REGISTRATION FORM

Welcome! Thank you for choosing Pediatric Associates for your pediatric and breast feeding support services. Please read, complete, and sign this form and the attached Consent to Payment & Treatment.

Pediatric Patient Information:

Patient Name ____ Date of Birth ___/___/______
First MI Last
Preferred Name _______________________ Primary Language________________Sex_____

Ethnicity: Hispanic or Latino ___Yes ___No

Race: White, Black or African American, American Indian/AK Native, Asian, Native HI/Pacific IS

Patient Name ____ Date of Birth ___/___/______
First MI Last
Preferred Name _______________________ Primary Language________________Sex_____

Ethnicity: Hispanic or Latino ___Yes ___No

Race: White, Black or African American, American Indian/AK Native, Asian, Native HI/Pacific IS

Patient Name ____ Date of Birth ___/___/______
First MI Last
Preferred Name _______________________ Primary Language________________Sex_____

Ethnicity: Hispanic or Latino ___Yes ___No

Race: White, Black or African American, American Indian/AK Native, Asian, Native HI/Pacific IS

Patient Name ____ Date of Birth ___/___/______
First MI Last
Preferred Name _______________________ Primary Language________________Sex_____

Ethnicity: Hispanic or Latino ___Yes ___No

Race: White, Black or African American, American Indian/AK Native, Asian, Native HI/Pacific IS

ADDRESS_____
Street City State Zip

Primary Cell Phone # _____

(This is for ALL appointment notifications via TEXT ONLY)

How did you hear about our office

_____
_____
_____

Parent/Guardian 1 Information

NAME _____ Relationship to Patient _____
First MI Last

Primary Language _____ DOB ___/___/___ Driver's License # _____

Lives with patient? Yes/No If No, Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Also, a patient of Pediatric Associates' NEPA Breastfeeding Center? Yes ____ No ___

Parent/Guardian 2 Information

NAME_____ Relationship to Patient _____
First MI Last

Primary Language _____ DOB ___/___/___ Driver's License # _____

Lives with patient? Yes/No If No, Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Also a patient of Pediatric Associates' NEPA Breastfeeding Center? Yes ____ No ____

If parents are divorced or separated (Only complete if applicable)

Who has custody of patient _____

Are there any legal restrictions that would limit or prevent the non-custodial parent from consenting to medical treatment for the patient or from obtaining information about the patient's medical treatment?

Yes ____ No ____

If Yes, please explain and provide a copy of any supporting legal paperwork:

_____

_____

HIPAA

<u>*MUST COMPLETE AUTHORIZED INDIVIDUALS SECTION FOR PRIVACY ***</u>**

Additional Authorized Individuals/Contacts (other than custodians)

The individuals identified below are authorized to accompany, provide consent for treatment, and or receive protected health information about the pediatric patient.

First	Last	Relationship	Phone Number
First	Last	Relationship	Phone Number
First	Last	Relationship	Phone Number

_____I understand that an authorized individual <u>must</u> present a valid photo ID at the visit.
(Initial)

Preferred Pharmacy:

Name _____

Location _____ Phone Number _____

CONSENT TO PAYMENT & TREATMENT

PRIMARY INSURANCE: Subscriber Name _____

Relationship to Pediatric Patient _____

Date of Birth ___/___/_____

Relationship to Breastfeeding Center of NEPA Patient (if applicable) _____

Insurance Company _____ ID# _____

SECONDARY INSURANCE: Subscriber Name _____

Relationship to Pediatric Patient _____

Date of Birth ___/___/_____

Relationship to Breastfeeding Center of NEPA Patient (if applicable) _____

Insurance Company _____ ID# _____

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment directly to Pediatric Associates of Kingston, LLC ("Pediatric Associates"), and to any physician employed by or contracted with Pediatric Associates, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the pediatric patient and the NEPA Breastfeeding Center patient, as applicable. If pediatric patient and/or NEPA Breastfeeding Center patient is eligible for Medicaid, I have requested Medicaid services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the pediatric patient's and/or the Breastfeeding Center of NEPA patient's account is paid in full.

