

Date Completed	
Primary Care Provider	

Patient Registration Form (Please fill in all fields completely)											
Patient Information											
Child's Full Legal Name (Last, First, Middle)	Date of Birth	Se	x	Prefer	red Name						
Other Children in family:											
Child's Street Address (City, State, Zip Code)	Telephone#where ch	ild lives Par	rent's Work #	Parent	t's Email Address:						
			Mom	□ M	om						
			Dad		ad						
Race: American Indian or Alaska Native		lack or Africar	n American								
☐ Native Hawaiian and other Pacific Islander	☐ White										
Ethnic Group:											
Patient's Primary Language: English Spanish	Other										
Parent's/Legal Guardian's Primary Language: English	Spanish Other										
Does the parent/legal guardian require an interpreter?											
If there is insurance for child/children, please present the insura	ance card to the check-in staff.										
Emergency Contacts											
Mother's Name (Last, First, Middle)	Home #	,	Work #		Cell #						
Home Address (City State Zin Code) (if different from al	hove)										
Home Address (City, State, Zip Code) (if different from above)											
Father's Name (Last, First, Middle)	Home #	,	Work #		Cell #						
Home Address (City, State, Zip Code) (if different from al	bove)										
Additional Control (Last First Middle)	Home #		Work #		Cell #						
Additional Contact (Last, First, Middle)	nome #		WOIK #		(Relationship to Patient)						
Home Address (City, State, Zip Code)					<u> </u>						
, , , , , , , , , , , , , , , , , , ,											
Who may we thank for referring you to our practice?				Birth Hospit	al						
who may we thank for referring you to our practice:				Diftii Hospit	ai						
Guarantor Information (Person financially re	esponsible)			<u>I</u>							
T T	elationship to Patient			Emanc	ipated Minor? □ Yes □ No						
Street Address (If different from patient)	ity	State		Zip							
Data of Birth	H	XX1- #		C-11 #							
Date of Birth Ho	ome #	Work #		Cell #							
Employer Name Ci	tv	State		Zip							
1.3.				r							
Insurance Information (if insurance is provide	led, please complete t	he informat	tion below)								
Insurance Name Claims Address Telephone #											
Subscriber ID # Patient Relationship to Subscriber:											
Cuka arihar?a Nama											
Subscriber's Name DOB:											
Subscriber Address (if different than guarantor)			Subscriber Empl	over							
Subscriber Address (if different than guarantor) Subscriber Employer											



				Patient Nam	e:			
Nice Pediatric Clinic						DOB:_		
Children's Healthcare						202		
						Date:		
Allennis (Include Donn D		1 0	(0 1)					
Allergies: (Include Drug, R	eaction, a	and Ag	e of Onset):					
Current Problems:								
IP-1								
<u>History</u> :								
Birth History:								
Dinth I amath.):	4.			Dinth Haad Cine, make			
Birth Length: B Discharge Weight: G	βirtn weign 3estational	t: Age at B	Birth (weeks): _		Birth Head Circumfer Delivery Method: V		tion	_
Duration of Labor:	zootationai	rigo ai E	(If C-Section why?			_
APGAR 1m:		APGAR	5m:		APGAR 10m: _			
APGAR 1m: nfant Feeding:Breast Bottle B	oth	Formula	Name?		-			_
Comments: Newborn Hearing Scr	eening: P	ass Fail	, Other Comm	nents:				
Medical History: (Check Appropr	iate Box ar	nd Comm	nent in Margins	(;				
(,				
ADD/ADHD		No]	Allergic F	Rhinitis		Yes	No
Anemia	_ Yes	No	4	Asthma	L'	L;	Yes	No
Congenital Heart Disease Developmental delay	Yes Yes	No No	4	Constipa	ition	———	Yes Yes	No No
Eczema	Yes	No	=	Food Alle	ergies		Yes	No
GE Reflux	Yes	No	┪	Mental II	Iness		Yes	No
Murmur	Yes	No		Prematu	rity		Yes	No
Recurrent Otitis (ear infections)		No	1	Recurrer	nt Strep Throat		Yes	No
Seizures		No	7		ce Abuse		Yes	No
UTU		No	7	Vision Pr	roblems	`	Yes	No
/esicoureteral Reflux	Yes	No]		9		Yes	No
Other Medical History:								
Surgical History: (Check Appropr	iate Box)							
			D-4-		0			
Adenoidectomy (adenoids removal	I) Yes	No	Date		Surgeon			
Appendectomy (appendix removal)		No	+					
Ear Tubes	Yes	No	+					
-undoplication	Yes	No	1					
Gastrostomy Tube Placement		No						
Heart Surgery	Yes	No	<u></u>			·		
Hernia Repair	Yes	No		-				
Orthopedic Surgery	Yes	No						
Fonsillectomy	_ Yes	No	_					
Jrologic Surgery	_ Yes	No						
/P Shunt	_ Yes	No						
VP ShuntOther Surgical History:	Yes	No						



Patient Name:	
	DOB:
	Date:

