PATIENT REGISTRATION FORM **Guarantor**_____

(In Office Use Only)

Biological/Adoptive Parents/Legal Guardian/Information

This document may only be completed by the biological/adoptive mother or father of your child(ren) unless you have legal documentation stating you have legal responsibility for the following child(ren). If you are a Step-Parent or Other, please stop now and see a receptionist.

Are parents: ❑Married ❑Separated ❑Divorced ❑Widowed/Widower ❑Single

Who is bringing the child in today:

- ❑ Biological Parent
- ❑ Adoptive Parent
- ❑ Legal Guardian (Please provide legal documentation)
- ❑ Foster Parent

Biological/Adoptive Parent/Legal Guardian

1: Last Name: _____ **First Name:** _____ **Middle Name:** _____

Sex: ❑Male ❑Female

Street Address: _____Apt No. _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____Driver's License # _____

Home Phone #: _____ Cell Phone #_____ Email: _____

Employer: _____ Business Phone: _____

Employer Address: _____ State: _____ Zip: _____

Biological /Adoptive Parent/Legal Guardian

2: Last Name: _____ **First Name:** _____ **Middle Name:** _____

Sex: ❑Male ❑Female

Street Address: _____Apt No. _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____Driver's License # _____

Home Phone Number: _____ Cell Phone Number: _____ Email: _____

Employer: _____ Business Phone: _____

Employer Address: _____ State: _____ Zip: _____

Authorization to treat in absence of a parent: **Guarantor** _____

(In Office Use Only)

Persons Authorized to Accompany and Provide Consent for Treatment Other than the Biological Parent, Adoptive Parent, or Legal Guardian.

(Example: Step-Parent, grandparent, aunt, uncle, baby-sitter, neighbor, or anyone who will bring your child to our office etc.)

I consent for the following person(s) to authorize evaluation and treatment for the patient(s) identified in the "Child(ren) Information section of this contract. This authorizes the following person(s) to consent to medical and surgical procedures and immunizations for the patient(s) listed above. If my child is 16 years of age or older, I agree that they can come in without a parent/legal guardian. I agree to be financially responsible for the cost of such care. The duration of this consent is indefinite and continues until revoked in writing by myself.

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

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Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Biological/Adoptive Parent
Legal Guardian Name (please print): _____

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Emergency Contact Information

Emergency Contact: (These persons should live in the same state, but not in the same household)

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Immunization Policy

Alpine Pediatrics, PC follows the current immunization guidelines established by the American Academy of Pediatrics (AAP) and the Center for Disease Control's Advisory Committee on Immunization Practices (ACIP). Any desire to follow a modified schedule must be discussed with a provider.

Biological/Adoptive Parent
Legal Guardian Name (please print):_____

Biological/Adoptive Parent
Legal Guardian Signature:_____Date:_____

Child(ren) Information

Guarantor ______________________________
(In Office Use Only)

Alpine Pediatrics participates with several State and Federal programs that require race and ethnicity for each patient. Please complete the following information for each patient.

Consent for Treatment

I hereby authorize employees of Alpine Pediatrics, PC (including physicians, physician assistants, nurse practioners and other employees and staff members) to render medical evaluations and care to me or my child(ren) that I have listed below. The duration of this consent is indefinite and continues until I revoke in writing. ***I understand that by not signing this consent, my child(ren) will not be provided medical care except in case of emergency.***

Biological/Adoptive Parent
Legal Guardian Name (please print): ____

Biological/Adoptive Parent
Legal Guardian Signature: ______________________________ Date: ____________________

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth:** ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth**: ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth:** ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth:** ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth:** ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ____________________ **First Name:** ____________________ **Middle Name:** ______________
Preferred name child goes by: ____________________**Date of Birth:** ____________________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Financial Responsibility

Guarantor _____

(In Office Use Only)

I hereby authorize payment of medical benefits directly to Alpine Pediatrics PC and/or the attending provider for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim.

I understand and agree that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance plan.

I understand and agree that I will be responsible for all charges accrued by my child(ren) who have turned 18 until such time as I notify Alpine Pediatrics in writing prior to services being provided, that I no longer accept financial responsibility.

I understand and agree that all patient balances and costs are due in full upon request.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me below for any reason, including to contact me about my account balance or to provide notices to me as required by law or otherwise. I agree to notify Alpine Pediatrics if any telephone number or address listed below ceases to be my number or address and to provide a replacement number or address to Alpine Pediatrics. I understand and agree that such calls may be initiated by Alpine Pediatrics or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

Utah law requires Alpine Pediatrics to provide the biological/adoptive parent(s) or other responsible parties with notice, by certified/priority letter or text message, 45 days prior to placing any delinquent balance with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand I will be charged a fee of $10.00 if any such notice is sent to me by certified/priority letter.

I understand and agree that should my account become delinquent, and it is referred to an outside collection agency, I shall pay an additional collection fee of up to 40% of the amount owing as allowed by Utah Code Annotated, sec. 12-1-11. I also agree to pay reasonable attorney fees incurred by Alpine Pediatrics in connection with enforcement or collection of this agreement.

Returned checks are automatically forwarded to a collection agency for immediate collections and I may be charged a $20.00 return check fee on all returned checks. If the returned check amount is not resolved, additional charges may be applied as per Utah Law.

I understand and agree to arrive to my scheduled appointment on time. If I am 20 minutes late for my scheduled appointment, I may be asked to reschedule.

I understand and agree to give 24 hours cancellation notice of any pre-scheduled or confirmed appointments and at least 1 hour cancellation notice for same day appointments. I understand and agree that I will be charged a fee of $25.00 for each appointment that I fail to give proper notice of cancellation.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, Alpine Pediatrics cannot bill my insurance and I am responsible for payment of services in full on the date of service. This is applicable for all of my children listed in this contract.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Other Phone: _____ Email: _____

Arbitration Agreement

Guarantor _____

(In Office Use Only)

I acknowledge that I have been provided a copy of the Arbitration Agreement of Alpine Pediatrics, PC regarding all patients on the other side of this form.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Acknowledgement of the Receipt of HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Alpine Pediatrics PC is furnishing you with the attached notice, which provides information about how Alpine Pediatrics PC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law, regarding all patients on the other side of this form.

By signing this form, you acknowledge that you have received a copy of Alpine Pediatrics PC Notice of Health Information Practices.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____