CPAM Patient Registration Form

Information About Your Child

Patient's Full Name: _____ DOB: _____ Sex: ❑ *M* ❑ *F*

Name prefers to be called: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Race: (check box) ❑ *Native Am/AK Native* ❑ *Asian* ❑ *Black/African American* Native ❑ *HI/Pacific Islander* ❑ *White* ❑ *Prefer not to Answer*

Preferred Language: _____

Ethnicity: (check box) ❑ Hispanic *or Latino* ❑ *Non-Hispanic or Latino* ❑ *Prefer not to Answer*

Provider you would prefer to see: ❑ *Dr. Joe Kappes* ❑ *Dr. Daniel Allen* ❑ *NP Julie Kappes* ❑ *No Preference*

Mother's Maiden Name (First and Last): _____

Siblings We Have Seen in This Office

Full Name: _____ Nickname: _____ Date of Birth: _____

Full Name: _____ Nickname: _____ Date of Birth: _____

Full Name: _____ Nickname: _____ Date of Birth: _____

Full Name: _____ Nickname: _____ Date of Birth: _____

Reminders: I authorize reminders and other notices to be sent by text to my cell number:

Contact Name: _____ *Cell:* _____

Patient Portal

Would you like to sign up for our patient portal so you can securely view and print your child's medical record? We will text or email you the link so you can sign up. ❑ *Yes* ❑ *No*

Contact Name: _____ *Cell Number or Email:* _____

Mom's Info

Full Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Dad's Info

Full Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Patient Lives With: ❑ *Both Parents* ❑ *Mom* ❑ *Dad* ❑ *Other* _____

If you are not the parent, are you the authorized caregiver? ❑ *Yes* ❑ *No*

Authorized Caregiver (who patient lives with, if not Mom or Dad)

Full Name: _____ DOB: _____

Relationship to Child: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

If separate addresses, is bill sent to: (check one**)** ❑ *Mom* ❑ *Dad* ❑ *Authorized Caregiver*

Other Contacts:

List people other than Mom, Dad, Authorized Caregiver who we are allowed to contact for appointments, picking up information, etc. (*for ex: grandparent, nanny etc.*)

Full Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Do you want him/her to have access to your child's private medical information? ❑ *Yes* ❑ *No*

Full Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Do you want him/her to have access to your child's private medical information? ❑ *Yes* ❑ *No*

Full Name: _____ Relationship to Child: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Do you want him/her to have access to your child's private medical information? ❑ *Yes* ❑ *No*

Emergency Contact: _____ Cell Phone: _____

Relationship: ❑ *Mom* ❑ *Dad* ❑ *Grandparent* ❑ *Uncle* ❑ *Aunt* ❑ *Authorized Caregiver* ❑ *Stepmom* ❑ *Stepdad* ❑ *Other* _____

Insurance Information

Primary Insurance

Insurance Company: _____ Effective Date: _____

Policy Holder Name: _____ DOB: _____

Policy #: _____ Group #: _____

Copay: _____

Does your insurance pay for vaccines? ❑ *Yes* ❑ *No* ❑ *Not Sure* Initials _____

Secondary Insurance

Insurance Company: _____ Effective Date: _____

Policy Holder Name: _____ DOB: _____

Policy #: _____ Group #: _____

Copay: _____

Release of Information
I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes any provider of CPAM for submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claims.

Health Information Exchanges (HIE)
I understand that CPAM may participate in one or more health information exchanges (HIEs) and consent to CPAM electronically sharing the patient's health information including but not limited to, information related to infectious or contagious disease (including HIV and/or AIDS), drug or alcohol abuse or treatment, genetic test, and/or psychiatric or psychological conditions, for treatment, payment and/or healthcare operations purposes with other participants in the HIEs. I agree that if I do not want the patient's information shared with any HIE in which CPAM participates, I must opt-out by filling out a form obtained from CPAM patient representatives.

Consent to Treat
I give my consent for the examination and treatment of my child including immunizations and injections when indicated and properly authorized. I certify that I am a legal guardian of the above-named patient to consent for examination and treatment.

Assignment of Benefits
I authorize my insurance company to pay and assign directly to CPAM all benefits, if any, payable to me for services as described on this form. I further acknowledge that any insurance benefits received by CPAM will be credited to my account.

Payment Agreement
I understand that it is my responsibility to provide CPAM with the current insurance information. I am aware that payment remains my personal responsibility regardless of insurance or other third-party involvement (including court orders). I understand that if at any time a collection agency is employed to collect past-due balances that I am responsible for the past due amount and any fees incurred. I understand that payment is expected at the time of the visit unless prior arrangements have been made. All copays, coinsurance, and deductibles are to be paid at the time of service. Copays may be due for additional services not usually covered at a wellcheck visit (ADHD medchecks, a sick child, etc.).

Notice of Privacy Practices
I acknowledge by signing below that the Notice of Privacy Practices is available to me and posted for my review in the waiting room and on our website.

Cancellations and Missed Appointments
I have been given a copy of the **Cancellations and Missed Appointments Policy.**

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____

Signature of Parent of Responsible Party (or patient >18 yrs) Date