KIDS HEALTH ALLIANCE PA
PATIENT REGISTRATION

Patient Information

Patient's Legal Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F
First Middle Last

Address: _____ Apt. _____ Home Phone: (_____)_____

City: _____ State: _____ Zip Code: _____ SS# _____

Race: Select Ethnicity: Select Primary language: Other

Child is living with: (check one) ☐ Both Parents ☐ Father ☐ Mother ☐ Parent & Step Parent ☐ Other _____

Are Parents: (check one) ☐ Married ☐ Single ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Are there any other significant adults involved? If so, who are they? _____

Family Information

Father

Name: _____

SS# _____ DOB _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____

Mother

Name: _____

SS# _____ DOB _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____

Emergency Contact Information (A local person other than Parents or Guardians)

Name: _____ Relationship to Patient: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____)_____

We appreciate referrals. Whom may we thank for referring your family to our office? _____

IMPORTANT! Please read and sign the other side of this form.

KIDS HEALTH ALLIANCE PA

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

Consent is hereby given to perform any and all examinations, tests, procedures and treatments necessary and or advisable; and in an emergency, without the presence of parents or responsible adults. I hereby authorize examination and treatment of the above named child by the physician, any assistants or designees deemed necessary by the physician. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice. If I cannot bring my child (ren) , the persons listed bellow will have the authority to bring in and authorize treatment :

Name:	Relationship to patient:
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Any person, not listed above must have a dated and signed letter of consent from myself, or treatment could be refused or delayed. I understand that in unusual circumstances, efforts will be made to contact me prior to rendering of treatment, but that medical treatment will not be withheld if I can not be reached. This authorization will remain in effect unless so designated that such consent for treatment of a minor is cancelled. I have read all the information on this sheet and have completed all the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Kids Health Alliance. of any changes to this information in the form of a signed and dated letter.

AUTHORIZATION TO FILE INSURANCE CLAIMS, TO RELEASE MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS

☐ I authorize Kids Health Alliance. to file insurance claims for services and supplies rendered to and for my/our child (ren).

☐ I authorize Kids Health Alliance. to release information, including my/our child (ren) medical and billing information, to referring or consulting doctors and to my insurance company. The transmission of all information may be done electronically, including the Internet.

☐ I authorize that payment of all third party benefits otherwise payable to me be made directly to Kids Health Alliance.

☐ I assign to Kids Health Alliance. all payments for medical services and supplies provided to my dependent child(ren).

☐ I understand that I am financially responsible to Kids Health Alliance for the above named patient (s). If my insurance company fails to fully compensate Kids Health Alliance any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 30 days after notification from Kids Health Alliance. and or a billing company acting on its behalf.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

☐ I understand that Kids Health Alliance cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided.

☐ I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

I UNDERSTAND I HAVE A RIGHT TO REVIEW NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THIS NOTICE IS POSTED IN THE LOBBY AND MADE AVAILABLE AT ALL TIMES. THIS NOTICE OF PRIVACY PRACTICES DESCRIBES MY RIGHTS AND INTERNAL MEDICINE PRACTICES' DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. BY SIGNING BELOW, I CERTIFY MY AGREEMENT AND ACCEPTANCE OF THE ABOVE.

_____ _____

Patient Name **DOB**

_____ _____ _____

Parent/Guardian Signature **Name** **Date**