Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

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

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

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

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

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

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address:

_____

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

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____

ID# _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's SSN:* _____

Insurance Carrier: _____

ID# _____ *Group #* _____

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

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

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

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home e-mail / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

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

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

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

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: _____

_____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

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

Who has 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.

_____

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _____ *Phone*: (_____) _____ - _____

2: _____ *Phone*: (_____) _____ - _____

CONSENT FOR TREATMENT

As the parent or legal guardian of the child, designated above as the patient, I hereby authorize Country Kids Pediatrics physicians, mid-level practitioners, and/or medical representatives to perform the required medical treatment considered advisable for the patient. I realize that no guarantees can be made as to the eventual outcome of the medical treatment advised or performed. However, I may expect the medical treatment advised or performed by Country Kids Pediatrics physicians, **non-physician practitioners, and/or their medical representatives to be reasonably sound by accepted medical standards. Also, as a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your phone number, you consent to receiving such calls at this number.

**Non-physician practitioners are either Nurse Practitioners or Physician Assistants, licensed by the state to diagnose and treat illnesses, injuries, disease or other medical conditions. They typically hold a master's degree with advance education in pediatrics. These practitioners work together with the patient's primary care physician, providing preventative care, well child examinations, physical, immunizations, and developmental screenings. **

We ask that a parent/guardian be present for your child(ren)'s initial appointment and well child visits. We must be able to obtain pertinent family background and medical history that is necessary for the treatment of you child(ren). It is the policy of Country Kids Pediatrics that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals (other than parents) are authorized to act in your place with respect to any medical matters after your initial appointment. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

NAME(S):	PHONE NUMBER:	RELATIONSHIP:

PARENTAL CONSENT IN CASE OF DIVORCE

(If you have a court order, please present us with a copy for your child(ren)'s file)

According to Texas Statutes-Family Code 153.073(a), unless limited by a court order, a parent appointed as a "conservator" (managing or possessory) of a child has at all times the following rights:

- Right of access to medical, dental, psychological, and education records of the child
- Right to consult with a physician, dentist, or psychologist of the child
- Right to be designated on the child's records as a person to be notified in case of an emergency
- Right to consent to medical, dental, and surgical treatment during and emergency involving an immediate danger to the health and safety of the child

_____ _____

PRINT NAME PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN

_____ _____

RELATIONSHIP TO PATIENT DATE

CKP Financial Policy

It is the policy of this office to help keep healthcare costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. **Your signature indicates you understand and agree.**

Patient/Guardian responsibility:

- Bring your child's insurance card and your photo ID to **EVERY** office visit.
- Notify us of any demographic changes (i.e., insurance, address, phone number, etc.).
- Copay and deductible are due at the time of service.
- If you do not have insurance, be prepared to pay for the visit in full at the time of service.
- Confirm with your insurance that Country Kids Pediatrics/Charlie Ann Morehead, MD is a provider for your policy.
- Verify coverage limitations prior to appointment. It is the responsibility of the insured to know their terms of coverage.
- As a courtesy to our patients, we file insurance claims for you. However, **the guarantor is responsible for any payments not covered by their insurance.**

Patient/Guardian financial responsibility:

- $35 fee for RETURNED CHECKS
- $10 fee to fill out ANY HEALTH FORMS (i.e., shot records, school, camp, daycare, etc) **NOT completed at Well Child Check. Shot records can be found on the patient portal at no cost.**
- $25 fee for FMLA form
- $25 SPORTS PHYSICAL with form **NOT completed at Well Child Check**
- $25 fee for NO SHOW APPOINTMENTS
- $25 fee for SAME HALF DAY CANCELLATIONS
- $75 EAR PIERCING
- To request/transfer records there is a $25 fee in addition to mailing, shipping, or delivery fees.
- Monthly statements are mailed out for balances which are due within 14 days of statement date. If there are any disputes, concerns, or questions please contact our office.

Child's Name: **Date of Birth:**

_____
_____
_____
_____

_____ _____ _____

Print Name of Parent/Guardian: **Signature of Parent/Guardian:** **Date:**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I hereby acknowledge my receipt of Country Kids Pediatrics Notice of Privacy Practices which explains how my child's medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

CHILD'S NAME:	DATE OF BIRTH:

_____ _____

PRINTED NAME OF PARENT/LEGAL GUARDIAN SIGNATURE OF PARENT/LEGAL GUARDIAN

_____

DATE

___ Patient/legal guardian declined to accept Notice of Privacy Practices

___ Patient/legal guardian received Notice of Privacy Practices, but refused to sign acknowledgement form

_____ _____

PRINTED EMPLOYEE NAME SIGNATURE OF EMPLOYEE NAME

_____

DATE

PATIENT NAME:	DOB:

I authorize the release of the following information:

All my child's listed information the provider has in his or her possession.

- Radiology Reports
- Lab Results
- Immunizations
- All Record

I authorize the release of my health information for the following specific purpose:

- Transferring Care Permanently
- Othe Purpose

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or the quality of my child's treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be active immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance of this authorization before receiving my written notice.

Guardian Name: _____ **Relation:** _____

Guardian Signature: _____ **Date:** _____

**Please fax medical records requested to fax number provided below. Thank you!*

Charlie A. Morehead, M.D.
1815 10th Street
Floresville, Tx 78114
P: (830) 251-0860
F: (830) 251-0866