COASTAL PEDIATRIC ASSOCIATES
REGISTRATION FORM

PATIENT INFORMATION: Please note it is your responsibility to notify us of any changes.

LAST NAME	FIRST NAME	MI	CHILD'S DATE OF BIRTH	GENDER

STREET ADDRESS (PO BOX if applicable)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL ADDRESS (only if patient is legal adult list their email here)

PRIMARY GUARANTOR INFORMATION: **To Whom Statements are sent; if you are primary custodian/parent, you are the guarantor unless legal documentation is on file at practice to designate another financially responsible party.**

RELATIONSHIP TO THE PATIENT ____

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER	SSN

STREET ADDRESS (only if different from patient above)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

EMAIL ADDRESS (required for portal registration, indicate access type) **ACCESS TYPE:** **FULL ACCESS** **BILLING ONLY ACCESS**

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

SECONDARY GUARDIAN/PARENT INFORMATION: **Please provider other custodian/parent's information; this is not the person financially responsible for the party.**

RELATIONSHIP TO THE PATIENT____

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER	SSN

STREET ADDRESS (only if different from that of patient above)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

EMAIL ADDRESS (required for portal registration, indicate FULL ACCESS or BILLING ACCESS ONLY) **ACCESS TYPE**: FULL ACCESS BILLING ONLY ACCESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

PRIMARY INSURANCE INFORMATION: **Relationship to patient:** ___________________________________ ***Please provide staff with copy of insurance card.***

INSURANCE CARRIER NAME	INSURANCE ID #	INSURANCE GROUP #
POLICY HOLDER'S NAME	POLICY HOLDER'S DOB	POLICY HOLDER'S SSN#

SECONDARY INSURANCE INFORMATION: **Relationship to patient:** _________________________________ ***Please provide staff with copy of insurance card.***

INSURANCE CARRIER NAME	INSURANCE ID #	INSURANCE GROUP #
POLICY HOLDER'S NAME	POLICY HOLDER'S DOB	POLICY HOLDER'S SSN#

EMERGENCY CONTACT: ***This individual will be added to the Authorization/Disclosure Form if not already done.***

NAME	RELATIONSHIP TO CHILD	DAYTIME PHONE NUMBER

Signature of Guarantor/Guardian:	***Print Name:***	***Date:***

Updated NOV 2021

PERMISSION TO SPEAK TO/ DISCLOSE INFORMATION FORM

The purpose of this authorization is to meet the patient's request for information disclosures and uses. This authorization form permits Coastal Pediatric Associates (CPA) to use or disclose protected health information listed below to the individuals or organization listed for the following patient:

Patient Name ____ *Date of Birth*_____________________

Please provide the front desk with a copy of any legal paperwork describing guardianship or financial responsibility if other than the biological parent(s). Please note that both biological parents are legally entitled to receive medical information on a minor unless otherwise ruled by the Judicial System and documentation is presented to CPA. Once the minor reaches 18 years of age he/she will be required to complete all patient paperwork unless otherwise stated by the Judicial System with proper documentation presented to CPA.

Please list two phone numbers with voicemail where CPA may leave a message or communicate with you by automated, prerecorded, and/or artificial voice telephone calls that we initiate. These calls can pertain to appointments, office closures, financial/insurance details and clinical information related to the patient. Entry of any telephone contact number constitutes written consent to receive the above communications initiated by the practice. To alter or revoke this consent, please contact the office directly.

You understand that if I decline to receive the above forms of communications from the practice via the methods indicated or if my voicemail is full or not set up, that the practice will resort to US Postal mail to the address on file and cannot guarantee timely receipt.

