olson PEDIATRICS

Adult Patient Registration Form 18+

- **Patient Information:**

Name _____ Date of Birth _____ M ☐ F ☐ Doctor_____
First Full Middle Last

Address _____ City _____ State _____ Zip_____

Please check box of preferred phone method for reaching you

☐Home Phone _____ ☐Cell Phone _____ ☐Other _____

Email _____ SSN # _____- _____-_____

Race: ☐White ☐Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Not Provided Preferred Language: _____

- **Parents/Guardians/Emergency Contacts:**

Relationship to patient ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Foster Parent ☐ Other _____

Name _____ DOB _____ SSN # _____- _____-_____

Cell Phone _____ Home Phone _____ Other _____

Relationship to patient ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Foster Parent ☐ Other _____

Name _____ DOB _____ SSN # _____- _____-_____

Cell Phone _____ Home Phone _____ Other _____

Who referred you to our office? _____

- **Pharmacy Information:**

Name _____ Street Name _____ City _____

- **Insurance Information:**

Primary Insurance Company _____ Member ID# _____ Grp ID# _____

Subscriber Name _____ Subscriber DOB _____ Effective Date _____

Note: If secondary insurance applies, please provide that information below. Both insurance parties must be made aware that the other exists. If they do not, please contact necessary parties. Medicaid is always secondary to commercial insurance.

Secondary Insurance Company _____ Member ID# _____ Grp ID# _____

Subscriber Name _____ Subscriber DOB _____ Effective Date _____

Pharmacy Authorization:

By signing below, you are agreeing that Olson Pediatric Clinic, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment and payment purposes. I hereby provide informed consent to Olson Pediatric Clinic, LLC to enroll me in the e-Prescribe Program.

Patient Centered Primary Care Home:

As a Patient Centered Care Home "Medical Home", OPC is committed to providing the highest quality patient centered care. OPC care will be delivered by a team of healthcare professionals including Physicians, Registered Nurses, and other Skilled Staff. I will be encouraged and supported as I become involved in my care. The goal is to ensure that my healthcare is coordinated so that I have the best possible health outcome.

Authorization and Consent for Treatment, Assigning of Benefits, Financial Responsibility, HIPAA Acknowledgment:

I hereby authorize Olson Pediatric Clinic to provide medical services to the above named patient(s) and to use and release medical information as required for treatment and health care operations. I hereby authorize Olson Pediatric Clinic to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Olson Pediatric Clinic all benefits for service rendered. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of service will result in additional charges. I have received or reviewed a copy of the current Notice of Privacy Practices.

Signature _____ **Printed Name** _____ **Date** _____

Please fill out the bottom portion of this form if you wish to grant access to your medical information to anyone other than yourself

- **Consent to Discuss Medical Information and Protected Health Information**

I authorize Olson Pediatrics and it's physicians to discuss my medical/financial information with the following individuals listed below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ Financial _____ General Medical _____ Protected Health Information (Drug/Alcohol Diagnosis, Mental Health, AIDS/HIV, Genetic, Sexually Transmitted Diseases testing and/or treatment)

I understand that I may refuse to sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect. This consent if effective as of the date signed. I have the right to revoke this consent at any time.

Signature _____ **Printed Name** _____ **Date** _____