Patient Registration CVCC

☐ New Patient ☐Update only Cards scanned:_____
Patient registration entered by:_____

Patient Information:

Name: Last_____ First _____Middle_____ suffix____
Nickname_____
Patient's Social Security #: _____-_____-_____ Date of Birth_____ Gender_____
Address_____ Phone# _____ preferred email_____
Race: American Indian or Alaskan Native Caucasian Black Pacific Islander Decline
Ethnicity: Hispanic Non Hispanic Decline
Language: English Spanish Other_____

If minor, Parent information

Name:
Last_____ First _____MI_____ Date of Birth_____
Relationship_____
Last_____ First _____MI_____ Date of Birth_____
Relationship_____
Street address_____ Apt #_____
City_____ State_____ Zip code_____
Phone: Home (____) _____ Cell (____) _____Work (____) _____
Social Security **#: _____-____-_____**
Mailing address (☐ same as above)_____

Person to contact in case of an emergency if unable to reach the parent/legal guardian listed above.

Name: _____ Phone: (____) _____
Relationship to patient: _____ Address: _____

Primary Insurance*: Although we scan your insurance cards not all the information necessary to file a claim is on the card. Please complete the following.* ***If the information is not complete, the account will be set as self-pay until we have the information necessary to file a claim.***

Plan Name: _____ Plan Type: _____
Co-Pay _____ Effective date: _____
Subscriber Number: _____ Group Number: _____
Policy Holder Last: _____ First: _____ MI: ____ DOB: _____
Street address_____ Apt #_____
City_____ State_____ Zip code_____
Gender: _____ Relationship to patient: _____ Employer: _____
Social Security **#: _____-____-_____**

Secondary Insurance:

Plan Name: _____ Plan Type: _____
Co-Pay _____ Effective date: _____
Subscriber Number: _____ Group Number: _____
Policy Holder Last: _____ First: _____ MI: ____ DOB: _____
Street address_____ Apt #_____
City_____ State_____ Zip code_____
Gender: _____ Relationship to patient: _____ Employer: _____
Social Security **#: _____-____-_____**

Other information:

Preferred Pharmacy _____

Person filling out form_____
Relationship to patient: _____Date completed: _____
How did you hear about us? _____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Castle Valley Children's Clinic to disclose all or any part of the patient's medical record and/or clinic charges (including information regarding alcohol or drug abuse, psychiatric illness or communicable disease related information including HIV) to any person or corporation (i) which is or may be liable or under contract to Castle Valley Children's Clinic for reimbursement, subrogation and/or direct recovery and coordination of benefits for this and all future claims including but not limited to hospital/medical service companies, workers' compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. Except, as above, Castle Valley Children's Clinic will require the patient's, or in the case of a minor child, a natural parent or legal guardian's, written consent to release information about the patient. I also agree that in all instances, the original medical records (including x-rays and laboratory specimens) remain the property Castle Valley Children's Clinic.

Guarantor Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

In the event the patient, his/her authorized representative or the guarantor signing below, is entitled to benefits of any type arising out of any policy of insurance insuring the patient or any other party liable to the patient, those benefits are hereby assigned to Castle Valley Children's Clinic for application against the patient's bill. Such payment shall discharge that insurance company of any obligation under the policy to the extent that payment has been made correctly according to the terms of the policy. The undersigned shall remain responsible for any and all charges not paid by the insurance company and/or not covered by this assignment.

I assign the benefits payable for services to the organization furnishing the services or authorize such organization to submit a claim for Payment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Castle Valley Children's Clinic.

Guarantor Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I agree that in return for the services provided to the patient by Castle Valley Children's Clinic, or other health care providers, I will pay the account of the patient prior to discharge or make financial arrangements satisfactory to Castle Valley Children's Clinic or any other providers for payment. I understand and I agree (regardless of my insurance status) to assume full financial responsibility for all charges incurred, including collection fees, interest, Attorney fees and court costs.

Guarantor Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

By signing below, I state that I am the natural parent or legal guardian having legal custody of _____, a minor, and age _____, born on _____. I give permission for Castle Valley Children's Clinic Inc. to perform or administer examination, anesthetic, medical or surgical diagnosis and/or treatment under the general or special supervision and on the advice of any physician or surgeon licensed in the State of Colorado, when the need for such treatment is clear, and when efforts to contact me are unsuccessful.

This authorization shall remain effective for one (1) year from the date of signature unless sooner revoked in writing and delivered to Castle Valley Children's Clinic.

Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT

Our Notice of Privacy Practices provides information about the privacy rights of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgment. A copy of our Privacy Policy is available at the front desk.

By signing this form you knowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name of Patient Print Name of Authorized Representative

If you would like a copy of this agreement, please request one from the front office when you return your paperwork to them.