Kids First Pediatric Clinic, LLC
1673 10th St., West Linn, OR 97068
Phone: (503) 699-3313, Fax: (971) 229 – 4678
website: www.kidsfirstclinic.com
email: westlinn@kids1stclinic.com

Today's date: _____

Registration Form

1. Patient Name _____ Date of Birth _____ Gender _____
2. Patient Name _____ Date of Birth _____ Gender _____
3. Patient Name _____ Date of Birth _____ Gender _____
4. Patient Name _____ Date of Birth _____ Gender _____

Address _____
Street City State Zip

Primary Home Phone _____ **Primary E-mail** _____

GIVE BOTH PARENTS INFORMATION

Parent Name _____ Other Parent Name _____

Check if biologic parent ☐ Check if biologic parent ☐

Address (if different) _____ Address (if different) _____

Date of Birth _____ Date of Birth _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Cell Phone _____ Cell Phone _____

Email Address _____ Email Address _____

Please type X in one of the following boxes:

Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino ☐ Not Specified

Preferred Language: _____

Race(s): American Indian or Alaska Native/ Asian, Black or African American/ Native Hawaiian or Pacific Islander/ White/ not specified

How did you hear about our office? _____

X _____ Initials

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Registration Form Continued…..

Insurance Information

Subscriber Name _____ Date of Birth _____ Gender _____

Address: _____

Primary Insurance _____ Effective Date _____

Ins. Identification _____ Group Number _____

Guarantor Name (if different from Subscriber _____ Date of Birth _____

Address _____

Secondary Insurance _____ Effective Date _____

Insurance Identification _____ Group Number _____

Guarantor Name (if different from Subscriber) _____

Address_____ Date of Birth_____

Do you have Active/ Pending OHP Insurance ☐ Y ☐ N

Child # 1 ☐ **Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

Child # 2 ☐ **Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

_____

Child # 3 ☐ **Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

Child # 4 ☐ **Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

I verify that this information is correct and up to date. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.

Responsible Party (print name) _____ Relationship to Child_____

Signature Date

_____ _____

X _____ Initials

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Office Policies

Welcome to Kids First Pediatric Clinic! We're thrilled you've chosen us as your child's medical home. Our goal is to provide a friendly and welcoming environment for parents and children, ensuring quality care in a warm and supportive atmosphere.
We look forward to supporting your child's health for years to come. The following information outlines our office policies to help make each visit as smooth and pleasant as possible.

Appointments Policies

Sick and Well Waiting
For your convenience, we provide separate sick and well-waiting areas. If you visit the office with more than one child and one of them is unwell, please proceed to the sick waiting room. Newborns and children here for routine exams, rechecks, or follow-ups from a previous illness (and feeling better) should use the well-check waiting room. This helps maintain a safe and comfortable environment for all our patients.

Sick Appointments:
Sick appointments are available on the same day, ensuring timely care for urgent needs.

Well Child Appointments:
We adhere to the American Academy of Pediatrics' recommended well-child and teen check-up schedule. Please schedule your child's appointment 6 to 8 weeks in advance to ensure timely visits and vaccinations.

Appointment Cancellations:
If you need to cancel a scheduled well or other visit, please notify our office at least 24 hours in advance. This allows us to accommodate families on our waiting list for earlier appointments.

No-Shows Policy:
A $25.00 fee may be applied to your account for each missed appointment without prior notice. Per our office policy, three or more no-shows may result in dismissal from the practice. This policy is in place to ensure consistent care for your child and timely service for other families.

Late for Scheduled Appointments
A no-show fee will be charged to your account if you arrive late to your appointment. If you anticipate being late, **you don't need to call** our office. For urgent visits, we will do our best to accommodate your child on the same day, though this may result in a longer wait time. For non-urgent appointments, we may need to reschedule for a later date.

After Hours Calls

Providers are available to her patients 7 days a week for emergencies. For routine questions, please call during office hours.

Release of Medical Records

Our office will process requests for your child's medical records within 15 business days. There is a $25.00 fee for copying the first 30 pages, with an additional charge of $0.25 per page thereafter. Medical records can be transferred to another physician at no cost.

Shot Records & School Forms

Immunization records will be processed within 2–3 business days after your request. Please allow 3–5 business days to complete school, camp, and sports physical forms.

Medication Refills

Please allow our office 72 hours to process prescription refills. Refills will only be handled during regular business hours. For new prescriptions, the patient must be seen in person before any new medication is prescribed.

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Kids First Pediatric Clinic
Listening, Caring Growing

Financial Obligation

All payments are due at the time of service.

Our office is contracted with various insurance providers, and all patients are expected to provide up-to-date insurance information and have an understanding of their coverage benefits. To support our patients, our providers participate in a range of managed care plans, and we advocate for our patients by assisting with tasks such as pre-certifications, eligibility verification, and similar paperwork.

While we offer this assistance, it is ultimately the patient's responsibility to understand their benefits and ensure we have their current information to facilitate timely processing.

Our mission is to prioritize the health and well-being of our patients. Please note that your health insurance is a contract solely between you and your insurance provider, and you are financially responsible for any services not covered by your plan. By signing our Consent Acknowledgement Form, you confirm that you have read, understood, and agreed to our Financial Obligation Policy.

Patient Financial Responsibilities

1. **Payment Policy**:
   - All payments are due at the time of service.
   - Patients (or their guardians) are responsible for co-pays, deductibles, and any costs not covered by insurance. Payment methods include cash and major credit cards.
2. **Primary Care Physician Requirement:**
   - If the insurance mandates a primary care physician selection, the guarantor must do this before the patient's appointment.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that my health information may be used for the following purposes:

- To conduct, plan, and manage my treatment and follow-up across the multiple healthcare providers involved in my care, both directly and indirectly.
- To obtain payment from third-party payers and support standard healthcare operations, including quality assessments and physician certifications.

As part of my healthcare, Kids First Pediatric Clinic maintains records that include my health history, symptoms, examination and test results, diagnoses, treatments, and future care or treatment plans.

I have received, read, and understand the Notice of Privacy Practices, which describes how my health information may be used and disclosed. I understand that this organization reserves the right to update its Notice of Privacy Practices, and I may contact them at any time to request the most current version.

By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.

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Consent Acknowledgement

1. Patient Name _____ Date of Birth _____ Gender _____

2. Patient Name _____ Date of Birth _____ Gender _____

3. Patient Name _____ Date of Birth _____ Gender _____

4. Patient Name _____ Date of Birth _____ Gender _____

1. **HIPAA (Health Insurance Portability and Accountability Act)** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to Kids First Pediatric Clinic requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.

   Parent/ Guardian Initials _____

2. Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions, Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.
   Parent/ Guardian Initials _____

3. **Appointment Policy/ Office Policies:** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Office/Appointment policies handout and understand my responsibilities. I have read and understand them.
   Parent/ Guardian Initials _____

The office policies and protocols will be updated periodically as the practice grows, and changes will be made accordingly.

I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of Kids First Pediatric Clinic policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, and I was given the opportunity to ask any questions.

Today's Date: _____

Print Parent/Guarantor name: _____ Signature: _____

X _____ Initials