Patient Registration Form

Primary care provider:

☐ Celida Rangel, MD

☐ Lisa Hunt, MD

How did you hear about our practice? _____

_____

Patient Information

Child's name	*Sex (circle one)*	*Date of birth*	*Ethnicity (optional)*	*Race (optional)*
	male • female		hispanic • not hispanic	
	male • female		hispanic • not hispanic	
	male • female		hispanic • not hispanic	
	male • female		hispanic • not hispanic	
Address			choices for race: 1—American Indian 2—Asian 3—Black/African American 4—More than one race 5—Native Hawaiian 6—Other Pacific Islander 7—White	
City /state /zip				
Home phone number				

Parent Information

Name		*Name*	
Relationship to patient	mother • father • step-parent • guardian	Relationship to patient	mother • father • step-parent • guardian
Date of birth		Date of birth	
Social security number		Social security number	
Cell phone number		Cell phone number	
Employer		Employer	
Occupation		Occupation	
Work phone number		Work phone number	

Insurance Information

Primary		*Secondary*	
Insurance company		Insurance company	
Policyholder name		Policyholder name	
ID number		ID number	
Group number		Group number	
Employer name		Employer name	

Emergency Contacts

Name	Phone	Relationship to patient
Name	Phone	Relationship to patient

Communication

We must call on occasions to discuss confidential protected health information. Our policy is to contact the parent or guardian at the preferred telephone number you have given us, which we update at each visit. If there is no answer at that number or if a person other than a parent or guardian answers, please indicate below your instructions regarding leaving a message.

☐ OK to leave a message with protected health information

☐ Not OK to leave a message with protected health information

Preferred phone number

Consent For Medical Care

I state that I am the natural parent or legal guardian of the patient(s) listed above. If I am not available to give my consent in person, the following persons have my permission to authorize any and all medical treatment (persons listed on first page under Parent Information are automatically included). I understand that I must notify Celida Rangel, MD/ Lisa Hunt, MD in writing with changes of authorized caregivers. This consent is valid until revoked in writing.

Signature		Relationship to patient
Print Name		Date
Witness		Date
Name	Phone	Relationship to patient
Name	Phone	Relationship to patient

Privacy Practices

Dr. Celida Rangel and Dr. Lisa Hunt have provided a Notice of Privacy Practices for my review. I understand I may have a copy of the Notice upon my request.

Signature	Print Name	Date

Office use only:

Attempt was made to obtain written acknowledgement above. Unable to obtain because:

☐ Individual refused to sign ☐ Communication barrier existed Employee signature

☐ Emergency situation arose ☐ Other: Date

Financial Policy

I have read and understand Dr. Celida Rangel's and Dr. Lisa Hunt's Financial and Office Policy, and agree to abide by its terms. This signature authorizes our office to treat my child and file appropriate insurance claims.

I agree to be financially responsible for any charges not covered by insurance.

Signature	Print Name	Date

Office use only: Version _____ Copy given to parent/guardian by: _____

Photo Release Form

Celida Rangel, MD and Lisa Hunt, MD

We like to keep a patient photo as part of his/her medical record.
All medical records are protected and maintained per our privacy policy and upheld to HIPPA Standards.
By signing below, you allow a patient photo to be taken and **updated periodically** as part of the medical record.

Child's name	*Sex (circle one)*	*Date of birth*
	male • female	
	male • female	
	male • female	
	male • female	

☐ Decline photo

Parent/guardian signature	Date

Vaccines for Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual of record, or by the healthcare provider. ***This same record may be used for all subsequent visits as long as the child's VFC eligibility has not changed.*** Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of three years.

