Coastal Healthcare REGISTRATION PEDIATRICS

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

PATIENT INFORMATION *PRINT* *REFERRED BY:*_____

Last: _____
First_____ MI_____
Nickname:_____
Address_____
City_____
State_____ Zip_____
Please put an (X) next the your preferred contact number:
Home#_____(___)
Cell #_____(___)

PRIMARY CARE DR:_____
Date of Birth_____
Sex: ____Male ____Female
Marital Status: ____ Single ____Married

PATIENT'S INFO:
Social Security #_____
Employer:_____
Employ status: __F/T __P/T
Student: ___F/T ___P/T

PRIMARY INSURANCE	SECONDARY INSURANCE
INS CO _____	INS CO. _____
ID #_____ COPAY $ _____	ID #_____ COPAY $ _____
PT's Relationship: ___Self __Spouse __Child __Part	Pt's Relation: __Self __Spouse __Child __Partner
If insured is other than patient (self):	
Insured name: _____	Insured name: _____
SS#_____ DOB_____	SS#_____DOB_____
Employer:_____	Employer:_____

EMERGENCY CONTACT:

Name:_____ Relationship_____
Address if different that patient: Phone:_____
Street:_____ City_____ Zip_____

Private Insurance Authorization Assignment of Benefits/ Information Release:
I, the undersigned, authorize payment of a medical benefit to Coastal Healthcare for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

Patient Signature:_____ **Date:**_____

If the patient is a minor or under 18 years of age, the parent or guardian must complete the information below and sign. Signature of Responsible Party Required.

Parent/Guardian Name: _____
Social Security:_____ **Date of Birth**_____
Address if different than Patient: _____
Phone if different than Patient _____
Signature:_____ **Date**_____

Coastal Healthcare PATIENT INFORMATION

PLEASE COMPLETE ALL INFORMATION. PRINT AND SIGN WHERE REQUIRED

Patient Name: _____ Patient/Guardian Email: _____

OK to use email and/or text for appointment confirmation?

EMAIL ____Yes ___No TEXT ____ Yes ____No

OK to leave message at

____ HOME	____Brief	or	____Extended	_____
____ CELL	____Brief	or	____Extended	_____
____ WORK	____Brief	or	____Extended	_____

Race: (Check one below)

- _____ American Indian or Native Alaskan
- _____ Asian
- _____ Native Hawaiian or Other Pacific Islander
- _____ Black or African American
- _____ White
- _____ Hispanic
- _____ Other Race
- _____ Other Pacific Islander
- _____ Unreported or refused to report

Ethnicity: (Check one below)

- _____ Hispanic or Latino
- _____ Not Hispanic or Latino
- _____ Refused to Report

Language other than English:

_____

PATIENT EMPLOYMENT INFORMATION

Employer address: _____ City _____ Zip _____

Employer Phone number: _____

PHARMACY INFORMATION

Please list your preferred Local and Mail Order Pharmacy. Prescriptions will be done electronically directly

LOCAL PHARMACY:

Name: _____

Address: _____

City: _____ Zip _____

Phone # _____

Fax: _____

MAIL ORDER PHARMACY:

Name: _____

Address: _____

City: _____ Zip _____

Phone # _____

Fax: _____

ERx History Consent:

I hereby give **Coastal Healthcare** and its affiliated providers permission to view my prescription information and history from all external sources. By signing this consent form, I agree that **Coastal Healthcare** can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for all treatment purposes.

Patient Signature _____ Date _____

COASTAL HEALTHCARE

PATIENT'S MEDICATION FORM – Completed by Patient/Guardian.. Please Print

Name:	Phone #:	DOB:

Emergency Contact Name & Phone #

ALLERGIC TO:	Describe reaction:

Do you prefer generic if it is recommended and available? _____***YES*** _____***NO***

LIST ALL ***Prescribed Medication and dosage** ***Over the Counter meds** ***Vitamins**	Frequency: daily Twice/DAY every M---W---F etc)	What time of the day do you take this medication?				Name of doctor that prescribed the medication	Stop Date
		Morning	Noon	Supper	Bedtime		

PATIENT/GUARDIAN SIGNATURE: DATE:

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice:**
   I have been offered a copy of *Coastal Healthcare's* Notice of Privacy Practices.