Family History: (Check all boxes that apply)

	ionship CHILD	Name	A:Alive	D:Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		Α	D																		
	Father		Α	D																		
Sibs	Sister		Α	D																		
	Brother		Α	D																		
Aunts/	*M Aunt		Α	D																		
Uncles	*M Uncle		Α	D																		
	*P Aunt		Α	D																		
	*P Uncle		Α	D																		
Grand-	*MGM		Α	D																		
parents	*MGF		Α	D																		
	*PGM		Α	D																		
	*PGF		Α	D																		

Comments (including other family medical problems	s):
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Additional Family History, including other siblings, may be added below:

Relationship to CHILD

N	2	m	_

Α	D									
Α	D									
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Α	D									

Home	Envir	onmo	nt.
поше		onine	nı:

Home Environment:					
Number of People at Home: Lives with biological parents: Foster Care: Primary Care Givers (circle): Daycare (hours/day): Time at Relatives (hours/day): Pets:	Yes Yes Parents Yes	No No Daycare	e Relatives	Others:	
Parent's Status:					
Parent's Marital Status (circle):	Marri	ed	Divorced	Single	Other
Mother's Occupation:Father's Occupation:					

^{*}M=Maternal, the patient's mother's side of the family

^{*}P=Paternal, the patient's father's side of the family



Delegation of Consent

Name of Patient	
atient's Date of Birth	
hearby authorize (when I am unavailable to	give consent) to the following individual(s):
Name of person	Relationship to child
Name of person	Relationship to child
Name of person	Relationship to child
Name of person	Relationship to child
Name of person	Relationship to child
o consent to any and all medical care and att	ention for this child which is deemed necessary
	ensed in the state of Texas. This consent includes
	ervention and elective as well as emergency care
his delegation shall be valid until I withdraw	delegation of consent.
ignature of Parent/Guardian/Patient (if 18 years or o	older)
Relationship to Patient	
ate	
/itness	
ranslator/Reader (if applicable)	



Consent to Treat

Written Acknowledgement of Receipt of ALICE PEDIATRIC CLINIC Notice of Privacy Practices

(Please initial)	explains how APC may use and disclose your prote	C (APC) Notice of Privacy Practices (The Notice). The Notice seted health information for treatment, payment and healthcare means your personal health information found in your medical and
	If you have questions about the Notice, Please con information located in the Notice.	tact the APC Privacy Office. You may find their contact
	General Consent	to Treat
(Please initial)	I am the parent/guardian of to medical and surgical treatment for this patient.	(name of patient). I have the legal right to consent
	form, I am giving permission to the doctors, nurses,	are, treatment and diagnostic tests that Dr. eve are necessary for this child. I understand that by signing this physician assistants and other healthcare providers in this medical is child is a patient in this office, or until I withdraw my consent.
	Consent to Release and Ob	tain Information
(Please initial)	this child in order to provide continuity of care and t may obtain from any source and examine and use, information to treating hospital personnel and agen committees, care evaluators and governmental age history, examinations, diagnoses, treatments any p HIV or AIDS information. This consent to release a	allow ALICE PEDIATRIC CLINIC to deliver the necessary care to reatment. ALICE PEDIATRIC CLINIC and/or the patient's provider or discuss and disclose, the patient's medical record and its, other healthcare providers, medical records auditors, professional encies. This information can include, but is not limited to: medical sychiatric, drug and alcohol abuse or genetic testing information, or not obtain information is valid until revoked. The undersigned may the regard to disclosures that have already been made in reliance on
(Please initial)	I have read this form or this form has been read to a ask questions about it.	ne in a language that I understand, and I have had an opportunity to
	Electronic Prescriptions	(E-Prescribing)
(Please initial)	which allows healthcare providers to electronically	o allow E-Prescribing for the patient's mail order prescription, ransmit prescriptions to the pharmacy of my choice, review history as long as this child is a patient at this office, or until I
Name of Patient		
Patient's Date of Bir	th	
Printed Name of Pat	tient's Representative	
Relationship of Patie	ent's Representative	
Signature of Patient	or Patient's Representative	
Date		



2013

APC FINANCIAL POLICY

WE at Alice Pediatric Clinic (APC) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your APC financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer
 information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and APC with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS

Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:

APC does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do do not currently have Medicaid insurance (Please Initial Response)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)

Each time you make an appointment with a APC physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current card at each visit.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to APC or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- I understand that this practice has a no show appointment fee of \$25 dollars. I am responsible for paying the fee if I do not cancel an appointment with 24 hours notice
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature:	Date:
Print Name	Guarantor Date of Birth:
Relationship to Patient:	
PATIENT(S) NAME:	Date of Birth:



Acknowledgement of Privacy Practices

Written Acknowledgement of Receipt of Alice Pediatric Clinic Notice of Privacy Practices

By signing below, you acknowledge receiving the Alice Pediatric Clinic (APC) Notice of Privacy Practices (Notice). The Notice explains how APC may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

APC reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout APC and on our website at ALICEPEDIATRIC.COM. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register to any APC for treatment or healthcare services, APC will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.

If you have any questions about the Notice, please contact the APC Medical Record Office. Contact information is located in the Notice.

Printed Name of Patient
Patient's Date of Birth
Printed Name of Patient's Representative
Relationship of Patient's Representative
Signature of Patient or Patient's Representative
Date