Children's National
Primary Care
Children's Pediatricians and Associates

PATIENT REGISTRATION

DATE _____

PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____

LAST NAME _____ SEX ☐ M ☐ F

DATE OF BIRTH _____ EMAIL _____

HOME ADDRESS _____

CITY, STATE ZIP _____

HOME PHONE _____ CELL PHONE _____

RACE

☐WHITE OR CAUCASIAN
☐BLACK OR AFRICAN AMERICAN
☐HISPANIC OR LATINO
☐ASIAN
☐AMERICAN INDIAN / ALASKA NATIVE
☐OTHER_____

ETHNICITY

☐HISPANIC OR LATINO
☐NOT HISPANIC OR LATINO

PREFERRED LANGUAGE

☐ENGLISH ☐FRENCH
☐SPANISH ☐OTHER_____

REFERRAL SOURCE

☐FRIEND / FAMILY ☐CHILDREN'S HOSPITAL ☐ WALK-IN
☐EXISTING PATIENT ☐INSURANCE ☐ HOSPITAL
☐OB-GYN (PLEASE SPECIFY) _____
☐OTHER (PLEASE SPECIFY) _____

PRIMARY CARE PROVIDER _____

RESPONSIBLE PARTY / GUARANTOR (Person Financially Responsible for Patient's Account)

FIRST NAME _____ MI _____ LAST _____ SEX ☐ M ☐ F DATE OF BIRTH _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

SOCIAL SECURITY # _____ RELATIONSHIP _____ DAYTIME PHONE _____

EMAIL _____ EMPLOYER _____ PREFERRED PHONE ☐HOME ☐CELL ☐ DAY

PARENT / GUARDIAN

FIRST NAME _____ MI _____ LAST _____ SEX ☐ M ☐ F DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____ DAYTIME PHONE _____

SOCIAL SECURITY # _____ RELATIONSHIP _____

INSURANCE INFORMATION

POLICY HOLDER NAME _____ DATE OF BIRTH _____ SEX ☐ M ☐ F RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ CO-PAY $ _____

INSURANCE COMPANY _____ POLICY # _____ GROUP #_____ HOME PHONE _____

PHONE _____ FAX _____ CELL PHONE _____

SOCIAL SECURITY # _____ EMPLOYER _____ DAYTIME PHONE _____

SECONDARY INSURANCE INFORMATION

POLICY HOLDER NAME _____ DATE OF BIRTH _____ SEX ☐ M ☐ F RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ CO-PAY $ _____

INSURANCE COMPANY _____ POLICY # _____ GROUP # _____ HOME PHONE _____

PLAN PHONE _____ PLAN FAX _____ CELL PHONE _____

SOCIAL SECURITY # _____ EMPLOYER _____ DAYTIME PHONE _____

EMERGENCY CONTACT

PATIENT'S RELATIONSHIP TO CONTACT _____ SEX ☐ M ☐ F

FIRST NAME _____ MIDDLE _____ LAST NAME _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

Office Use Only:

Intergy Pt Person # _____

SIBLINGS

NAME _____ DOB _____ NAME _____ DOB _____

NAME _____ DOB _____ NAME _____ DOB _____

NAME _____ DOB _____ NAME _____ DOB _____

PREFERRED PHARMACY

PHARMACY NAME _____

PHARMACY ADDRESS _____

PHARMACY PHONE NUMBER _____ PHARMACY FAX NUMBER _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Children's Pediatricians & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Children's Pediatricians & Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree to pay any collections and/or legal fees necessary for collection, if such situation was to arise. If I cancel an appointment less than 48 hours prior to the appointment time I will be charged a cancellation fee of $35.00. If I do not show for an appointment I will be charged a $35.00 no show fee.

_____ _____

Signature (Parent/Guardian), or Legal Representative **Date**

_____

Relationship to patient (If signed by legal representative)

Office Use Only:

Intergy Pt Person # _____

Children's National
Primary Care
Children's Pediatricians and Associates

Children's Pediatrician & Associates Consent for Procedures and Treatment

I understand that Children's National Medical Center, including all corporate entities and off-site locations (Children's), requires a signed Consent for Services before proceeding with treatment. I hereby give consent to Children's, its employees and/or contractors to examine and treat this patient.

