HEALTHYLIVING
FAMILY MEDICAL CENTER

PEDIATRIC REGISTRATION FORM

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT			
Child's Legal Name Last: ____________________________ First: __________________________ Preferred Language: ☐English ☐Spanish ☐Other: ___________________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐Hispanic ☐Non-Hispanic Race: __________________________
Child's Legal Name Last: ____________________________ First: __________________________ Preferred Language: ☐English ☐Spanish ☐Other: ___________________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐Hispanic ☐Non-Hispanic Race: __________________________
Child's Legal Name Last: ____________________________ First: __________________________ Preferred Language: ☐English ☐Spanish ☐Other: ___________________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐Hispanic ☐Non-Hispanic Race: __________________________
Child's Legal Name Last: ____________________________ First: __________________________ Preferred Language: ☐English ☐Spanish ☐Other: ___________________	DOB:	☐Male ☐Female	Ethnicity & Race *(Meaningful Use Data)* ☐Hispanic ☐Non-Hispanic Race: __________________________

PARENT/GUARDIAN INFORMATION		
☐Father ☐Mother ☐Other: ____ Name: ___________________________________ DOB:___________________ Email: ____	Address:	☐Cell ☐Home Primary Phone #:
☐Father ☐Mother ☐Other: ____ Name: ___________________________________ DOB:___________________ Email: ____	Address:	☐Cell ☐Home Primary Phone #:

EMERGENCY CONTACTS ***(LIST ADDITIONAL PERSONS WHO MAY BRING CHILDREN FOR APPOINTMENTS OR WHO WE ARE AUTHORIZED TO COMMUNICATE WITH FOR MEDICAL INFORMATION)***		
Name:	Relationship to child:	☐Cell ☐Home Primary Phone #:
Name:	Relationship to child:	☐Cell ☐Home Primary Phone #:
Name:	Relationship to child:	☐Cell ☐Home Primary Phone #:

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST		
INSURANCE:	Subscriber:	DOB:
INSURANCE:	Subscriber:	DOB:

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ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

✓I understand that I am financially responsible for all professional charges that my children may incur.

✓All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.

✓I hereby authorize payment of medical benefits direct to Advanced Pediatric Associates. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.

✓Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Advanced Pediatrics to treat my child in their office as required by the events of that emergency situation.

✓Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Advanced Pediatric Associates.

_____

Parent/Guardian Signature (Patient Signature if 18 or older)

_____ _____

Printed Name Date

HEALTHY LIVING
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FINANCIAL POLICY

Healthy Living Family Medical Center (HLFMC) is dedicated to providing excellent care and outstanding overall service to every patient at every visit. APA participates with many of the major healthcare plans. Because the benefits and exclusions are provided to only the subscriber and the members in their family, APA has no way of knowing what they include. **Therefore, it is the responsibility of the guarantor and subscriber to know the**

By signing I acknowledge that I have read, understood, and agree to the above financial policy set forth by HLFMC (If you would like a copy of this financial policy, please ask the receptionist for one.):

_____
Printed name

_____
Signature

_____
Relationship to patient

_____
Date

HEALTHY LIVING
FAMILY MEDICAL CENTER

FOR PATIENTS 18 AND OLDER (must sign if parent is to continue paying for medical services by HLFMC):

By signing this form, I agree to allow, _____, my _____, to be financially responsible for all of the expenses related to the medical care I may receive at APA. I authorize the staff of APA to disclose only the information specifically regarding my financial account with APA to this individual. I further authorize APA to send all statements or requests for insurance information to this individual without constraint. I understand that I may revoke these privileges at any time making my financial account solely my responsibility. I acknowledge that this authorization does not authorize APA to fully disclose my medical record, and I must fill out the appropriate medical release of information to allow this.

_____ _____

Printed name *Signature Date*

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THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.

By signing I acknowledge that I have read and understood the above policies (if patient is 18 or older, patient must sign):

_____
Printed Name

_____
Signature

_____
Relationship to patient

_____
Date

HEALTHYLIVING
FAMILY MEDICAL CENTER

***OPTIONAL:* AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (ie. Nanny, Grandparent, Stepparent, and/or teen by themselves)**

I,_____ (Please Print), do hereby consent and authorize Healthy Living Family Medical Center and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give the Providers and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines, and the best number to reach me for this is: _____.

_____ _____

Signature Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.