University Hospitals Medical Practices

University Pediatrics of Lorain

PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION **Today's Date** _____

Last Name_____ First Name_____ MI____

Mailing Address_____ **Male or Female/Birthdate**_____
(circle)

City_____ ___ State____ Zip Code_____ Phone (H)_____

Patient's Social Security #:_____

RESPONSIBLE PARTY/GUARANTOR: _____/_____
(relationship)

The responsible party/guarantor receives the bill and is responsible for payment.

Primary Language: □ English □ Spanish □ Other: _____

Race: □ American Indian □ Asian □ African American □ White □ Other: _____

Ethnicity: □ Central American □ Cuban □ Dominican □ Hispanic/Latino □ Mexican □ Not Hispanic/Latino □ Puerto Rican □ South American □ Spaniard

PARENT/GUARDIAN INFORMATION

MOTHER

Last	First	MI	Date of Birth	Soc Sec #
Cell Phone	Home Address if different from patient			
Work Phone				
Employer	Employer Address			

FATHER

Last	First	MI	Date of Birth	Soc Sec #
Cell Phone	Home Address if different from patient			
Work Phone				
Employer	Employer Address			

INSURANCE & POLICYHOLDER INFORMATION

Primary Insurance Company Name_____ Employer_____

Member ID # _____ Group # _____

Policy Holder Name_____/_____ Relation to Pt.: Self FTHR MTHR Other
DOB

Secondary Insurance Company Name_____ Employer_____

Member ID # _____ Group # _____

Policy Holder Name_____/_____ Relation to Pt.: Self FTHR MTHR Other
DOB

PHYSICIAN INFORMATION **Primary** Doctor's Name _____

Whom may we contact in case of an emergency that is not listed above:

Name	Phone #	Name	Phone #
_____	_____	_____	_____

In the event you are not able to bring _____ / _____ to his/her
Child's Name DOB
appointments please list below any individuals that you give consent to accompany him/her to office visits and treatment that requires only general consent. I have already signed the general consent form. **Ok for minor child to come by self: yes / no**
circle

_____ relationship to child_____

_____ relationship to child_____

_____ relationship to child_____

_____ relationship to child_____

I, the undersigned, authorize University Pediatrics of Lorain and its physicians and employees to release information from my child's (name listed above) medical records as deemed necessary during the course of the office visit. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, HIV test results, AIDS, AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

Release of Immunization Records:
I acknowledge that my child's school [Name of School: _____] may request immunization records. I hereby give permission to University Pediatrics of Lorain to disclose my child's immunization records directly to the school. I understand any other protected health information, such as school medical forms, will not be released without my specific authorization.

My failure to sign this authorization may result in my information not being released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.

_____
Signature of Legal Guardian

_____
Date

PLEASE PROVIDE YOUR EMAIL ADDRESS:_____
(optional)
** Email addresses are NOT used for disclosure of medical information. They may be used for general office communication from our staff and/or questionnaires to help us enhance our services to you.

If applicable, please complete the following:

Stepmother:_____ _____ _____-____-_____
name DOB SS#

Stepfather:_____ _____ _____-____-_____
name DOB SS#

Please list other siblings that are patients of this office **AND** have the same guarantor:

_____ _____ _____ _____
name DOB name DOB

_____ _____ _____ _____
name DOB name DOB

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Medical Practices

Pediatric Registration Form

(please print)

FINANCIAL AND MANAGED CARE POLICY STATEMENT

University Primary Care Practices adheres to the policies below. The patient / responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

1. Patients with an insurance co-payment are expected to make payment when checking in for the appointment.
2. Patients with **high deductible** ($1000 or more) plans are required to pay the following fees prior to their doctor visit: $100.00 for first new patient visit, $50.00 for each subsequent visit, $100.00 for consultations, $50 for urgent care visits. Patients will be refunded or billed for additional amounts as appropriate after claim(s) are processed by their insurance company.
3. Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
4. Not all services are covered benefits of all insurance plans. The patient / responsible party maintains the responsibility of verification of applicable coverage.
5. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at time of service.
6. Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.
7. UHMSO does not bill third parties in legal situations or injuries (non work related). We bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient account.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). Returned checks and balances older than 45 days may be subject to additional collection fees. We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today's appointment. Thank you for your understanding and cooperation with this policy.

1. **I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.**
2. **I agree that this authorization is valid regardless of when I receive services at this office, that the information on pages above is accurate, and that I am the patient or authorized to sign this document.**

Patient/Responsible Party Signature:_____ Date: _____

GENERAL CONSENT

GENERAL CONSENT-SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

[Patient/Patient's legal representative] agree to permit authorized personnel of University Hospitals [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may used for educational purposes.

I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.

Authorization to Release Information

The undersigned hereby permits University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or educating students, performance improvement initiatives, discharge planning, risk management and/or as required by law. The undersigned hereby permits its affiliated healthcare providers and/or their authorized personnel to access electronic prescription data. Provided I have been advised of the risks and benefits of any administered immunization, I grant permission for University Pediatrics of Lorain to transmit information regarding my child to Impact SIIS, Ohios on-line immunization registry

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Assignment of Benefits

In consideration of the Hospital's and/or physician(s)'s services received or to be received for medical/surgical services, I assign to the Hospital and/or my physican(s), all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and /or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

Medicare/TRICARE/Champus Payment /Notice of Privacy Practices

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Record Retention Policy

The Hospital retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data

I understand that my medical records will be accessible to authorized Hospital personnel through computers and that the Hospital will comply with certain safeguards established by federal state and local law as well as Hospital policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. In understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on the form. Otherwise, subject to applicable law, this consent will expire at the same time the Hospital's record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimbursable Items

I understand that the Hospital is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe. I understand and agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorize the hospital to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

Other Uses of Medical Information

The undersigned hereby understands and recognizes that University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by UH and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations, as well as Hospital policies regarding research studies.

Additional Permitted Uses and Disclosures of Confidential Medical Information

The undersigned understands and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency; an appropriate Public Health Authority; for purposes required by State and/or Federal Law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation; to organ procurement organizations; and for any other permissible purpose as outlined in University Hospitals Notice of Privacy Practices.

Notice of Privacy Practices - Acknowledgment

PLEASE CHECK THE APPROPRIATE BOX:

☐Yes ☐No ☐N/A I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").

If no, reason acknowledgement of NOPP not received:_____

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

Printed Patient Name	Hospital No.	
Signature of Patient / Parent or Legal Guardian of Minor	Date	Time
Signature of Legal Represenative, if patient is unavailable	Relationship	Date
Witness	Date	