

Community Care Physicians Pediatric Patient Registration Form

Date: _____

Patient ID#: _____
(for office use only)

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: () _____

Cell #: () _____ Preferred daytime phone: ☐ Home ☐ Work ☐ Cell

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female ☐ Other _____

E-mail Address: _____ Would you like to participate in the patient portal?
☐ Yes ☐ No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Black/African American
☐ White
☐ Other

Ethnicity: Select One
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ **Emergency Contact DOB:** ____/____/____

Emergency Phone: () _____ **Relationship to Patient:** _____

Mother's maiden name _____

First Name

Maiden Name

Primary Care Physician: _____ **Referring Physician:** _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

☐ E-Mail (when available) ☐ Text ☐ Office may leave a message at home

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FINANCIALLY RESPONSIBLE PARTY

In accordance with Community Care Physicians' Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. **Co-pays are due and expected at time of service.**

Financially Responsible Parent/Guardian's Last Name _____ First _____

Relationship to Patient ☐ Mother ☐ Father ☐ Other: _____

Address ☐ Same as Above Street: _____ City/State/Zip _____

Home Phone # () _____ Work Phone # () _____ Cell Phone # () _____

Date of Birth ____/____/____ Guarantor: ☐ Yes ☐ No

Other Parent/Guardian's Last Name _____ First _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Other _____

Address ☐ Same as Above Street: _____ City/State/Zip _____

Home Phone # () _____ Work Phone # () _____ Cell Phone # () _____

Date of Birth ____/____/____ Guarantor: ☐ Yes ☐ No

MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ____/____/____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Co-pay: \$ _____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ____/____/____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Co-pay: \$ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

Signature of Patient / Guardian

_____/_____/_____
Date

PATIENT HIPAA AUTHORIZATION TO SEND RECORDS TO COMMUNITY CARE

Patient's Full Name (Last, First)	Patient's Date of Birth

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **SENT TO** the following Community Care Physicians location:

Pediatrics Clifton Park
942A Route 146
Clifton Park, NY 12065-8000
P: 518-371-8000 F: 518-371-5338

Step 2: Where is Your Information Coming From?

Name/Entity: _____ Phone: _____

Address/City, State, Zip: _____ Fax: _____

Step 3: What Can CCP Receive?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____ to: _____ (If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

Please Initial: _____: I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information below. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment**

☐ **HIV-Related Information**

☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care to a CCP Provider ☐ Other: _____

Step 4: When Does this Authorization Expire?

This authorization will expire on _____

{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date: _____

Relationship to Patient: _____