PARK AVENUE PEDIATRICS OF MANHATTAN, PC

Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex:* _____ *Primary Language:* _____

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex:* _____ *Primary Language:* _____

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex:* _____ *Primary Language:* _____

Mailing Address:

_____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (_____) _____ - _____

Who lives at this household? _____

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____

ID# _____ *Group #* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____

Insurance Carrier: _____

ID# _____ *Group #* _____

PARK AVENUE PEDIATRICS OF MANHATTAN, PC (2)

Contact 1: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Home Email

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home e-mail / Work Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact 2: *Name*: _____ *Relation to Patient*: _____

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Work Phone*: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here: _____

_____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? Yes / No / _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Emergency Contacts, other than parents: Name & Relationship

1: _____ *Phone*: (_____) _____ - _____

2: _____ *Phone*: (_____) _____ - _____

PARK AVENUE PEDIATRICS OF MANHATTAN, PC

FINANCIAL RELEASE FORM

I, _____hereby attest that I fully understand my financial responsibility for the charges resulting from today's visit.

I am responsible for:
Deductibles
Co-pays
Non-covered services
Coinsurance

I am responsible for services/procedures performed that may not be covered by my plan.
The service/procedure(s) I am having include:
Visits for routine preventive care
Visits for illness, treatment and follow-up care, including emergency/unscheduled visits
Visits for reassurance and consultations,
All immunizations recommended by the physician/provider
Any laboratory procedure recommended for diagnostic or screening purposes.
Any procedure, visit, test, report required by legal authorities, schools, camps, after-school and sports programs, insurance companies and government agencies.

I understand that it is my responsibility to designate a PCP from this office for my child and that I am responsible for any charges should a different PCP be assigned by my Insurance.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW THE TERMS OF MY INSURANCE COVERAGE, AND TO MONITOR COMPLIANCE WITH THE LIMITS OF MY PLAN. I UNDERSTAND THAT I WILL BE RESPONSIBLE IF SERVICES EXCEED THE LIMITS OF MY PLAN.

I understand that as a **WALK-IN** patient, I am responsible for any additional fees associated.
I understand that if I **CANCEL** prior to providing a 24-hour notice or if I **NO-SHOW**, I am responsible for any additional fees associated.

Due to the prohibitive costs of billing for small balances, we ask that you keep a credit card or prepaid credit on file.
As with all of your personal and medical information, we will not release this information without your permission.
We regret the need for this policy, and hope that you will understand the necessity.
I authorize Park Avenue Pediatrics to charge my credit card, debit card or medical savings plan card for amounts
not to exceed $_____.
Credit Card #: _____ Exp Date: _____
Cardholder's Name: _____
Signature: _____

Parent's Signature, if patient is a Minor:_____
Patient Name: _____
Date of birth:_____

Member Ins. Plan and Identification Number:_____
Name of Insured: _____
Date:_____

PARK AVENUE PEDIATRICS OF MANHATTAN, PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent **PARK AVENUE PEDIATRICS** may use and disclose protected health information (PHI) about my child(ren) to carry out treatment, payment and healthcare operations (TPO). Please refer to **PARK AVENUE PEDIATRICS'** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **PARK AVENUE PEDIATRICS** reserves the right to revise its Notice of Privacy Practices at Any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the **PARK AVENUE PEDIATRICS** Privacy Officer at 1111 Park Ave, NYC. 10128

With my consent **PARK AVENUE PEDIATRICS** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to clinical care, including laboratory results among others.

With my consent, **PARK AVENUE PEDIATRICS** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **PARK AVENUE PEDIATRICS** restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **PARK AVENUE PEDIATRICSs** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **PARK AVENUE PEDIATRICS** may decline to provide treatment to my dependants.

I have received and read the HIPAA Privacy Notice.

_____
Signature of Patient or Legal Guardian

_____ _____ (in effect for 1 cal yr)
Patient's Name Date

_____
Print Name of Patient or Legal Guardian