Ptarmigan Pediatrics, LLC

3543 E Meridian Park Lp, Ste A, Wasilla, AK 99654
Phone: 907-357-4KID (4543) **Fax:** 907-357-4533

Patient Registration Form

Mother ☐Bio-mother ☐Stepmother ☐Guardian ☐Other:_____

Full Name_____ **SSN** _____ **DOB** _____ _____

Mailing Address _____ Zip code _____

Physical Address _____ Zip code _____

Home/Work (circle one) Phone _____ **Cell Phone** _____

Preferred Contact Method: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Father ☐Bio-father ☐Stepfather ☐Guardian ☐Other:_____

Full Name_____ **SSN** _____ **DOB** _____ _____

Mailing Address (if different than above) _____ Zip code _____

Physical Address _____ Zip code _____

Home/Work (circle one) Phone _____ **Cell Phone** _____

Preferred Contact Method: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Preferred Pharmacy _____

Family's Preferred Language (although we cannot guarantee we can communicate with you!)**:** ☐ English | ☐ Other: _____

*** INSURANCE INFO (present card(s) to front desk) ☐ Self Pay

Primary Insurance Company:_____ Policy#:_____ Group#:_____

Policy Holder's Name: _____SSN: _____ DOB: _____

Secondary Insurance Company: _____Policy#:_____ Group#:_____

Policy Holder's Name: _____SSN: _____ DOB: _____

1. Child's Full Name _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

Primary Race: ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

Ethnicity: (Your active culture, *such as*: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

2. Child's Full Name _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

Primary Race: ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

Ethnicity: (Your active culture, *such as*: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

3. Child's Full Name _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

Primary Race: ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

Ethnicity: (Your active culture, *such as*: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

4. Child's Full Name _____ **Date of Birth** _____ **Gender:** ☐ M ☐ F

Primary Race: ☐ African American, ☐ Alaska Native, ☐ American Indian, ☐ Asian, ☐ Caucasian, ☐ Hispanic, ☐ Pacific Islander

Ethnicity: (Your active culture, *such as*: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

★ ***Signature of parent or legal guardian*:** _____ ***Date:*** _____

Printed name of Parent of Legal Guardian: _____

If you are submitting this remotely, please mail / fax this completed form **with a copy of Insurance ID card(s)** to the address at the top of this page.

Revised 7/6/2015

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HIPAA Acknowledgement, Office Policies, Assignment of Benefits

By signing below, I, _____, hereby…
(Printed name of parent or legal guardian)

1. …acknowledge **receipt of or access to Ptarmigan Pediatrics, LLC's, HIPAA / Privacy Notice** and recognize that changes to this policy may occur at any time without notice. I will always have access to the most recent Notice at the clinic website: *www.ptarmiganpediatrics.com*, or posted in the clinic office waiting room. **I may request a written copy at any time**.
2. …believe that Ptarmigan Pediatrics, LLC, is **committed to providing the highest quality medical care** for my family members aged birth through 17 years. Doctors are available by phone 24/7 to answer any pressing medical questions I may have.
3. …recognize that while Ptarmigan Pediatrics, LLC, strongly *supports* the use of **childhood vaccines,** receiving vaccines is NOT a condition of care at this clinic.
4. …commit to **canceling appointments** with as much notice as possible, and understand that failure to notify this office of my inability to keep any appointment will result in a "no-show." Repeated no-shows are serious and may involve a fine which must be paid prior to the child being seen again in this clinic, acceptance at the clinic on a walk-in basis only (as time allows), or both. Insurances do NOT cover no-show charges. Patients **over 15 minutes tardy** may be asked to reschedule.
5. …understand that Ptarmigan Pediatrics, LLC, is proud to be a **mentoring / training facility** for certified medical assistants and nursing students, who may provide care to my child under the supervision of the licensed medical staff.
6. …agree that **my child cannot be seen in this clinic without a parent or legal guardian** (or my representative designated in writing) being present. "Guardianship agreement" forms are available in our office or via download on our website.
7. …authorize Ptarmigan Pediatrics, LLC, to **submit claims to my child's insurance company(s)** on my child's behalf, and my child's insurance company(s) to pay benefits directly to Ptarmigan Pediatrics, LLC.
8. …understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay over these funds to Ptarmigan Pediatrics, LLC.
9. …understand that **an "out-of-network" insurance carrier may limit payments** for any or all services provided by Ptarmigan Pediatrics, LLC, regardless of the advertised benefits package. (i.e., they may pay less than our standard charges, even if they advertise "100% benefit").
10. …agree that upon acceptance of services provided by Ptarmigan Pediatrics, LLC, **I assume responsibility for any deductible, co-pay and coinsurance, *as well as any other balance not covered by my child's insurance carrier*. Copays and estimated coinsurances are due at the time of service.** If my account is turned over to **Cornerstone Credit Services** for collections**, I agree to pay any resulting collection and legal fees**.
11. Furthermore, I understand that if I personally pay all billed charges in full at the time of service, I am eligible for a **20% "prompt-pay/self-pay discount."** (Already discounted school/sports physicals not included).
12. **VACCINE ADMINISTRATION RECORD**: Patient immunization records may be released to the state vaccine registry (VacTrAK), any school, any day care program, any physician office, any medical clinic, any hospital, and to the State of AK DHHS offices.

Name(s) of Children / Patients: _____

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____**Date:** _____

A photocopy of this assignment is considered to be as valid as the original.