KID'S HEALTH ALLIANCE, PA
PATIENT REGISTRATION

Patient Information

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

Address:_________________________________ Apt._________ Phone :(________)______________________

City:____________________________ State:______ Zip Code:____________ SS#______________________

Preferred Pharmacy Name/Location: ____

Race: ☐ Caucasian (White) ☐ African American ☐ Other: _____________ ☐ Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____________ ☐ Refused to Report

Primary Language: ☐ English ☐ Spanish ☐ 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	**Mother**
Name:_________________________________	Name:_________________________________
SS#____________________ DOB______________	SS#____________________ DOB______________
Home Phone :(________)______________________	Home Phone :(______)______________________
Work Phone :(_________)______________________	Work Phone :(_______)______________________
Cell Phone :(__________)______________________	Cell Phone :(________)______________________
Email:_________________________________	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.

Revised: 01/01/2023

CONSENT FOR EXAMINATION, MEDICALTREATMENT AND CONDITIONS OF EXAMINATION IN OFFICE OR VIA TELEMEDICINE

Consent is hereby given to perform any and all examinations (including genital exam), tests, procedures and treatments necessary and or advisable; and in case of an emergency, without the presence of parents or responsible adults, I hereby authorize examination and treatment of the above-named patient by the physician, nurse practitioners, physician assistants or designees deemed necessary by the physician. I also authorize telemedicine visits and I am aware of limitations of telemedicine including but not limited to, interruptions, unauthorized access and technical difficulties, and I know I can disconnect the call at any time. I authorize to view and download external medication history of the patient. 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 examinations in this pediatric practice. If I cannot bring my child, the persons listed below will have the authority to bring in and authorize treatment:

Name:	Relationship to patient:
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________
4. ______________________________	______________________________

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 cannot 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 Kid's 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 ASSIGNMENTOF BENEFITS

- I authorize Kid's Health Alliance to file insurance claims for services and supplies rendered to and for my child or myself.
- I authorize Kid's Health Alliance to release information, including my child's or my 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 Kid's Health Alliance.
- I assign all payments for medical services and supplies provided to my dependent child or myself to Kid's Health Alliance.
- I understand that I am financially responsible to Kid's Health Alliance for the above-named patient (s). If my insurance company fails to fully compensate Kid's 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 Kid's 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 Kid's 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 child's or my account for any services not covered or not paid by my insurance plan.

At Kid's Health Alliance we appreciate and respect our staff. It is our belief our staff should have a work environment free from verbal and physical abuse. We expect each of you to treat each one of our staff members, as you would like to be treated. Outbursts against our staff, physicians, and covering physician's will not be tolerated and will result in your immediate discharge from the practice.

I understand that I have the right to review the "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 child's or my rights and Kid's Health Alliance' duties with respect to my child or my protected health information. By signing below, I certify my agreement and acceptance of the above.

______________________________		______________________________
Patient Name		**DOB**
______________________________	______________________________	______________________________
Parent/Guardian Signature	**Print Name**	**Date**

Revised: 01/01/2023