I understand that:

- Tests and immunizations may be included as part of the examination and treatment;
- I may be required by Children's policy to give a separate written consent for some treatments and procedures;
- I have the right to cancel this Consent in writing and/or limit my disclosures. If I notify Children's in writing to cancel this Consent for Services, Children's may stop examining and treating my child;
- There are no guarantees regarding outcomes and results of these examinations and treatments.

TEACHING, TRAINING AND EDUCATION: I understand that Children's is a teaching institution and provides education and training for students pursuing careers in the medical field; all examinations, treatment and procedures at Children's are performed under the direction of members of Children's medical staff (faculty).

PUBLICATIONS, MARKETING AND FUNDRAISING: Children's may use medical information, patient statements, artwork, and videos or pictures in which the patient appears, for educational purposes or in publications, marketing and fund raising, provided the patient is not identifiable.

PATIENT RIGHTS *(PARENT'S/LEGAL GUARDIAN'S INITIALS HERE)*:
_____ I have received information about Patient Rights and the Notice of Patient Privacy Practices at Children's in a language that I understand. I know who to contact with questions, concerns or to file a complaint.

SPECIMENS AND BLOOD TESTING: I agree that blood, tissues and other samples taken in the normal course of tests or during procedures and resulting in waste materials, may be used for education or scientific purposes or in medical chart review provided the patient is not identifiable. These activities must be approved by an Institutional Review Board and are exempt under the Office for Human Research Protections, the federal governing body of human research. If anyone comes into contact with the patient's blood or body fluids: I consent to testing of the patient for infectious diseases including HIV. I agree that the exposed person may be given the results. I understand that Children's will comply with regulations that require reporting certain medical outcomes to government agencies.

ACCESS TO INFORMATION, VISITORS: Except in cases where Children's has been presented with a court document restricting or redirecting parental rights, I understand that either parent may see the medical record, visit the patient, take the child home, or make care decisions. I agree to provide the names of any alternative representative(s) who I authorize to receive patient information. I agree to alert Children's to alternative methods of contacting me such as by phone, cell phone, fax, mail, or e-mail.

DISCLOSURE OF INFORMATION: I understand that Children's complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's can use private health information for treatment, payment and hospital operations as defined in the Notice of Privacy Practices. I agree to Children's use of de-identified health information about my child for appropriately reviewed and approved research and quality improvement activities.

Office Use Only:

Intergy Pt Person # _____

CRISP: We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

PAYMENT, INSURANCE, ASSIGNMENT OF BENEFITS: I assign to Children's the right to bill and collect from any insurance that covers the patient. I agree to cooperate with Children's in seeking payment including alerting Children's to any resources for payment of the patient's bill. I will pay any deductible, co-payment, and any amounts denied or not covered by insurance. If the patient is uninsured, I agree to apply for any applicable medical assistance program including but not limited to Medicaid. If the patient is uninsured and not eligible for a medical assistance program I agree to complete financial information forms to determine eligibility for reduced charges or charity funds. I understand that I may have: requested services that are outside of my insurance company's network; knowingly requested services outside my highest level benefit option (e.g., Preferred, POS Choice, Select, etc.) and that my "out-of-pocket" financial responsibility may be greater; not provided Children's with the proper referral form, referral information and/or authorization; not provided the Hospital with adequate proof of insurance; or voluntarily requested that Children's not bill any insurance I may have, without regard to whether these services are covered by any such insurance. I further understand and agree that I am personally responsible for making full payment for all charges resulting from this Consent for Services.

Signature of Parent/Legal Guardian/Patient 18 yrs. of age or older **Date/Time**

_____

Patient Name

Witness Name & Signature **Date/Time**

Office Use Only:

Intergy Pt Person # _____