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PATIENT REGISTRATION FORM
(please complete entire form)

Today's Date: _____

Patient Name: _____ DOB: _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other_____

Ethnicity: ☐ Latino/Hispanic ☐ Other: _____ Gender: ☐ F ☐ M ☐ _____

Home Phone: _____ Cell: _____

Address: _____City: _____State:____Zip:_____

Contact for appointment reminders (can choose any or all)? ☐ text ☐ home phone ☐ cell phone ☐ email

If you would like your Patient Portal PIN emailed to you please provide your email: _____

Primary Insurance: _____

Member ID and/or Group#: _____

Policy Holder: _____

Policy Holder SS#: _____

Policy Holder Employer: _____

Secondary Insurance: _____

Member ID and/or Group#: _____

Policy Holder: _____

Policy Holder SS#: _____

Policy Holder Employer: _____

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Parent/Guardian Information:

Parent: ☐ **Bio Mother** ☐ **Bio Father** ☐ **Stepmother** ☐ **Stepfather** ☐ **Foster Parent** ☐ **Other** _____

Name: _____DOB: _____SS#:_____

Home Phone#:_____ Work#:_____ Cell/Other:_____

Address: _____City: _____State:_____Zip:_____

Employer/Occupation: _____

Parent: ☐ **Bio Mother** ☐ **Bio Father** ☐ **Stepmother** ☐ **Stepfather** ☐ **Foster Parent** ☐ **Other** _____

Name: _____DOB: _____SS#:_____

Home Phone#:_____ Work#:_____ Cell/Other:_____

Address: _____City: _____State:_____Zip:_____

Employer/Occupation: _____

Signature: _____ **Date:**_____

_____
Print Name/Relationship to patient

If parents are divorced or separated, please fill out this section:

Who has legal custody? _____ _____

Are there any legal restrictions that would restrict non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes / No**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction:
(If you are unable to provide the legal paperwork to our office, PGNA will be unable to enforce any/all of the restrictions listed below).

_____

_____

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Financial Policy/Disclosures

It is our goal to provide you the best care we possibly can. Please understand that part of your care includes billing your insurance. As such, please provide your correct and complete billing information. PGNA does not exclude, or otherwise discriminate against any person based on race, gender, religion, color, national origin, disability, or any unlawful reason.

Please read the following information as it may answer some of your questions regarding our billing policies.

Copay and Coinsurances: These are to be paid prior to seeing the provider at each visit. Please present your payment to our front office.

HMO/Managed Care plans: We need a copy of your current insurance card so that we may bill for the visit. It is your responsibility to make sure a current referral/authorization has been obtained for your care with our office. If no referral/authorization has been obtained, your appointment may need to be rescheduled until you have a current referral/authorization. You will be billed for any remaining balance after your insurance plan(s) have processed the charges.

Commercial or Group Health plans: We need a copy of your current insurance card so that we may bill for your visit. It is your responsibility to verify if we are contracted with your insurance carrier. Benefits may vary if we are out of network. Please ask for our billing department if you have any questions or need assistance. You will be billed for any remaining balance after your insurance plan(s) have processed the charges.

Non-Contracted Insurance plans: It is your responsibility to verify with your insurance company whether the practioner you are scheduled to see is contracted. You are financially responsible for all fees, to be paid at the time of your appointment when PGNA is not contracted with your insurance.

Secondary Insurance acknowledgment: PGNA will gladly bill your secondary insurance company as a courtesy to you. However, please keep in mind that it is ultimately your responsibility to understand the policies and provisions of your insurance coverage. If your secondary insurance company should not pay for remaining balances owed to PGNA the amount owed will be billed to you. If you should disagree with your secondary insurance's decision to not pay for deductibles, coinsurances, co-payments or any other amounts applied to patient responsibility; it is important that you contact your secondary insurance company with your concerns. Although you may dispute how the secondary insurance company has processed a claim, the balance remaining will still be your responsibility.

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Non-Sufficient Funds: All payments returned to PGNA by the financial institution due to non-sufficient funds will be charged a 25.00 fee.

If you need a procedure: If the physician recommends a procedure, you will speak with one of our patient care coordinators. They will help you with any specific questions you may have. We will obtain pre-authorization for your procedure, based on the insurance information provided. Payment is expected PRIOR to scheduling the procedure. Based on the information your insurance company provides us about your individual policy, we will ESTIMATE your responsibility to the best of our ability and collect this amount. After receiving a claim from us the insurance company will determine (based on your individual policy) their payment to us and the EXACT amount you must pay. This information will be sent to both you and us in an Explanation of Benefits (EOB) document. We will then send you statements for or refund to you the difference between the EXACT and ESTIMATED amounts.

Alternatively, you may request to place your credit card on file. If a valid credit card and authorization is on file, the payment will not be due until the EXACT amount you owe is determined by your insurance company. We will automatically charge your card once this amount is determined. Please refer to the credit card authorization agreement for full details. We are still required to collect the office visit co-pay at the time of the office visit, but any additional estimated charges will be deferred until the EOB is received.

Minors: A parent or legal guardian must accompany patients who are minors for the patient's visits. This accompanying adult is responsible for payment of the account, according to the policy written above.

Appointment No Show Policy: We encourage all patients to keep their appointments. With the overwhelming demand for pediatric gastroenterology services in our community, this allows us to help as many patients as possible every day. For this reason, failure to give 24-hour notice of cancellation of an appointment or not showing up for an appointment will be subject to a cancellation fee of 30.00, which will be charged to your account. Failure to pay a no-show fee will be treated the same as our policy on unpaid patient balances. Continued "no shows" may result in the patient being discharged from our practice.

