KAPA'A PEDIATRICS LLC

Registration Form · Disclosures · Consents

Acceptance Code _____

Patient Name (Last, First) **Date of Birth** (MM/DD/YYYY) **SEX**

1. _____ ____/____/_____ ☐M☐F
2. _____ ____/____/_____ ☐M☐F
3. _____ ____/____/_____ ☐M☐F
4. _____ ____/____/_____ ☐M☐F

For medical concerns related to your child, who should we call first? ☐Mom ☐Dad ☐Other _____

MOTHER/GUARDIAN'S LEGAL NAME: _____ BIRTH DATE: _____
PHONE # Cell: _____ Other # (Home/Work): _____
EMAIL: _____ Occupation/Employer: _____
Address: _____

FATHER/GUARDIAN'S LEGAL NAME: _____ BIRTH DATE: _____
PHONE # Cell: _____ Other # (Home/Work): _____
EMAIL: _____ Occupation/Employer: _____
Address: _____

MARITAL STATUS OF PARENTS: ☐ Married ☐ Not Married ☐ Divorced ☐ Other _____

GUARANTOR INFORMATION (Person who is financially responsible):
NAME _____ ADDRESS (If different from above)_____

EMERGENCY CONTACT (If parents cannot be reached):
NAME / RELATIONSHIP_____ PHONE # _____

AUTHORIZATION, CONSENT, & NOTICE OF PRIVACY PRACTICES

☐**Responsibility for Payment:** I understand that the billing statements for services rendered to a minor child under the age of 18 years old will be sent to the Guarantor listed above. All co-payments must be paid at the time of service by the parent/guardian who accompanies the child to the visit. I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered. I understand that delinquent accounts may be subjected to a collections service.

☐**Authorization to Mail, Call, E-Mail, or Text Message:** I understand the privacy risks of the mail, phone calls, e-mail, and text messaging. I hereby authorize a Kapa'a Pediatrics LLC representative to mail, call, e-mail, or text message me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand I can rescind this authorization at any time by a written notification.

☐**Consent to Treatment:** I hereby consent to evaluation, testing, and treatment as directed by my Kapa'a Pediatrics LLC physician.

***I have read the above payment policies, disclosures, consents and will abide by them. I further authorize Kapa'a Pediatrics LLC the release of any medical or other information necessary to my insurance company that may be necessary for insurance claim processing.

***I was given a copy or provided the web link of Kapa'a Pediatrics LLC's Notice of Uses and Disclosures of Protected Health Information

Patient/Guardian: _____ _____ _____
Signature Print Name Date