PRIMARY PHONE NUMBER:	SECONDARY PHONE NUMBER:
May contact me and or leave a message at this number regarding the following: Appointments Financial, Insurance Details: Clinical Information: May send SMS/TEXT messages to this number if it is a mobile number	May contact me and or leave a message at this number regarding the following: Appointments: Financial, Insurance Details: Clinical Information: May send SMS/TEXT messages to this number if it is a mobile number

With my permission, I hereby authorize the following individual(s): to consent to all medical care and attention for this child in which is deemed necessary and appropriate by a healthcare provider at CPA. This consent includes, but is not limited to, emergency services, lab tests, procedures, and immunizations. The listed individuals are given the authority to discuss and change appointments, financial or insurance details, and clinical information including lab results.

Name or Organization:	Relationship to Patient:	Contact Phone Number:

By verifying the identity of the individual calling above, I give Coastal Pediatric Associates the authority to send vaccination records via fax or email to specified daycare centers, schools, or other health care facilities once verbally requested. Verification information will include, but is not limited to patient's address, phone numbers, insurance, and appointment information

I understand that I have the right to refuse to sign this authorization and that treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient, Parent, Legal Guardian (include court documentation), or Personal Representative (as defined by HIPAA):

Signature	**Print Name**	**Date**

Description of Personal Representative's Authority (attach documentation, if necessary):

****

Office Use Only: Receiving Employee ____ Date Received _________________

☐Copy given to Patient

Updated NOV 2021

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, ACKNOWLEDGEMENT OF CPA POLICIES

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Coastal Pediatric Associates (CPA). I/we consent to testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician, nurse practitioner, or physician assistant. I/we also consent to minor, procedural treatment, such as, but not limited to circumcision, ingrown toenail removal, frenotomy, and cryotherapy if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science, and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me/us this consent and understand and agree to its contents.

Virtual/Telehealth Options

CPA offers patients the opportunity to connect to a provider through HIPAA complaint video visits. By signing this, you are agreeing that you have had a chance to read through the Telehealth informed consent, CPA Notice of Privacy Practices, Financial Policy, Immunization Policy and Well-Exam Visit Helpful Facts. This information can be found on our website CPAkids.com. You agree to the terms set forth by the policy as well as the opportunity to ask questions. I agree and understand if I use Telehealth, I may be financially responsible for the service/visit and understand the risks and benefits of Telehealth.

Authorization for Release of Information and Assignment of Insurance Benefits

CPA is authorized to release any medical information required in the processing of applications or submission of information for financial coverage and the continuation of care, such as, but not limited to third party referrals to receive therapy services and treatment from specialists, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious disease including AIDS/HIV. I/we also agree to the release of medical, vaccination, medication history or other information about me/the minor to the state vaccination registry (CARES), pharmacy benefit managers via Surescripts, and/or government regulatory agencies (federal or state) as required by law. For Medicaid/Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicaid/Medicare benefits.

Acknowledgement of Receipt of CPA Policies

I hereby acknowledge that I have received or reviewed the CPA Notice of Privacy Practices, Financial Policy, Immunization Policy and Well-Exam Visit Helpful Facts. This information can be found on our website CPAkids.com. A printed version of this information will be provided upon request.

I/we understand that I have the right to refuse to sign this authorization and that my/our child's treatment will not be conditioned on signing. I/we understand that I/we have the right to revoke this authorization at any time by providing a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I/we understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

By signing below, I acknowledge that I have read and understand the above statements of Coastal Pediatric Associates:

Signature	***Print Name***	***Date***

OFFICE USE ONLY

Documentation of "Good Faith" Attempt to get acknowledgement signature.

☐ Document presented to parent/patient, but parent/patient refused to sign acknowledgment.

☐ Patient presented with an emergency and there was no time to give the Notice or receive a signature. Attempt to give the Notice and get any acknowledgement will be handled as soon as possible.

☐ Documentation was presented to the parent/patient, but a communication failure prevented us from receiving the acknowledgement.

☐ The documentation was mailed to the parent/patient but never returned to us.

☐ Other____

Employee preparing the document Printed Name and Signature

____Date______________

Updated NOV 2021