PEDIATRIC ASSOCIATES

NEW PATIENT REGISTRATION

Please complete the patient's demographic information. ***ALL ITEMS MUST BE COMPLETED.***

PATIENT INFORMATION

PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:	PATIENT'S MIDDLE INITIAL:	DATE OF BIRTH:

GENDER:	PATIENT'S CELL NUMBER (16 & OLDER):	PREFERRED PRIMARY CARE PROVIDER:	PREFERRED PHARMACY/ LOCATION:

LANGUAGE(S) SPOKEN IN HOME:
☐ ENGLISH
☐ SPANISH
☐ OTHER _____

ETHNICITY (SELECT ONE):
☐ HISPANIC/LATINO
☐ NOT HISPANIC/LATINO
☐ UNKNOWN/REFUSED

RACE (SELECT ONE):
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN
☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐ WHITE
☐ UNKNOW/REFUSED

INSURANCE INFORMATION

PRIMARY INSURANCE:	MEMBER NUMBER:	POLICY HOLDER'S NAME:

☐ NO INSURANCE/SELF-PAY
☐ HEALTHSHARE PLAN/SELF-PAY

WOULD YOU LIKE TO RECEIVE A SLIDING FEE SCALE APPLICATION? ☐ YES ☐ NO

WOULD YOU LIKE INFORMATION ABOUT OUR MEMBERSHIP PROGRAM? ☐ YES ☐ NO

PARENT/GUARDIAN INFORMATION

PARENT/LEGAL GUARDIAN'S NAME (PRIMARY CONTACT):	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	PHONE NUMBER:

MAILING ADDRESS:	CITY, STATE, ZIP:	EMPLOYER:

PHYSICAL ADDRESS (IF DIFFERENT THAN MAILING):	CITY, STATE, ZIP:	EMAIL (FOR PORTAL ACCESS/ UNDER AGE 14 ONLY) :

PARENT/LEGAL GUARDIAN'S NAME (SECONDARY CONTACT):	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	PHONE NUMBER:

MAILING ADDRESS (IF DIFFERENT THAN MAIN CONTACT'S):	CITY, STATE, ZIP:	EMPLOYER:

PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE):	CITY, STATE, ZIP:	EMAIL (FOR PORTAL ACCESS/ UNDER AGE 14 ONLY):

EMERGENCY CONTACT (NAME, PHONE, RELATION TO PATIENT):	HOW WOULD YOU LIKE TO RECEIVE REMINDERS & NOTIFICATIONS? (CHOOSE 1 OR MORE) ☐ EMAIL ☐ PHONE ☐ TEXT

WHO IS THE PRIMARY CAREGIVER OF THE PATIENT?
☐ BOTH ☐ MOTHER ☐ FATHER ☐ OTHER (COMPLETE NEXT SECTION)

IF APPLICABLE, WHO HAS CUSTODY OF THE PATIENT? ☐ BOTH ☐ MOTHER ☐ FATHER
☐ OTHER (COMPLETE NEXT SECTION & PLEASE PROVIDE LEGAL DOCS SHOWING CUSTODY)

FOSTER CARE/GUARDIANSHIP/POWER OF ATTORNEY CUSTODY INFORMATION

1. HOW LONG HAS THE CHILD BEEN IN YOUR CARE?

2. ARE YOU RELATED TO THE CHILD IN YOUR CARE?
☐ YES RELATIONSHIP TO PATIENT: _____
☐ NO (SKIP TO 8)

3. IF RELATED, DO YOU HAVE KINSHIP CUSTODY (LEGAL CUSTODY WITH COUNTY & PHYSICAL CUSTODY WITH YOU) OR ARE YOU WITH A FOSTER AGENCY OR DO YOU HAVE GUARDIANSHIP COURT DOCS/POA?
☐ KINSHIP ☐ FOSTER CARE (THROUGH AGENCY)
☐ LEGAL GUARDIAN/POWER OF ATTORNEY (SKIP TO 6)

4. DO YOU HAVE A COUNTY CASEWORKER? ☐ YES ☐ NO

5. IF YES, WHAT IS YOUR COUNTY CASEWORKER'S NAME AND PHONE NUMBER (IF AVAILABLE)?

6. HAS THE GUARDIANSHIP/POWER OF ATTORNEY DOCUMENTATION BEEN FILED WITH THE COUNTY?
☐ YES ☐ NO

7. IF YES, WITH WHICH COUNTY WAS DOCUMENTATION FILED?

8. WHAT FOSTER CARE AGENCY ARE YOU WITH? ☐ ARIEL ☐ KIN CONNECT
☐ TOP OF THE TRAIL ☐ WHIMSPIRE ☐ GENERIC (OUT OF STATE)

9. FOSTER CARE AGENCY CASEWORKER'S NAME AND PHONE NUMBER

10. CAN YOU PROVIDE GUARDIANSHIP/KINSHIP/POWER OF ATTORNEY DOCUMENTATION AT THE TIME OF SERVICE (IF NOT, PLEASE COMPLETE A DOCUMENTATION POLICY FORM. BE AWARE THAT POWER OF ATTORNEY DOCUMENTS EXPIRE EVERY 12 MONTHS)?
☐ YES ☐ NO

PLEASE TURN OVER TO COMPLETE BACK PAGE

NEW PATIENT REGISTRATION *(continued)*

SIBLING INFORMATION (LIST ONLY IF ESTABLISHED OR FUTURE PATIENTS)	
PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH:	**PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH:**
PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH:	**PATIENT'S FIRST AND LAST NAME/DATE OF BIRTH:**

CONSENTS

Please read carefully and initial each line before signing below:

_____ I understand I am financially responsible for all medical and mental health charges that my child(ren) may incur at Pediatric Associates. If the child(ren) is/are in foster care or legal custody is with the county or state, I understand I am not financially responsible for the charges incurred; however, I am responsible for communicating financial matters to the county or state on behalf of the child(ren) in my care. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payments, deductibles, or co-insurance at the time of service and promptly when billed. I understand that insurance cards should be presented at EVERY VISIT.

_____ Preventative services such as developmental, vision and hearing screenings are billed separately from your preventative care visit and may not be covered by your insurance. If you receive a statement for these screenings, please contact our billing department.

_____ I understand I will be listed as the guarantor and will receive the financial statements; however, both parents are financially responsible regardless of custody arrangements unless the child(ren) is/are in foster care or in the custody of the county or state. In the case of foster care/kinship, the county or state is the guarantor and is financially responsible and will receive the financial statements.

_____ I hereby authorize payment of medical benefits directly to Pediatric Associates. I further authorize the release of any medical information necessary for processing the insurance claims. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.

_____ I am aware that Pediatric Associates no longer courtesy bills Healthshare plans as of September 1, 2021. Healthshare plans are not considered insurance but considered underinsured and have limited benefits. I am aware that I am responsible to pay for services rendered at the time of service and commercial vaccines are full price.

_____ In the event of an emergency and I cannot be contacted, I give my permission to Pediatric Associates to treat my minor child/the minor child in my care (under age 18) in their office as required by the events of that emergency situation.

_____ I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Practices for Pediatric Associates.

_____ I give permission for telemedicine appointments, when deemed necessary.

_____ I consent to receive text, voice and/or email notices as a way to contact me about appointment reminders, billing and health notifications and announcements.

_____ I authorize Pediatric Associates to share immunization records with the child(ren) in my care/my child(ren)'s school and the Colorado Immunization Information System (CIIS).

_____ I understand patient portal access is limited on patients age 14 and up due to confidentiality laws and I will have access to billing only.

SIGNATURE:	RELATIONSHIP TO PATIENT:	DATE: