REGISTRATION FORM

Today's Date:	MR#:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name:	Maiden Name:

Birth Date: / /	Age:	Sex: ❑ male ❑ female

Street Address:	City:	State:	Zip Code:

Telephone#: ( )	Cell #: ( )	Work phone #: ( )

E-mail adress:_____

Marital Status: □ single □ married □ divorced □ widow

Ethnicity: Are you Latino/Hispanic? □ yes □ no

Race: □ White □ African American □ Asian □ other: _____

Name of Parent or Guardian:	Telephone#: ( )

INSURANCE INFORMATION

Name of Person Insured:	Birth Date: / /	Telephone#: ( )

Insurance Name:

Group #:	Policy #:

Patient's relationship to person insured: ❑ self ❑ spouse ❑ child ❑ Other: _____

Name of **secondary** insurance (if applicable):

Group #:	Policy #:

Patient's relationship to person insured: ❑ self ❑ spouse ❑ child ❑ Other: _____

COMMUNICATION

You can mail test results and other correspondence to my home: □ yes □ no
You can call me to notify me of appointments or discuss results: □ yes □ no
Please list any other persons in your home with whom we can share your medical information:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

IN CASE OF AN EMERGENCY

Name of Family or Friend:	Relationship:	Telephone #: ( )	Work phone#: ( )

Patient/Guardian Signature *Date*

CONSENT FOR DIAGNOSIS AND TREATMENT

I hereby authorize this office to administer such diagnostic procedures, test and treatments which may be deemed necessary and advisable by the attending physician (including residents) for the above named patient. I further understand that the attending physician is responsible for determining the course of treatment. I am also aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examination in the office. I also authorize this office to retain, preserve and use for scientific or teaching purposes, or dispose of, any specimens or tissues taken from my body during the course of services rendered**. I am aware of electronic medication prescribing and give the providers at Vida Pediatrics, LTD consent to access my electronic medication history.**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Vida Pediatrics, LTD and its providers to release any medical records or other information to my insurance carrier, Medicare, Medicaid, health plans, employer insurance groups, and to any utilization/certification/authorization organization acting on their behalf, to obtain reimbursement on my behalf for the treatment rendered to me by Vida Pediatrics, LTD and its providers. I understand that I may revoke this authorization in writing at any time for any reason except to the extent that action has already been taken. If not previously revoked this consent will be valid until my bills are paid and/or utilization review has been completed.

I understand that I am placing no limitation on the release of medical records, to the above referenced agencies, in terms of dates of service, history of illness or diagnostic and therapeutic information including mental health, alcohol and drug abuse treatment and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV testing.

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT

In consideration of Vida Pediatrics, LTD and medical services rendered by Vida Pediatrics, LTD and the provider(s), I hereby assign to all my rights and claims for reimbursement under any health insurance policy, Medicare, Medicaid, or group accident or health insurance for which benefits may be available for payment of the services provided.

I understand that I am responsible to conform to any requirements of my insurance company or managed health care plan for referral from my primary care physician, authorization, notification, and pre-certification and that I am responsible for the payment of any reductions in payment by my insurance because of a failure to meet the requirements.

If my medical insurance coverage is not sufficient to satisfy the office and physician charges in full, I acknowledge that I am fully responsible for payment of the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectable pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorney's fees.

PATIENT RESPONSIBILITIES

I understand that it is my responsibility to keep my appointment. I also understand that if I miss or cancel my appointment for any reason that I am responsible for contacting the doctor's office to reschedule an appointment. I understand that if I arrive more than 15 minutes late for my appointment, I may have to reschedule for another day or wait to see if I can be seen.

I understand that all lab work ordered by my provider is for the benefit and greater understanding of my current and ongoing health status. If I am unable to pay for or choose not to have lab work done within the time parameters designated by my provider it is my responsibility to request to speak with my provider to discuss alternative methods. I understand that if I choose to return on another day to have my lab work done that it is my responsibility to return to the clinic for this lab work. I understand that it is not the responsibility of the office to call, mail or otherwise attempt to contact me with a reminder of orders pending. I further understand that I may attempt to have lab work done at another facility at my own cost and that it is my responsibility to bring records of these results to my next clinic appointment so that my provider may have the most accurate information regarding my health status.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED TO ACCEPT THE ABOVE TERMS ON THE PATIENT'S BEHALF. ADDITIONALLY HE/SHE CERTIFIES THAT HE/SHE HAS RECEIVED A COPY OF VIDA PEDIATRICS NOTICE OF PRIVACY PRACTICES.

Signature of Patient/Responsible Party _____ Date _____

Relationship to Patient _____ Reason why patient did not sign _____

Witness _____ Date _____