Patient Registration Form

Patient's Name ____
First Middle Last

Street Address ____
Street/Rt. # Apt# City/State Zip

Primary Phone __________________ Day Phone ____________________ Secondary Phone ______________________

Date of Birth _____/_____/_____ SS Number ________________ Child Lives with: Father ______Mother ______ Guardian__________

Meaningful Use Information

The American Recovery and Reinvestment Act (ARRA) of 2009 established criteria for the use of electronic health record systems (EHR's). The purposes of "Meaningful Use" are to improve quality, reduction of disparities, research and outreach in the use of EHR. We are required to document in each patient's chart: the preferred language, insurance type, gender, race, ethnicity, smoking status (patients 13 yrs +), and date of birth.

Please Circle:

Primary Language: Chinese English French Japanese Korean Spanish; Castilian Vietnamese Other______________________

Race:

American Indian or Alaska Native
Asian
Black or African American
More than One Race
Native Hawaiian or Other Pacific Islander
Other Race
Unknown/Not Reported
White

Ethnicity: No, not Hispanic/Latino Yes, Hispanic/Latino

Smoking Status of Patient: (age 13yrs+) **Yes** **No**

Mother or Guardian ____
First Middle Last **(Maiden)**

Street Address (if different than patient) ____
Street/Rt. # Apt# City/State Zip

Home Phone ______________________________ Cell Phone ______________________________

Date of Birth _____/_____/_____ SS Number ________________ Email Address ______________________

Employer ______________________________ Day Phone ______________________________

Father or Guardian ____
First Middle Last

Street Address (if different than patient) ____
Street/Rt. # Apt# City/State Zip

Home Phone ______________________________ Cell Phone ______________________________

Date of Birth _____/_____/_____ SS Number ________________ Email Address ______________________

Employer ______________________________ Day Phone ______________________________

NON-Parent Emergency Contact/ Relationship __________________________ Phone__________________

Continued on next page

Patient Registration Form Contd.

Parental Consent: - In my Absence I Authorize: (Must be over the age of 18)

Name/Relationship to Patient ____ Name/Relationship to Patient ____

Name/Relationship to Patient ____ Name/Relationship to Patient ____

To make any medical or surgical decisions or to participate in the treatment of my child. I also give consent for them to pick up medication samples, written prescriptions, or health information that I have requested from the physician. Information about me or my child may be disclosed to the following person(s) to the extent of that person's involvement with me or my child's care or payment for care. I furthermore authorized the medical staff at Physicians to Children, Inc to carry out any medical procedures and treatments that are deemed appropriate.

______ **(Initial) PRIVACY ACKNOWLEDGEMENT:** I acknowledge that the Physicians to Children's Notice of Privacy Practice, Dated September 23, 2013 has been made available to me. I understand the Notice of Privacy Practice provides me with detailed information how my protected health information may be used and disclosed.

______ **(Initial) DEEMED CONSENT:** Virginia State law provides that when a healthcare worker is exposed to the body fluids or another person in a manner which may transmit human immunodeficiency virus (HIV – the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to testing for HIV and to the release of the results to the exposed person and the local health department.

______ **(Initial) ASSIGNMENT OF BENEFITS:** By signing below, I assign to Physicians to Children, Inc. any and all rights to receive payment pursuant to any insurance policy, and any recoveries upon any claim for injuries which are payable on account for the services rendered to the patient. I understand that I am financially responsible for all charges incurred for services rendered whether or not they should be paid for by insurance or by someone else. Should legal action be initiated as a result of nonpayment of any charges incurred with Physicians to Children, Inc., then I agree that the proper location of such actions will be the City of Roanoke and in addition to charges due, I agree to pay court costs and to pay attorney's fees up to an amount equal to 30% of the unpaid charges on that account.

______ **(Initial) VIRGINIA LAW GOVERNS:** I agree that any dispute, cause of action, or any disagreement of any nature relating in any way to this consent or the treatment, diagnosis, administration of drugs or procedures, or any other interactions between the doctors, nurse practitioners, and employees of Physicians to Children, Inc. and me shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia, but without regard to its or any other state's principles of conflicts of laws, and shall be binding upon me and my heirs, and personal representative. In the event this consent is signed by a parent or personal representative of the patient, this choice of law provision binds both the patient and personal representative.

______ **(Initial) PHARMACY CONSENT:** I authorize Physicians to Children to electronically obtain medication history from pharmacies to include in Physicians to Children medical record.

By signing below I am agreeing and acknowledging to the above (Consent to Treat, Privacy Acknowledgement, Deemed Consent, Assignment of Benefits, Virginia Law Governs and Pharmacy Consent) and understand that if the mentioned responsible party does not pay that I will be responsible for payment.

Patient Signature: **(18 years and older)** ____ Date: ______________________

Responsible Party/Parent Signature: ____ Date: ______________________

Printed Name: ____ Relationship to Patient: ________________________

Insurance Information: We will need to scan your insurance card. Please give your cards to registration.

How did you hear about us?

Former Patient_____ Sibling is a Patient _____ Referred by other Provider's Office ______________________

Hospital _____ Internet Search _____ Phone Book _____ PTC's Reputation _____Other ___________________________