PEDIATRIC PATIENT REGISTRATION-ENGLISH

Please Print Today's Date:				
Patient Information				
First and last name		Preferred language		
Address		City, State Zip Code		Social Security Number
Telephone (Home)	Telephone (Cell)	Telephone (Work)	Email address:	
Date of Birth	Age	Sex ☐ Male ☐ Female ☐ Other : ____		
Contact preference: ☐ Telephone (Home) ☐ Telephone (Cell) ☐ Telephone (Work) ☐ E-mail address *Your selection gives us permission to contact*				
Name of school or employer				
Emergency Contact Name		Relation		Telephone (cell)
How did you find out about our office?				

Siblings			
Name	**Date of Birth**	**Sex(M/F/Other)**	**Relevant Health Issue**
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		
	_____/_____/_____		

Financial Responsibility			
Person responsible for the account		Relation to patient	
Address (if different)		City, State Zip Code	Driver's License Number
Telephone (Home)	Telephone(Cell)	Telephone(Work)	Place of employment
Date of Birth	Social Security Number	Sex ☐ Male ☐ Female ☐ Other : _____	

Legal Guardians (Parent's) Information		
Name	Relation to Patient	
Address (if different)	City, State Zip Code	Driver's License Number
Telephone (Home)	Telephone (Cell)	Telephone (Work)
Place of employment	Social Security Number	☐ Male ☐ Female ☐ Other

Primary Insurance: HMO or PPO or Medicare or Medicaid **(circle one)**		
Insurance name	Phone number of Insurance	
Address of Insurance	City, State Zip Code	Driver's License Number
Name of Insured	Identification Number	Group number
Relation to Patient	Date of Birth	Social Security Number

Secondary Insurance: HMO or PPO or Medicare or Medicaid **(circle one)**		
Insurance name	Phone number of Insurance	
Address of Insurance	City, State Zip Code	Driver's License Number
Name of Insured	Identification Number	Group Number
Relation to Patient	Date of Birth	Social Security Number

Consent to Treatment

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign and date this form.

☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other Relationship: _____

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

_____

Name Date Relationship

I, _____, give permission for _____ to seek medical treatment for my child in my absence.

Witness: _____ Date: _____

NON-SUFFICIENT FUNDS (NSF)

Ancor Health Center will charge a minimum of $30.00 for any payment that has been returned as a non-sufficient funds (NSF). Ancor Health Center will notify the responsible party of the non-sufficient fund check by mail. The responsible party has seven business days to pay the non-sufficient fee of $30.00 to Ancor Health Center. If the non-sufficient fee has not been paid it will be applied to the responsible parties' balance. If a non-sufficient fund has occurred, Ancor Health Center will no longer accept checks from the responsible party.

Print Responsible Party Name _____ Date _____

Signature of Responsible Party Name _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, _____ acknowledge that I have read and understand
Guardian Name

The Notivce of Privacy Practices as given to me this ____ day of _____ , 20 _____.

Signature: _____

Printed Name: _____

Witness : _____

Patient Name: _____

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO FRIENDS AND FAMILY

If you desire to have certain family members or other specific people receive your personal protected health information on your behalf, you should provide their information below. We value your privacy and ask that you help us identify the individuals with whom you would like us to discuss your treatment.

Please identify anyone you wish Ancor Health Center to discuss your relevant health information with:

☐ I GIVE PERMISSION for Ancor Health Center to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below:

Name: _____ Name: _____

Relation: _____ Relation: _____

Name: _____ Name: _____

Relation: _____ Relation: _____

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

* Patient is a minor (_____years of age)* OR is unable to give permission because:

Signature of individual signing on behalf of patient: _____ Date: _____

Legal authority to act on the patient's behalf: _____

PROTECTED MEDICAL INFORMATION

The above information is release for the following purpose and that purpose only, and other use is forbidden: Establish Care with Ancor Health Care Center. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parent's Signature: _____

Relationship to Patient _____

Address: _____

Telephone: _____

Date: _____ Witness: _____

HIPAA AUTHORIZATION FOR CONSENT/USE OF PHOTOGRAPHS

Ancor Health Center, PA (Ancor) is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received with us. Sharing your story can help others who are interested in knowing more about the patient services provided by Ancor and can help Ancor promote its mission to provide excellent healthcare.

Ancor respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Ancor seeks your permission to allow us to take and use photographic material of you in Ancor's internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as newspapers and magazines).

To ensure that Ancor is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Ancor will keep a copy of your written permission on file. .

- ❒I do give my permission for Ancor to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of Ancor, and consent to take and make use of my and/or my child's photographic images in publications produced by or on behalf of Ancor. This permission extends both to electronic versions on the Ancor websites and other internet/electronic applications as well as to printed.
- ❒I do give my permission for Ancor to release my or my child's name and details of his/her medical care to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to take images (digital or otherwise) of me or my child for purposes of illustrating my treatment and experience as a patient of Ancor.

  You can request a copy of this authorization verbally with the Medical Records Department, and/or request to have it mailed to you. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and photographic material.

  I am aware that my protected health information will exist forever in either printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

  I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Ancor Health Center at 818 N. Fourth Street Longview, TX 75601. I understand that Ancor, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Ancor's control that have not been previously published.

Patient Name: _____

Signature: _____

Address: _____

Phone: _____

Date: _____

DESIGNATION OF PERSONAL REPRESENTATIVE

I. WHY THIS FORM?

As required by the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, you have a right to designate a person to act on your behalf with respect to your protected health information (PHI). By completing this form, you are informing us of your wish to designate the named person as your personal representative.

Patient Name: _____ Address: _____

Date of Birth: _____ Telephone Number: _____ _

II. Designation of Personal Representative.

At my request, I hereby name the following individual as my personal representative.

Designee Name: _____

Designee Phone Number: _____

Relationship to Patient/Member: _____

III. I authorize the named Designee to have access to my Protected Health Information in order to do the following related to my healthcare (check each box that applies):

- ☐ Make, change, or confirm appointments
- ☐ Speak with a physician regarding the coordination of my care
- ☐ Speak with the Financial Department regarding billing.
- ☐ Other: _____

IV. Expiration of Designation (optional). Check the box and list the date for expiration.

☐ Date: _____

V. Designation Signatures

_____

Patient Signature Printed Name Date

_____

Witness Signature (optional) Printed Name Date

VI. Revocation Section.

I understand that I may revoke this designation at any time by signing the revocation section of this form and returning it to Ancor Health Center facility where I received services. I further understand that any such revocation does not apply if the person authorized to use or disclose my protected health information have already acted on my behalf.

_____

Patient Signature Printed Name Date

_____

Witness Signature (optional) Printed Name Date

For personal representatives, please provide the following:

I _____ represent that I am the

(insert your name)

health care agent/guardian/surrogate/parent of the patient above.

(circle one of the above)

Personal Representative Signature: _____

Address: _____

Phone: _____

If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.