New Heights Pediatrics, LLC

New Patient Registration Form

Copay $ _____

Child's General Information (please print)

Name: _____ DOB _____ Sex: ☐M ☐F

Primary address _____

City _____ State _____ Zip _____

Primary Caregiver's Name _____ Relationship _____

Phone _____ Alternate phone _____

Primary Caregiver's Name _____ Relationship _____

Phone _____ Alternate phone _____

E-mail _____ Authorize E-mail? ☐Y ☐N

Pharmacy name _____ Phone _____ Fax _____

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _____ NO _____ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of New Heights permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Primary Insurance

Insurance name _____ Subscriber's name _____

Insurance ID#: _____

Social Sec # _____ DOB _____ Relationship to insured _____

Secondary Insurance

Insurance name _____ Subscriber's name _____

Insurance ID#: _____

Social Sec # _____ DOB _____ Relationship to insured _____

Please initial each statement indicating that you understand and agree to the following:

_____ *Patient Authorization for ePRESCRIBE*

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of New Heights Pediatrics to enroll me in the ePrescribe Program.

_____ *Patient Authorization for PHARMACY BENEFITS MANAGER*

I authorize the physician and/or staff of New Heights Pediatrics to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

_____ *Patient Authorization for MEDICARE PATIENTS*

I authorize the physician and/or staff of New Heights Pediatrics to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

_____ *Patient Authorization for PPO and HMO PATIENTS*

I authorize the physician and/or staff of New Heights Pediatrics to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to New Heights Pediatrics, LLC the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

_____ *Patient Authorization for ALL PATIENTS*

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and New Heights Pediatrics to photograph me for medically related documentation purposes.

_____ Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify New Heights Pediatrics of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by New Heights Pediatrics is the patient's responsibilities.

NOTICE TO PATIENTS: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgment, if you wish .

☐ I acknowledge that I have been offered a copy of the New Heights Pediatrics' Notice of Privacy Practices.

☐ I **would** like a copy ☐ I would **not** like a copy

_____	_____	_____
NAME	**SIGNATURE**	**DATE SIGNED**