PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

Today's Date:

PATIENT INFORMATION					
Patient's Last Name:	**First Name:**			**Middle:**	Nickname:
Date of Birth:	Age:		Gender:	Student: ☐ Part Time ☐ Full Time	
Patient's Address:		Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:			Mobile (Cell) Phone:	
Patient E-Mail Address: (if applicable)			Emergency Contact:		
Preferred Language:			Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer		

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Decline to Answer

Preferred Contact Method: (select one for each) ☐ No Contact (*contact guardian*)
Medical Issues/Problems: ☐ Cell Phone ☐ Home Phone ☐ No Contact (*contact guardian*)
Appointment Reminders: ☐ Text to Cell ☐ E-Mail ☐ No Contact (*contact guardian*)
Due for Visit: ☐ Text to Cell ☐ E-Mail ☐ Cell Phone ☐ Home Phone ☐ No Contact (*contact guardian*)

Hospital:	Referred By:

PHARMACY INFORMATION		
Name of Pharmacy:	Address:	Phone:

I authorize the Children's Health Center of VNA Community Services, Inc. personnel to view the patient's external prescription history via the electronic record system, eClinical Works.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

PARENT/GUARDIAN #1 INFORMATION (This parent/guardian will be listed as the primary contact for the patient listed above)					
Parent/Guardian's Last Name:	**First Name:**			**Middle:**	Nickname:
SSN:	**Date of Birth:**	Relation to Patient:	☐ Check here if patient is the genetic child of this parent ☐ Check here if patient lives with this parent/guardian?		
Address: (Leave blank if same as patient)		Apt:	City/Town:	State:	Zip Code:
Primary Phone:	Daytime (Work) Phone:			Mobile (Cell) Phone:	
Preferred Language:			Parent/Guardian Home E-Mail Address:		
Employer:			Occupation:		

Revised: 6/2022

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AUTHORIZED FAMILY MEMBER / CARETAKER INFORMATION (Persons listed in this section are permitted to accompany and consent to the examination and/or treatment of the patient listed above until expressly revoked by a parent/guardian)		
☐ Check here if you do not authorize any additional family members/caretakers to accompany and consent to the examination and/or treatment of this patient in the absence of a parent/guardian. (If selected please skip the next section)		
1st Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from ______________through______________. This authorization is effective from ______________until revoked by me in writing.	
2nd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from ______________through______________. This authorization is effective from ______________until revoked by me in writing.	
3rd Authorized Party Last Name:	First Name:	Relation to Patient:
Phone Number:	This authorization is effective from ______________through______________. This authorization is effective from ______________until revoked by me in writing.	

SIBLINGS			
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:
Last Name:	First Name:	Date of Birth:	Gender:

PRIMARY INSURANCE INFORMATON			
Insurance Company Name:	**ID Number:**		Group Number:
Guarantor's Name:	Gender:	**Date of Birth:**	Patient Relation to Guarantor:
Employer:		Employer Address:	

SECONDARY INSURANCE INFORMATON			
Insurance Company Name:	ID Number:		Group Number:
Guarantor's Name:	Gender:	Date of Birth:	Patient Relation to Guarantor:
Employer:		Employer Address:	

PATIENT REGISTRATION FORMS

In order to serve you, we need the following information. Please print.

STATEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by the Children's Health Center of VNA Community Services, Inc.

Child's Name: ____

I understand my insurance carrier may not approve or reimburse medical services in full due to benefit exclusions, coverage limits, lack of authorization, lack of eligibility or medical necessity.

I understand that I am responsible for the fees not paid in full, co-payments and policy deductibles and co-insurances except where my liability is limited by contract or by State or Federal Law.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

AUTHORIZATION FOR TREATMENT AND ACKNOLEDGEMENT OF FINANCIAL RESPONSIBILTY

- I hereby authorize all parents, guardians, family members, and caretakers listed above to accompany the above named patient to office visits at the Children's Health Center of VNA Community Services, Inc., and consent to the examination and/or treatment of the above named patient during the office visits. Parents and/or guardians must be listed above in order to obtain access to this patient's records via the Online Patient Portal.
- I hereby authorize the Children's Health Center of VNA Community Services, Inc., personnel to communicate via mail, phone call, patient portal, answering machine message, text message, and/or e-mail according to the information I have provided above.
- I hereby authorize the Children's Health Center of VNA Community Services, Inc., and associated parties to release medical and/or other information acquired in the course of my examination and/or treatment (with the exception of mental health records) to necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I certify that myself/my dependent(s) have health insurance coverage as indicated above. I hereby authorize the Children's Health Center of VNA Community Services, Inc., and/or its subsidiaries to submit for reimbursement on my/our behalf for all services rendered and assign directly to the Children's Health Center of VNA Community Services, Inc., all insurance benefits otherwise payable to me. I understand that all co-pays, co-insurances, and deductibles are due at the time of service and that a billing fee will be added to any co-pays not paid at the time of service. I further understand that if the Children's Health Center of VNA Community Services, Inc., is unable to verify active insurance coverage for this patient and/or the claim for reimbursement is not paid by my insurance that the patient (or patient's guardian, if a minor) is ultimately responsible for payment for services rendered. I agree that any balance due for services rendered will be paid immediately upon receipt of a bill.
  In the event that I do not pay my bill, I understand that I will be held responsible for all reasonable collection and legal fees.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

PATIENT REGISTRATION FORMS

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CONSENT FOR PRISMA INTEROPERABILITY IN ECW

I, ____, whose signature appears below, authorize the Children's Health Center of VNA Community Services, Inc. and its affiliated provider and staff to allow exchange of electronic health information to be activated in order to obtain my/my child's medical records from other providers and hospitals.

This consent will provide the provider with information from any hospitalization or specialist visits that myself or my child has had outside of the VNA.

This will enable our providers to have a clear understanding of your/your child's treatments for medical issues identified by other providers.

My signature certifies that I read and understand the scope of my consents and that I authorize the access.

Print Patient's Name:	Date of Birth:
Signature of Patient or Legal Guardian:	Date:

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I certify that I have been offered and/or have received a copy of the Children's Health Center of VNA Community Services, Inc.'s Notice of Privacy Practices.

Patient/Parent/Guardian Name:	Relationship to Patient:
Patient/Parent/Guardian Signature:	Date:

Please list below the names and dates of birth of all of your children/dependents who are patients of the Children's Health Center of VNA Community Services, Inc. with whom you wish to include in this authorization:

Name	Date of Birth