Child's name	*Sex (circle one)*	*Date of birth*
	male • female	
	male • female	
	male • female	
	male • female	

Parent/guardian/individual of record: **Provider:**

This child qualifies for vaccination through the VFC program because he or she (check only one box):

0. ☐ is enrolled in KidsCare
1. ☐ is enrolled in AHCCCS
2. ☐ does not have health insurance
3. ☐ is American Indian or Alaskan Native *(no matter what the insurance situation is)*
4. ☐ has health insurance that does not pay for vaccines
5. ☐ This child does not qualify for VFC

Date of eligibility changes and updates				
KidsCare	*AHCCCS*	*Un-insured*	*Native American/ Alaska Native*	*Under-insured*

☐ Check here if this child has health insurance that pays for vaccines

Please be advised:
If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines For Children Program retroactive and you are only eligible for the Vaccines For Children Program at the time of the visit. If you are unsure if the immunizations and well check-ups are covered, please contact your insurance company.
Thank you,
Please sign below indicating that you understand and agree with the above statement:

Signature	Date

Financial and Office Policy

West Phoenix Pediatrics

Lisa Hunt, MD

Phone 623-889-6186
Fax 623-889-6188

Dear Parent/Guardian,

Welcome! Please take a moment to review the following policies and procedures. We look forward to establishing a long and wonderful medical relationship.

Our office sees patients by appointment only. When making an appointment, please notify our scheduler of any changes in insurance, address, telephone number, or emergency contact. This eliminates unnecessary delays on the day of your appointment.

Walk-in and sibling add-on appointments will not be seen until the next available appointment slot. We want to take care of your child's illness, but it is unfair to patients who have scheduled an appointment to ask them to wait while someone without a pre-scheduled appointment is seen. If you feel your child cannot wait to be seen, ask to speak to our staff.

If you are unable to arrive for your appointment on time, please call to inform the staff. We will review the schedule and determine if you can be seen when you arrive or if your appointment must be rescheduled. There is no guarantee you will be seen if you arrive past your appointment time.

If you are unable to keep your appointment, we require you to call and cancel as soon as possible, preferably 24 hours in advance. This allows another patient to schedule an appointment with our physicians. If you do not cancel your child's appointment at least **two hours** before their appointment time, this will result in a "no-show" on the record and a **$25 charge** will be applied. **Repeated "no-show" appointments may result in the family's discharge from the practice.**

We require that a legal guardian accompany a minor unless prior written authorization is given. The adult accompanying the minor is required to pay in accordance with our policies. We do not accept third party assignment nor do we recognize or enforce the terms of divorce decrees.

Payment is expected at each visit, whether it is a deductible, co-payment, percentage or payment in full. If you are waiting for coverage to become effective or have no insurance, payment will be expected at the time of the visit. For your convenience, we accept cash, checks, Visa, and MasterCard. There is a $30.00 charge for all returned checks. If your check is returned for insufficient funds, your payment options will be cash, credit card or certified funds (cashier's check, money order, certified check) only.

Our office verifies insurance eligibility for every visit, but **it is the parent/guardian's responsibility to be familiar with the insurance plan's financial coverage.** Refer to the plan's benefits booklet or website for questions about coverage. Be aware that an authorization from the insurance company for treatment is **not** a guarantee of payment. For any billing questions, please call 602-427-4992. We realize there may be financial hardship, if so please communicate this to our billing staff. Any accounts with outstanding balances greater than 90 days from the date of service may be sent to a collection agency and result in the family's discharge from the practice.

Financial Policy

I have read and understand Dr. Celida Rangel's and Dr. Lisa Hunt's Financial and Office Policy, and agree to abide by its terms. This signature authorizes our office to treat my child and file appropriate insurance claims.

I agree to be financially responsible for any charges not covered by insurance.

Signature	Print Name	Date

If the above person is not financially responsible, please list:

Name of Guarantor	Relationship of Person signing form to Guarantor	Date

Staff member _____ (initals) verbally verified above Guarantor at _____ (phone number) on _____ (date)

Person listed is financially responsible Guarantor for all patients on this registration form. Unpaid balances will be sent to a collection agency. If the above Guarantor declines financial responsibility then I agree to be financially responsible.

Signature	Print Name	Date

Office use only: Version _____ Copy given to parent/guardian by: _____