Patient Registration Form
18 Years and Older, Foster

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Today's Date: _____

Patient Information

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile phone: _____ Email: _____

Parent/ Foster Parent Information

Parent Name: _____ Date of Birth: _____

Mobile Phone: ( )_____ Work Phone: ( )_____

Insurance Carrier Information

Insured's Name: _____ Date of Birth: _____

Name of Insurance: _____

Home Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Alternate Contact (relative or friend)

Alternate Contact Phone: ( ) _____

Relationship to patient: _____

Form Completed By:

Name (print): _____

Signature: _____

Date: _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/ARNP:

_____

Preferred Language:

_____

Your Race
(select one primary)

☐ American Indian *or* Alaska Native
☐ Asian
☐ Black/African American
☐ Chinese
☐ Filipino
☐ Hispanic
☐ Japanese
☐ Multiracial
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown
☐ Other _____
☐ Decline to answer

Your Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown
☐ Declined to answer

Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.

** Please return this form to the Front Desk before leaving the office. Thank you. **

Billing Guarantor Acknowledgement (18 years and older/Foster)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Patient Name:_____

Date of Birth:_____

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

**** PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor.*
The parent/guardian who is present for office visits is the Billing Guarantor - see below for details.

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment for all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pediatric Health Care Alliance, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Health Care Alliance, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Pediatric Health Care Alliance, PA may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child[ren], as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.**

Billing Guarantor Name *(print)*:_____ **Date of Birth** *(mm/dd/yyyy)*: _____ **Sex:** ☐ **F** ☐ **M**

Billing Guarantor Signature:_____ **Today's Date** *mm/dd/yyyy)*:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other:_____

Billing Guidelines

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Patient Name:_____

Date of Birth: _____

Pediatric Health Care Alliance billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

- **Co-pays:** It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.
- **Co-insurance/Deductibles**: Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.
- **Billing**: As a courtesy, Pediatric Health Care Alliance bills your health insurance provider on your behalf, with the following guidelines/exceptions:
  - **Insurance Card: It is critical that the most current insurance card is brought to every appointment.** We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
  - **Auto Insurance:** We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and we will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.
  - **Secondary Insurance:** PHCA only bills TriCare and Medicaid from the secondary insurance governmental plans.
- **Combined Visits:** If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
- **Evening/Weekend/Holiday Surcharge:** Some health insurance providers bill a surcharge if you see your pediatrician after normal business hours, on the weekend, or on a holiday.
- **Administrative Fees** : PHCA charges various fees for the following items, which require personnel and resources to address.
  - **Copies** of medical records given to the parent (no charge if sent directly to new provider)- $1.00/per page/first 25 pages, then 25¢/per page thereafter.
  - **Completion** of additional school physical forms, e.g. blue/yellow forms (1st set free at visit)- $1.00/per page
  - **Special request completion** of camp or sports physical forms (free during visit)- $20.00
  - **Special request** physician letters- $20.00
  - **Completion of** FMLA paperwork- $25.00
  - **Returned check** (for insufficient funds)- $29.00
  - **No-show / late cancellation fee** when a patient:
    - Does not show for their scheduled visit- $25.00
    - Cancels a sick appointment less than 4 hours in advance- $25.00
    - Cancels a well visit less than 24 hours in advance- $25.00
    - Cancels a consult visit less than 24 hours in advance- $35.00
    - Cancels any Behavioral Health visit less than 24 hours in advance- $50.00
    - Cancels less than 24 hours in advance or does not show for any Behavioral Health Testing visit - $100.00
    - Arrival late (15 minutes or more) for scheduled appointment time even if seen later in the day- $25.00

Signature *Date*

Release of Medical Information (18 years and Older)

PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home™

The following patients need to give consent: 18 years and Older, Married or Pregnant and under 18 years of age, Emancipated Minor, Certified Homeless.

Under the federal Health Information Portability and Accountability Act, or HIPAA, medical records are private information that is kept between you and your health care provider. Access to your health records and any discussion about your health is only provided to people you consent to, including your parents. This form will allow your parents or anyone else that you have identified access to your medical information.

Patient Name: _____ Date of Birth: _____

Please list the person(s) that you are allowing access to your medical information:

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

I authorize Pediatric Health Care Alliance to release the following information (check all that apply):

- ☐ Access to all medical records excluding confidential files.
- ☐ Access to all medical records including diagnosis for mental health, HIV, other STD, or pregnancy.
- ☐ Discuss my care with my Pediatric Health care Alliance provider.
- ☐ Schedule appointments (well, sick or consultations).
- ☐ X-Ray or other radiology reports
- ☐ Laboratory results (including HIV or other STD results)
- ☐ Pharmacy/ Prescription records
- ☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

I, _____ (please print), authorize the above listed person(s) access to my medical information (specific approval access above). ***In the event I would like to append my authorization, it is my responsibility to update this information.***

Patient's Signature:_____Date:_____

Acknowledgement of
Pediatric Health Care Alliance Vaccine Policy

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Dear Parents,

As part of our commitment to patient-centered care, we are dedicated to protecting the health of our patients and the community through vaccination. Vaccinating children and young adults is one of the most important health-promoting interventions we can perform as healthcare providers, and you can perform as caregivers. Routine childhood immunizations have resulted in a tremendous decline in serious infections, disability, and death. Unfortunately, these illnesses are still present in the United States and other countries and are often just a short plane ride away. We understand that parents have reservations about certain vaccines, and our pediatricians will be happy to discuss those concerns with you as a new patient.

At PHCA our vaccine policy requires that medically able patients need to be fully vaccinated, based on the CDC Recommended Immunization Schedule for Children and Adolescents.

We believe that failure to follow the recommendations about vaccination may endanger the health and life of a child, and others with whom a non-vaccinated child may come into contact. Failure to adhere to this policy will result in dismissal from PHCA. **Therefore, if you have already decided with absolute certainty that you will not vaccinate your child(ren), we encourage you to find another healthcare provider who shares your views.**

NOTE: In accordance with this policy, PHCA requires vaccine records/history prior to the first appointment for any transferring patient.

PHCA Standards for Vaccine Compliance	Vaccines Needed**			
By the age of 12 mos: Patients must have received these vaccinations recommended for ages 0-9 months	Hep B DTaP	Hib IPV	Pneumococcal	
By the age of 24 mos: Patient must have received these vaccinations recommended by 24 months of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 5 yrs & 11 mos: patient must have received these vaccinations recommended by 6 years of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 12 yrs & 11 mos: patient must have received these vaccinations recommended by 13 years of age	All of the above, plus Tdap			

***Please note: While PHCA strongly recommends all childhood vaccines, we are allowing limited exceptions to the vaccine compliance policy. Rotavirus, Hep A, Influenza, Meningococcal, COVID, and HPV vaccines are recommended but not required as part of our policy.*

The decision to adopt a more stringent policy regarding vaccination stems from the risk that a non-vaccinated child poses to other patients in our office, and vulnerable families such as newborns or children with weakened immune systems. As a pediatric group, we feel a powerful responsibility to work towards protecting our community from illness as much as possible.

Please note, that if you feel your child has a health condition that does not allow vaccination, please Let us know.

Patient Name:_____

Date of Birth: _____

Parent Signature:_____ **Date:**_____