



**Complete Care for Kids, LLC**  
**PATIENT REGISTRATION**

TODAY'S DATE: \_\_\_\_\_

**PATIENT INFORMATION**

NAME	DATE OF BIRTH	AGE	SEX: M/F

RACE:             American Indian  Asian  African American  Pacific Islander  White  
                   Other  Prefer not to answer

ETHNICITY:     Hispanic/Latino  Not Hispanic/Latino  Prefer not to answer

HOME ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

MOTHER'S SSN: \_\_\_\_\_ FATHER'S SSN: \_\_\_\_\_

HOME PHONE \_\_\_\_\_

MOTHER'S MOBILE \_\_\_\_\_ FATHER'S MOBILE \_\_\_\_\_

PRIMARY EMAIL ADDRESS: \_\_\_\_\_

BILLING ADDRESS (if different than above): \_\_\_\_\_

**How did you hear about us?**     OB/GYN (name): \_\_\_\_\_

Insurance: \_\_\_\_\_                       Internet: \_\_\_\_\_

Advertisement: \_\_\_\_\_                       Other: \_\_\_\_\_

**EMERGENCY CONTACT (Other than parents/legal guardian)**

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHARMACY NAME \_\_\_\_\_ LOCATION \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE COMPANY \_\_\_\_\_

ID/POLICY NUMBER \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER'S SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE COMPANY \_\_\_\_\_

ID/POLICY NUMBER \_\_\_\_\_ GROUP# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SUBSCRIBER'S SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**LIKE US ON FACEBOOK! [WWW.FACEBOOK.COM/CC4KIDS](http://WWW.FACEBOOK.COM/CC4KIDS)**

**Payment Authorization Policy/Hippa Acknowledgement**

I, \_\_\_\_\_, hereby authorize Complete Care For Kids, LLC to obtain benefits on my behalf for covered services rendered. I request from \_\_\_\_\_ insurance company that payments be made directly to the above named provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for any balance on my child/children’s account and that co-payment must be made at the time services are rendered, if applicable. By federal law and Managed Care Contract Law, this office is required to collect copays at the time of service. Payments are accepted in the forms of check or credit/debit card. There is a \$25 returned check fee. If collection becomes necessary, I agree to pay the costs and interest charged including court and attorney’s fees. I certify that all of the information (insurance and demographics) provided is true and correct. I understand that it is my responsibility to notify the office of any changes in my child/children’s insurance status. Furthermore, I understand that failure to provide true and correct information could result in my child/children’s appointment being rescheduled. I further authorize the release of any information, including medical, for this or any related claim to the above named billing agent, and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or Complete Care For Kids, LLC at any time in writing.

\_\_\_\_\_  
Guardian Signature/Date

**USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT**

PATIENT NAME(S): 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

This disclosure contains information regarding the privacy of your child's personal healthcare information. Please read it carefully before signing. COMPLETE CARE FOR KIDS will not be able to continue treatment if you do not sign this disclosure.

By signing this disclosure, I acknowledge and agree that COMPLETE CARE FOR KIDS may use or disclose my child's medical information for the purpose of treatment or obtaining payment for services rendered. I am aware that COMPLETE CARE FOR KIDS may disclose my medical information to a Business Associate for the same reasons, and that the Business Associate will be bound by all appropriate legal restrictions. Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights and the permitted uses and disclosures under HIPAA. Also, the Federal Government now restricts COMPLETE CARE FOR KIDS from discussing the health information and condition of your child with other family members or persons, unless you specifically give your written permission.

**By my signature below, I grant COMPLETE CARE FOR KIDS permission to discuss my child's protected medical information with the following individuals:**

\_\_\_\_\_  
\_\_\_\_\_

I HAVE READ AND UNDERSTAND THE PATIENTS RIGHTS AND PRIVACY PRACTICES FORMS. YES NO  
I CONSENT TO LEAVING NORMAL LAB RESULTS ON MY VOICE MAIL. YES NO

\_\_\_\_\_  
Parent/Guardian Name Signature Date

**Photo ID & Insurance Card**

I acknowledge that at the time of each visit, I am responsible for providing my photo ID and insurance card.

**(If a PCP is required by your insurance company you must contact your insurance company and select one of the physicians with Complete Care for Kids prior to date of service.)**

**Late & Missed Appointment Policy**

If you must cancel an appointment, please give us at least 24 hours notice or you will be subject to a \$50 missed appointment fee for well visits and consultations (including ADD/ADHD, behavioral, Lactation, and other extended appointments.) **More than 3 missed appointments may result in being discharged from the practice.**

**Appointment Reminders**

Please list the best phone number to receive appointment reminders. (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

**Treatment Authorization**

Authorization is hereby granted for my child/children:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

To have examination, immunizations or routine screening procedures as recommended by Complete Care for Kids. This authorization shall be continuous until revoked by you, parents or guardians. I also authorize Complete Care for Kids to initiate any medical treatment required in an emergency situation.

**Health Assessment & School Forms**

I understand that when requesting completion of school/daycare forms from Complete Care for Kids, it is my responsibility to provide an annual \$25.00 form fee, when forms are presented and/or prior to completion. The forms will not be completed until payment is made. **Please provide an addressed, stamped envelope if requesting forms to be mailed home.**

**Vaccination Policy**

All patients in the practice are henceforth required to adhere to the vaccination schedule determined by the American Academy of Pediatrics and Centers for Disease Control or comply with the “catch up” schedule as determined by the Centers for Disease Control. If you feel you can not comply with this policy, we will ask you to find another health care provider who shares your views.

By signing below, I understand and agree with the above mentioned policies.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
/Date