WESTMINSTER PEDIATRICS

Patient Registration

Child 1: *Last Name:* ______________________ *First Name:* ______________ *MI:* ____

D.O.B. ______________ *Sex:* _____ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Other *Race:* Asian / Black / White / Other

Child 2: *Last Name:* ______________________ *First Name:* ______________ *MI:* ____

D.O.B. ______________ *Sex:* _____ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Other *Race:* Asian / Black / White / Other

Child 3: *Last Name:* ______________________ *First Name:* ______________ *MI:* ____

D.O.B. ______________ *Sex:* _____ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Other *Race:* Asian / Black / White / Other

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Mailing Address:

________________________ ____________________ __________ ________________

(Street or PO Box) **(City)** **(State)** **(Zip)**

Home Phone: (_____ **)** _____ - __________

Who Lives at this household? ____

Insurance:

Primary Policy-

Policy Holder's Name: ____

Policy Holder's Birth Date: ______________________ *Policy Holder's Sex: Male / Female*

Insurance Carrier: ____

ID# ____________________________ *Group ID #* ________________________

Secondary Policy-

Policy Holder's Name: ____

Policy Holder's Birth Date: ______________________ *Policy Holder's Sex: Male / Female*

Insurance Carrier: ____

ID# ____________________________ *Group ID #* ________________________

Contact 1: *Name:* ______________________ *Relationship to Patient:* ________________

Lives with patient? Yes / No *Date of Birth:* ____________ *Home Phone:* ______________

Work Phone: ______________ *Cell Phone:* ______________

Email: ______________________________ *Employer:* ______________________

How would you like to ideally prefer to be contacted regarding *(circle one):*

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Contact 2: *Name:* ______________________ *Relationship to Patient:* ________________

Lives with patient? Yes / No *Date of Birth:* ____________ *Home Phone:* ______________

Work Phone: ______________ *Cell Phone:* ______________

Email: ______________________________ *Employer:* ______________________

Additional Contact Questions:

Who should receive billing statements: ____

May all contacts have access to the patient's records electronically? YES / NO

If Parents are divorced or separated, please fill out this section:

Who has custody? ____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES / NO

If yes, please explain and provide a copy of legal paperwork that supports this restriction.

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Emergency Contacts, <u>other than parents</u>:

1.) ______________________ ______________ ________________
(Name) **(Relationship)** **(Phone #)**

2.) ______________________ ______________ ________________
(Name) **(Relationship)** **(Phone #)**

WESTMINSTER PEDIATRICS

Westminster Pediatrics

Authorization of Treatment and Assignment of Benefits

I authorize Westminster Pediatrics to treat my child. I further authorize payment directly to Westminster Pediatrics for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

I authorize the following people to bring my child in for treatment if I am unavailable to bring my child in for care.

Name and Relationship	*Phone #*
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

______________________________ ______________

Signature of Parent/Guardian *Date*

Westminster Pediatrics, L.L.C
Privacy Notice to Patients

This notice describes how medical information about you or your minor child may be used and disclosed and how you can get access to this information. Please review this information carefully.

Our commitment to your privacy:
Westminster Pediatrics, LLC is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to him/her. We are required by law to maintain the confidentiality of health information that identifies your child. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

The following categories describe the different ways in which we may use and disclose your child's IIHI.

1. Treatment: Our practice may use your child's IIHI to treat your child. For example, we may disclose your child's IIHI as follows:
    - To order laboratory tests, which we may use the results to help us reach a diagnosis.
    - To write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for you.
    - To treat or assist others in the treatment of your child.
    - To inform you of potential treatment options or alternatives of programs.
    - To others who you have given permission to bring your child to the office for treatment.
    - To other health care providers for purposes related to their treatment.
    - To a parent or guardian or other responsible person.
2. Payment: Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items provided by us for your child.
    - To contact you child's health insurer to certify that your child is eligible for benefits and we may provide your child's insurer with details regarding your child's treatment to determine if the insurer will cover, or pay for your treatment.
    - To obtain payment from other third parties that may be responsible for costs
    - To bill you directly for services
    - To other health care providers and entities to assist in their billing and collections
3. Health Care Operations: Our practice may use and disclose your child's IIHI to operate our business. Examples:
    - To evaluate the quality of care
    - To other health care providers and entities to assist in health care
    - To contact you to remind you of your child's appointment
    - To inform you of health related benefits or services that may interest you
    - When we are required to by federal, state or local law.
4. You have the right to inspect and copy your minor child's medical records. (The provider is entitled to charge you a reasonable fee related to the cost of copying your medical records).
5. You have the right to receive a paper copy of this notice.
6. Provider is required by law to maintain the privacy of protected health information and to provide the patients with this notice. Patients will be provided with revised notices as appropriate.
7. If you as a patient or guardian believe that his or her privacy rights have been violated, the patient may wish to notify the provider or contact the U.S. Department of Health and Human Services. To notify the provider, please call our office and ask to speak with our designated Privacy Complaints Contact Person, Dr. Michael Beardsley (410)871-1000. Provider will not retaliate in any way against a patient for making a complaint.

____
Patient Name

______________________________ ______________________
Signature of parent/guardian Date