   Patient Name: _____ Date of Birth_____

2. **I wish to be contacted in the following manner (check all that applies):**

   Home Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

   Cell Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

   Work Telephone (OK to leave a detailed message) Number: _____
   □ Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

   Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. ***Coastal Healthcare*** operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **Designation of Certain Relatives, Close Friends and Other Caregivers:**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.
   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (other than patient) 1) _____ 2) _____

Relationship to Patient: 1) _____ 2) _____

Date of Birth: 1) _____ 2) _____

Telephone #: 1) _____ 2) _____

_____ _____
Signature of Patient/Parent/Guardian Date

Coastal Healthcare

FINANCIAL POLICY

Welcome to Coastal Healthcare. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:

We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up to date insurance information. We accept payment from all participating insurance plans, but require that you pay your copay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:

All missed appointments with the doctor and those cancelled with less than 24 hour notice may be subject to a $25.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge. There may be additional charges, not covered by insurance, including form processing fees (i.e., physicals, disability), after hour appointments, weekend appointments or appointments on a holiday.

Collection Agency:

All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.

Financial Hardship:

Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY AND AGREE AS FINANCIALLY RESPONSIBLE PARENT FOR **ALL** MY CHILDREN LISTED BELOW **REGARDLESS** OF WHO ACCOMPANIES THE CHILD FOR THE APPOINTMENT.

1)_____ 3)_____

2)_____ 4)_____

_____ _____ _____

Signature Relationship Date

Coastal Healthcare

OFFICE POLICY

Coastal Healthcare's goal is to provide and maintain a good physician--patient relationship. We start with skilled professional physicians and staff who recognize the importance of good communication on all levels.

1. CHECK IN:

- *Upon arrival, please check in at the front desk. For your initial visit, present a photo ID such as a driver's license and your Insurance Card. You will be asked to complete registration forms. Any payment due by patient is requested during check in.*
- *At all visits thereafter, check in at the front desk, present your current insurance card and any payment due at EVERY visit. Please inform us of any changes to your personal information such as address, phone or insurance.*

2. MEDICATION REFILLS:

- *All refills are done based on patient's adherence to scheduled appointments and medical necessity. Please be prepared to review your medication refill needs at the time of your visit. Contact your pharmacy to request refills outside of scheduled appointments as prescription refills are done electronically to and from your pharmacy. Please call your pharmacy first for your refills. They will contact the office. If you prefer a 3 month mail order, please allow ample time for the order to be processed and received through the mail. Refills for certain class drugs will need to be picked up at the office.*

3. INSURANCE: Under the guidelines of your insurance plan, it is your responsibility to understand your benefit plan.

- *REFERRALS/AUTHORIZATIONS: It is your responsibility to know if a referral or authorization is required to see a specialist. Three (3) business days is requested for non--emergent referrals and authorizations.*

*PATIENT SIGNATURE:*_____ *DATE:*_____

COASTAL
HEALTHCARE

PATIENT:_____ **DOB**_____

CONSENT FOR TREATMENT OF MINOR CHILDREN

Accompanied by an adult other than parent or legal guardian

I, _____

(Parent or legal guardian)

Authorize Coastal Healthcare to treat (child) _____
for routine and emergency medical treatment when deemed necessary
by qualified medical personnel when accompanied by:

_____ Relationship to child:_____
_____ Relationship to child:_____
_____ Relationship to child:_____

This authorization is valid for:

____ Today's visit only Date:_____
____ From (date) _____ to (date) _____
____ Until revoked in writing by me

THIS CONSENT WILL BE VALID FOR ONE (1) YEAR FROM THE DATE SIGNED

Printed name of parent/legal guardian_____

Signature of parent/legal guardian_____

Date:_____