharmacy: _____

Initial Here:_____ I authorize Pediatric Associates of Western CT to obtain a list of my current medications from pharmacy networks.

INSURANCE INFORMATION

Primary Policy: *Policy Holder's Name*: _____ *Policy Holder's Birth Date*: _____
Insurance Carrier: _____ *ID#* _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____ *Policy Holder's Birth Date*: _____
Insurance Carrier: _____ *ID#* _____ *Group #* _____

STATEMENT OF PATIENT FINANCIAL RESPONISBILITIES

Pediatric Associates of Western CT strives to provide the best medical care for your children**.** As a courtesy, we will file your insurance claim on your behalf. **It is your responsibility to provide us at the time of service, complete and accurate insurance information and to respond to all coordination of benefits requests by your insurance company.** Failure to do so may result in the associated charges becoming your financial responsibility. You are responsible for payment at the time of service for any form fee, deductible or co-payment as determined by your contract with your insurance carrier. After thirty (30) days of the first bill, a finance charge may apply to your account. Any bill over ninety (90) days past due may be subject to collection procedures. If you need to make payment arrangements, you may contact the billing office and we will be happy to assist you. All payment agreements must be followed through within the allotted timeframe. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

I have read the **Pediatric Associates of Western CT Financial Policies** and understand my financial responsibilities to Pediatric Associates of Western CT, for providing services to myself or to the named patient(s). I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pediatric Associates of Western CT, the full and entire amount of bill incurred by myself to the named patient(s); or, if applicable any amount due after payment has been made by my insurance carrier.

There is a $50.00 fee for any missed or cancelled appointments with less than 24 hours' notice.

Patient/Guarantor Signature_____ Date_____

Relationship to Patient_____

CONSENT TO TREAT

I (**patient**) _____ request and authorize Pediatric Associates of Western CT and its personnel to deliver medical care as may be deemed necessary in the diagnosis and treatment of my healthcare needs. I am also aware that I am responsible for payment of the patient portion of my visit at the time of service. I have the legal right to authorize Pediatric Associates and its personnel to deliver medical treatment and services. Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, etc.).

I have read, understand and give my consent to the above.

Patient Signature_____ Date_____

PERMISSION TO COMMUNICATE

Permission to speak with your parents/guardians

□ I,_____, give authorization to have access to/discuss my medical care to the following individual(s) with no limitations:

Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date

Patient Signature Date

□ **I do not give the doctors and nurses of PAWC permission to discuss anything with my parents/guardian.**

Patient Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient. We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

I acknowledge that Pediatric Associates of Western CT has offered or provided me with a copy of their Notice of Privacy Practices, which describes how medical information may be used and disclosed, and how I can access this information. I also understand that I am entitled to receive updates, upon request, if Pediatric Associates of Western CT amends or changes its Notice of Privacy Practices in a material way.

Patient/Guarantor Signature_____ Date_____

Relationship to Patient_____

OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY PEDIATRIC ASSOCIATES OF WESTERN CT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

Name and title of employee Date