I understand that I may be responsible for payment in full of any amount due that is not covered or paid for by my insurance policy, benefit plan, or other payor. I understand that in this case, I am obligated to pay Pediatric Associates in accordance with its regular rates and terms. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, and associated court costs and attorney's fees. I also agree that any patient or guarantor over payments may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the over payment.

Release of Information and Statement of Assistance

I authorize Pediatric Associates to furnish and release to my insurance carrier(s) or their representatives insuring the pediatric patient and/or the NEPA Breastfeeding Center patient any and all portions of the pediatric patient's and the NEPA Breastfeeding Center patient's medical records which may be necessary for completion of any claims for services, supplies, and equipment provided.

I consent for the Pediatric Associates and/or its attorneys to request, on my behalf, any information related to my health insurance policy (including, but not limited to, proof of insurance). This information may be given directly to Pediatric Associates and/or its attorneys.

I authorize Pediatric Associates to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to the pediatric patient and/or the NEPA Breastfeeding Center patient, as applicable.

I agree to assist Pediatric Associates in collecting benefits that may be due or payable under my insurance policy for the services, supplies, and equipment provided.

I agree to provide Pediatric Associates and/or its attorneys with any additional information needed to process claims for payment.

Consent for Treatment

In this section, the term "patient" refers to the pediatric patient. The term "patients" refers to both the pediatric patient and the NEPA Breastfeeding Center patient, if applicable.

I hereby voluntarily authorize treatment of the patient or patients, as applicable, at Pediatric Associates. I permit Pediatric Associates and its employees, physicians, fellows, residents, interns, and other qualified personnel involved in the patient's or patients' care to treat the patient or patients in ways they judge to be beneficial to the patient or patients. I understand that I have the right to ask questions and to receive information about the patient's or patients' care and treatment, and the right to withdraw my consent for treatment or tests.

I understand that the results of any treatments, tests or care cannot be guaranteed. I also understand that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law for the patient or patients.

I understand that medical, nursing, and other health care personnel in training may be observing and participating actively in the care of the patient or patients under the supervision of authorized personnel. I hereby give my consent to such observations and/or participation.

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of the patient's or patients' body/ies, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

ACKNOWLEDGMENTS

(PLEASE INITIAL)

__I hereby certify that I have read the foregoing Consent to Payment & Treatment, understand it, accept its terms, and was offered and/or received a copy of it.

___I hereby acknowledge that I was offered and/or received a copy of and read Pediatric Associates' Notice of Privacy Practices. We are asking you to acknowledge that you were offered or received a copy of our Notice of Privacy Practices. By signing below, you are not making any statement regarding the content of the Notice of Privacy Practices or about your agreement or disagreement with it or any portion of it. I understand that if I have questions or complaints relating to the Notice of Privacy Practices, I may contact the Practice Administrator at (570) 288-6543.

___I hereby acknowledge that I was offered and/or received a copy of and read Pediatric Associates' Intent to Immunize.

___I hereby acknowledge that I was offered and/or received a copy of and read Pediatric Associates' Financial Policy.

____I hereby certify that I am authorized as the pediatric patient's parent, guardian, or other legal representative to execute this Consent and, if applicable, that I am the NEPA Breastfeeding Center patient.

____I hereby authorize PAK to enroll the following email address for PAK Patient Portal:

Email Address _____

Account Name (First Name) _____ (Last Name) _____

Email Address_____

Account Name (First Name) _____ (Last Name) _____

_____ Date _____
Parent/Guardian Signature

_____Date _____
NEPA Breastfeeding Center Patient Signature
(please sign if applicable, even if you also signed as the pediatric patient's parent or guardian)
(This section to be completed by PAK staff)

Provided PAK policies as listed above to parent/guardian _____(Initial PAK Staff)

_____Date _____

Pediatric Associates Staff Verification: I verified information on registration form and has been entered correctly and scanned into PAK EHR

_____ _____

Staff Signature Date