PATIENT REGISTRATION FORM

Patient: Last Name ____ First Name ____ M.I. ____ DOB ____

Gender ☐ M ☐ F Race ____ Ethnicity ____

Appointment Reminders:

Email Address ____

Phone Number ____

☐ Sign-up for EMAIL reminders
☐ Sign-up for TEXT reminders
☐ Sign-up for VOICE CALL reminders

Emergency Contact (other than parents):

Last Name ____ First Name ____

Phone ____ Relationship to the Patient ____

Responsible Party (financially responsible): ☐ Mother ☐ Father ☐ Other ____

Patient(s) lives with: ☐ Mother ☐ Father ☐ Both ☐ Other ____

Parent/Legal Guardian Information: ☐ Mother ☐ Father ☐ Foster ☐ Other ____

Last Name ____ First Name ____ M.I. ____ DOB ____

Social Security Number ____ Primary Phone ____ Secondary Phone ____

Street Address ____ City ____ State ____ Zip Code ____

Employer ____ Employer's Phone Number ____

Other Parent/Legal Guardian Information: ☐ Mother ☐ Father ☐ Foster ☐ Other ____

Last Name ____ First Name ____ M.I. ____ DOB ____

Social Security Number ____ Primary Phone ____ Secondary Phone ____

Street Address ____ City ____ State ____ Zip Code ____

Employer ____ Employer's Phone Number ____

Insurance Information:

Insurance Company Name ____ Policy Holder Name ____

Subscriber/Policy Number ____ Policy Group Number ____

Policy Holder Information (only if the policy holder is not parent/legal guardian):

Last Name ____ First Name ____ M.I. ____ DOB ____

Social Security Number ____ Home Phone ____ Cell Phone ____

Street Address ____ City ____ State ____ Zip Code ____

Employee ____ Employer Phone Number ____

Authorization of Treatment and Assignment of Benefits:

I authorize **Healthy Steps Pediatrics** to treat my child. I further authorize payment directly to Pediatricians of **Healthy Steps Pediatrics** for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all of my insurance submissions. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________ Date: __________

Receipt of Notice of Privacy Practices:

Written Acknowledgement Form

I, ______________________, have been made aware that a copy of the HIPAA is located in the waiting areas of **Healthy Steps Pediatrics** and am aware that I can request a printed copy.

Signature: ______________________ Date: __________

Relationship to Patient(s): ______________________

Patient(s) Name: ______________________

Release of Information TO Healthy Steps Pediatrics

This release authorizes someone else such as your previous provider, another doctor's office or hospital to send us your child's records.

Patient's Name: ______ **DOB:** ______

Patients Current Address: ______

Patient's Previous Address: ______

Patient's Current Phone Number: ______

Release Records From:
Previous Provider: ______
Address: ______
______
Phone Number: ______
Fax Number: ______

Release Records To:
Healthy Steps Pediatrics
3911 Mary Eliza Trace
Suite 200
Marietta GA 30064
Phone: 678-384-3480
Fax: 678-384-3481

Description of Information to be Disclosed:

☐ Immunization Records, Growth Charts, Problem List
☐ Complete/All Records
☐ Other (specify): ______

Reason: To transfer or facilitate the medical care of the individual(s) listed above

Please Read and Sign

I understand the following:
1. I authorize the release of Personal Health Information (PHI) to **Healthy Steps Pediatrics**
2. I may revoke the authorization at any time by providing written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already take action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payments based on my signing of this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and longer protected by federal law.
7. I acknowledge that I had an opportunity to review this authorization and understand the intent and use.
8. I understand that I am entitled to a copy of this authorization at the time of its execution. If so, I will make my request known.

Parent/Legal Guardian Signature ______ Relation to Patient ______ Date: ______