FMLA Paperwork: Completing FMLA paperwork is very time consuming. A fee will be charged to have FMLA papers processed and mailed. You will be personally responsible for a fee of $35.00 at the time the form is left with us.

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Collection of Outstanding Balances: All outstanding balances shall be due within 30 days unless we have agreed to other payment arrangements in writing. It is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney. If your account is referred for collection, you will be responsible for paying all additional collection fees, which is payable in addition to your outstanding balance and any applicable interest. If your account is referred to an attorney, you will be responsible for paying all reasonable attorney's fees and expenses and court costs, which are in addition to your outstanding balance, and any applicable interest.

Notice of Privacy Practices:
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

All requested information should be relevant to the care and well-being of the individuals served. All information should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature of this Privacy Notice shall serve as an acknowledgement that Pediatric Gastroenterology & Nutrition Associates may use and share information for treatment, payment and overall healthcare operations that may include counseling, billing, and quality assurance. The use of sharing of any information not directly related to the services and supports shall have prior authorization. An example of information sharing, that may be necessary, without written consent or authorization is a life-threatening medical emergency.
Right of the Individual: The individual, in writing, may request restrictions on the use of sharing of information, receive confidential communication, inspect and receive copies of any shared information, receive an accounting of shared information and amend or revoke authorization.
Duties of Covered Entity: Maintain privacy and provide notice of legal duties and privacy practices. Abide by this effective notice and any restriction agreements. Provide notice of revised privacy practices.

The undersigned agrees that the medical clinic may furnish information which is part of the patient's healthcare/medical record as defined by NRS 52.320, 629.021 and other applicable statues, to any authorized individual upon request, for the purposes including but not limited to providing continuum of care, determining liability for payment. These may include, but are not limited to insurance companies, health care service plans, the patient's employer, health care providers and utilization review monitoring organizations. Special permission is needed to release this information where the patient is being treated for certain conditions involving restricted diagnosis.

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I authorize my insurance benefits be paid directly to PGNA. I authorize PGNA to release pertinent medical information to my insurance company when requested, needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform PGNA of any changes regarding my personal billing information or my insurance billing information.

The undersigned certifies that he/she has read the forgoing Financial Policy and is duly authorized by the patient as patient's general agent to execute the above and accept its terms. The undersigned agrees to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement and Assignment of Benefits as explained.

I acknowledge that I have received and reviewed the summary of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how may health information may be used or disclosed and that PGNA is not always required to agree to the restrictions I request.

_____ _____
Patient Name (Printed) Relationship to Patient

_____ _____
Signature Patient /**Patient's PARENT**/Agent or Representative Date

I consent to having detailed messages including but not limited to, appointments, authorizations, referrals, and Lab or test results on the following devices:

_____Phone: _____

_____Home: _____

_____Fax: _____

_____ Work: _____

_____ Email: _____

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24 Hour Cancellation & No-Show Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, PGNA reserves the right to charge **a fee of $30.00** for all missed appointments ('no shows") and appointments which are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

Signature ***Date***

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Medical
Record Authorization for Release of Information

I authorize (Facility Name): _____

Address: _____

Phone: _____

Fax: _____

To release my child's medical records to Pediatric Gastroenterology & Nutrition Associates. Please fax to (702) 791-6831 or mail to: 3196 S. Maryland Parkway #309, Las Vegas, NV 89109.

Patient Name: _____

Date of birth: _____

Signature of Parent/Guardian: _____

Print Name: _____

Relationship to patient: _____

Date: _____

(This authorization is valid only for the release of information from the above-named individual(s), hospital or organization and shall be valid unless revoked in writing by the patient, parent, or legal guardian)

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Authorization for Disclosure of Protected Health Information (PHI)

I authorize the use/disclosure of Health Information regarding my child as described below for treatment, payment, and Healthcare operations.

Patient Name: _____ Patient DOB: _____

A. Person(S) authorized to bring the above-named child to Pediatric Gastroenterology & Nutrition Associates, use of disclose the information i.e. Family Members, Nanny, Stepparents.

1. _____ _____
Relationship

2. _____ _____
Relationship

3._____ _____
Relationship

B. Person(s) or Organizations authorized to RECEIVE the information:

1._____

2._____

3._____

I understand that this form does not constitute legal advice and covers only federal, not state laws.

_____ _____
Signature of Patient or Patient's Representative/Relationship to Patient **Date**

(This authorization is valid only for the release of information from the above-named individual(s), hospital or organization and shall be valid unless revoked in writing by the patient, parent, or legal guardian)

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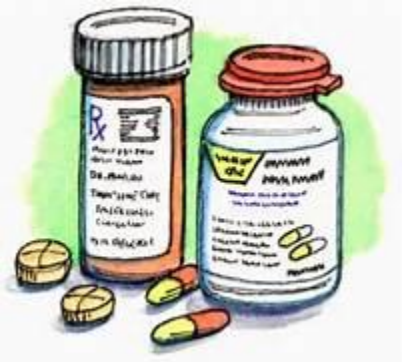
In order for the doctor to send electronic prescriptions to your pharmacy, we require the information below:

Patient Name: _____

Pharmacy Name: _____

Address: _____

Telephone:_____



Para que el doctor pueda mandar cualquier receta necesaria, necesitamos la información indicada abajo:

Nombre del Paciente: _____

Nombre de la farmacia: _____

Calles que cruzan: _____

Número de teléfono: _____

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