Patient Registration-Physicians to Children & Adolescents

Patient's Name: _____ DOB: _____ Social Security #:_____
Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____
Patient's Cell Phone:_____

Sex: Male or Female
Race: Caucasian (White) African American Hispanic Other: _____
Ethnicity: American Guatemalan Chinese Indian Japanese Latin American/Hispanic Mexican Other: _____
Primary Language Spoken: _____
Does Patient have an Advance Directive: ☐ Yes ☐ No
Parent/Legal Guardian Information:

Marital Status of Parents: Married Divorced Single Widowed

Mother/Guardian
Mother's Name: _____
Guardian's Name (if applicable):_____
DOB: _____ Social Security #:_____
Address (if different from patient):_____City:_____
State: _____Zip:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____
Married Divorced Single Widowed

Father/Guardian
Father's Name: _____
Guardian's Name (if applicable):_____
DOB: _____ Social Security #:_____
Address (if different from patient):_____City:_____
State: _____Zip:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____
Married Divorced Single Widowed

(Guarantor) Who is responsible for bills: Mother Father
Note: Your insurance company is **not** your guarantor; legal guardian is responsible for bills.
Insurance Information

Primary Insurance: _____
Policy Holder: _____
ID#:_____
Group#:_____

1. I hereby authorize the release of any medical information for treatment, payment and healthcare operations. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my or my dependents account. I understand that if for any reason my account should be sent to collections, I may be responsible for that collection agency fee. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

2. I give permission for Physicians to Children & Adolescents to access my pharmacy benefits data electronically through RXHub.

Responsible Party Signature: _____ Date: _____

PHYSICIANS TO CHILDREN & ADOLESCENTS HIPAA/CONSENT TO TREAT

We understand that it is not always possible to accompany your child during their office visits. It may be more convenient to have prior authorization in place, so that medical care including routine immunizations may be delivered to your child in your absence. This authorization will include a phone call to our nurse for medical advice.

If you choose not to pre-authorize treatment in your absence please be advised that a parent will be required to accompany the child at each office visit, unless other authorization is sent with your child.

☐ I **do not** wish to pre-authorize Physicians to Children & Adolescents to administer care for my child in my absence. I understand that I must accompany my child at every visit unless other authorization is sent with my child.

☐ I authorize Physicians to Children & Adolescents to administer care to my child when accompanied by the individuals listed below. I understand that it is my responsibility to inform the office if this information should change.

Name:	Phone:	Relationship to Patient:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

I have received a copy of Bardstown Primary Care Notice of Privacy Practices.

Parent or Guardian Signature:_____ Date:_____

Preferred Lab:
Some insurance companies require that your labs be sent to a specific company for processing. If your insurance company prefers a specific lab, please select below your preferred lab.
NOTE: All labs will be processed by Hardin Memorial under the following circumstances.
1. Labs that our physician needs immediate results
2. Patients with Passport Health Plan or Kentucky Medicaid
3. If you do not select a preferred lab below

☐ Hardin Memorial
☐ LabCorp
☐ Quest Diagnostic

Financial Statement:
Your health insurance may not pay for services provided in the office such as labs, vaccines, etc… Health insurers do not pay for all of your health care costs, it is your responsibility to know your healthcare benefits. Some sets of vaccines may cost up to 800.00.

By signing below you agree to take financial responsibility for the cost, if your health insurance does not pay for the services provided.

Parent or Guardian Signature:_____ Date:_____

Patients Name: _____
DOB: _____