Pediatric Neurosurgical Specialists

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name_____ First Name _____ MI___

Sex: ☐Male Female☐ Race _____ Language _____

Social Security #_____-_____-_____ Date of Birth ___/___/___ Patient's Age _____

Address_____ Apt#_____

City_____ State _____ Zip_____

Phone Numbers: Home (_____) _____ - _____ Work/Cell (_____) _____ - _____

Parent/Guardian Email: _____

For purposes which may include patient survey, patient newsletter, and/or medical alerts such as medication recalls only.

Referring Physician_____ Primary Care Physician _____

How did you hear about us? _____

PARENT/LEGAL GUARDIAN INFORMATION

Mother/Legal Guardian. Last Name _____ First Name _____

Social Security #_____-_____-_____ Date of Birth ___/___/___ Marital Status _____

Address_____ Apt#_____

City_____ State _____ Zip_____

Phone Numbers: Home (_____) _____ - _____ Work/Cell (_____) _____ - _____

Father/Legal Guardian. Last Name _____ First Name _____

Social Security #_____-_____-_____ Date of Birth ___/___/___ Marital Status _____

Address_____ Apt#_____

City_____ State _____ Zip_____

Phone Numbers: Home (_____) _____ - _____ Work/Cell (_____) _____ - _____

IN CASE OF AN EMERGENCY

Emergency Contact Person: _____ Relationship: _____

Primary Number: (_____) _____ - _____ Secondary Number: (_____) _____ - _____

INSURANCE INFORMATION

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____ Policy # _____

***If patient is not the policy holder please complete the following information ***

Policy Holder's Name:_____ Date of Birth:___/___/___

Secondary Insurance: _____ Policy # _____

***If patient is not the policy holder please complete the following information ***

Policy Holder's Name:_____ Date of Birth:___/___/___

Continued on back……..

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FINANCIAL AGREEMENT

PATIENTS WITH INSURANCE

Assignment and Authorization of Benefits

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Pediatric Neurosurgical Specialists. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Parent/Guardian Date

PRIVATE PAY OR PATIENTS WITHOUT INSURANCE

Financial acknowledgement

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Parent/Guardian Date

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ADDITIONAL CONSENTS AND COMMUNICATIONS

Acknowledgement of Review of Notice of Privacy Practices

_____**Initial**- I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my child's healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my child's information for the purposes described in the practice's Notice of Privacy Practices.

Consent to Email and Other Healthcare Communications

Patients in our practice may be contacted via email to access the patient portal, remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Initial ONE below:

_____**Initial** I consent to receive communication via email as stated above. I understand that this request to receive emails will apply to all patient portal communications/future appointment reminders/feedback/health information unless I request a change in writing.

OR

_____**Initial** I DO NOT consent to receive communication via email as stated above.

Please check all that apply below.

☐ I give permission to leave a message on my voicemail concerning my child's personal health information.
☐ I do not give permission to leave a message on my voicemail concerning my child's personal health information.

General Consent for Care and Treatment Consent

_____**Initial** This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for your child. If you have any concerns regarding any test or treatment recommend by your child's health care provider, we encourage you to ask questions.

I voluntarily request a Pediatric Neurosurgical Specialists physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought my child to seek care at Pediatric Neurosurgical Specialists. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Signature of Parent/Guardian	Date
Printed Name of Parent/Guardian	Description of Representative's Authority
Printed name of Practice Witness	Signature of Practice Witness