HOAG URGENT CARE PATIENT REGISTRATION / INFORMATION SHEET PEDIATRIC

Patient Name: _____
LAST FIRST MIDDLE NICKNAME

Date of Birth: _____ Gender: ◯M◯F Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

☐ **Emergency Contact** ☐ **Insurance Guarantor**

Name: _____

Relationship to Patient: _____

Address (if different than above) _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

☐ **Emergency Contact** ☐ **Insurance Guarantor**

Name: _____

Relationship to Patient: _____

Address (if different than above) _____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

*****By providing your email address, you are electing to receive email communication from Hoag Medical Group and its affiliates. ****

Phone Message

Do you give Hoag Medical Group permission to leave a detailed message regarding your care, at one of the phone numbers provided above? *Please mark at that apply*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ No, do not leave any messages regarding my care

Release of Information

I hereby authorize and request release my health information (PHI) to:

1. Name _____ Relationship _____
2. Name _____ Relationship _____

CONSENT TO TREAT A MINOR

I authorize Hoag Medical Group ("HMG") including Hoag entities and affiliates to provide medical care to the minor above including immunizations, physical examinations, and testing / treatment for the purpose of medical diagnosis and treatment, which is deemed advisable by and is to be rendered by the providers and staff of Hoag Medical Group.
Guardian Initial _____

Note: Minors 12 years and older may consent to medical diagnosis, or treatment of the following: infectious or communicable diseases which must be reported to the local health officer; STDs, rape or HIV testing, mental health therapy or drug or alcohol related problems. Minors of any age may consent to medical diagnosis and/or treatment of the following: contraception, pregnancy, and diagnosis or treatment of sexual assault.

ADDITIONAL PATIENT INFORMATION (OPTIONAL)

Race: ◯ American Indian ◯ Asian ◯ African American ◯ Native Hawaiian ◯ White ◯ Other ◯ Unknown

Ethnicity: ◯ Hispanic/Latino ◯ Non-Hispanic/Latino **Language:** ◯ English ◯ Other

*I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the INSURANCE INFORMATION PROVIDED is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits / coverage and tests ordered by my physician may NOT be covered**. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. By providing my email address, I am electing to receive email communication from Hoag Medical Group and its affiliates. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. Hoag Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Hoag Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill.*

I hereby agree to give consent for treatment. I understand that Hoag Medical Group ("HMG") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I understand that I may obtain a copy of the Notice of Privacy Practices that describes how my health information is used and shared, by visiting www.HoagMedicalGroup.com. I understand that HMG has the right to change this notice at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I am entitled to a copy of Hoag Medical Group's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the Hoag Medical Group website or from the office directly. I understand that this authorization remains in effect until it is revoked by my request in writing.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____