PEARLAND PEDIATRICS
& SPORTS MEDICINE

ADULT REGISTRATION FORM

Today's Date:_____

Patient Name (First, Middle, Last)	SEX (circle) MALE	FEMALE	DATE OF BIRTH	PREFERRED DOCTOR (check box)
	◯	◯		☐ONHAIZER ☐GRAY ☐DECKER ☐HUYNH ☐HUMMEL ☐PALACIOS ☐STROOPE ☐MASSANELLI

Demographic Information

Social Security #:				**Email Address:**	
Home Address:				**Employer:**	
City:		**State:**	**Zip Code:**	**Occupation:**	
Cell #:				**Home #:**	
Work #:				**Preferred Language:**	

Medical Insurance Information

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:		
Carrier Phone #:		
Policy #:		
Group #:		
Policy Holder:		
Social Security #:		
Date of Birth:		
Policy Holder Phone #:		
Policy Holder Address: **City:**	**State:** **Zip Code:**	**State:** **Zip Code:**
Do you participate in an HSA?		

Agreement To Release Patient Information

Our approach to the care of young adults age 18 and older meets Health Insurance Portability and Accountability Act (HIPAA) and state privacy and consent requirements making the young adult the sole decision-maker about care and about the sharing of personal health information. This means that we do not discuss any aspect of your care with anyone else unless you specifically ask that we do. We understand that many people involve family and close friends in their health care decisions and would like their physician to share information with those close to them. To allow others to be involved in your healthcare decisions requires legal authority through the signed consent of the young adult which we have in clinic. For those that cannot provide consent, we would need a legally valid custodial care or power of attorney documentation, or an adjudicated guardianship arrangement.

_____

NAME (PERSON AUTHORIZED TO ACCESS RECORDS) PHONE RELATIONSHIP TO PATIENT

_____

NAME (PERSON AUTHORIZED TO ACCESS RECORDS) PHONE RELATIONSHIP TO PATIENT

_____

NAME (PERSON AUTHORIZED TO ACCESS RECORDS) PHONE RELATIONSHIP TO PATIENT

I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

- I understand that there may be medical records from another doctor or another medical facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for treatment.
- I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

These authorizations are valid unless and until they are revoked, in writing, and presented to the records office of Pearland Pediatrics Pediatrics PC.

PATIENT CONFIDENTIAL COMMUNICATION PREFERENCE

Pearland Pediatrics will provide appointment reminders and contact you to keep you informed of any new services or upcoming events.

Preferred Phone #:_____

We text appointment reminders. If you prefer to opt out please indicate your preferred method:

☐Mailing Address ☐Work Phone ☐Home Phone ☐Email

Is it ok to leave a voicemail regarding labs/medical information? ◯Yes ◯No

GENERAL CONSENT TO TREAT

All references to "patient", "me" and "my" in this document means: **_____** (**name of patient**).

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Pearland Pediatrics and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, nurse practitioners, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until **I** withdraw my consent.

_____ (Please initial)

Sharing Records for Treatment

We share medical records with other health care providers to allow and promote continuity of care among providers. If you visit another provider, they may have access to your medical record.

_____ (Please initial)

Acknowledgement of Financial Policy

I acknowledge receiving Pearland Pediatrics' Financial Policy. This Policy explains my financial responsibility and how any past due balances will be handled. ***A copy may be obtained through the front desk, if you should have questions please contact our Billing Manager at (281) 485-9990.***

_____ (Please initial)

Acknowledgement of role in Patient Centered Medical Home (PCMH)

Pearland Pediatrics has been awarded level 3 certification from the NCQA. This means you will be surrounded by a dedicated team of health professionals, working together with you, to optimize your health goals using the best evidence-based medicine and resources available for you today. By initialing below, you consent to participate fully in your healthcare, including notifying our office of any outside care received from any other provider such as specialist, emergency room visits, and addressing any obstacles that may affect the prescribed treatment plan.

_____ (Please initial)

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Pearland Pediatrics' Notice of Privacy Practices ("Notice"). The Notice explains how Pearland Pediatrics' may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. ***If you have questions about the Notice, please contact our Office Manager at (281) 485-9990.***

_____ (Please initial)

Acknowledgment of Office Information & Policies

I acknowledge receiving Pearland Pediatrics' Office Information and Policies. By acknowledging this I am excepting the policies as stated. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

_____ (Please initial)

Signature of Patient or Patient's Representative: _____ Date: _____