MINOR

LeBauer Medical Center
Allergy, Asthma & Sinus Care

RANJAN SHARMA, MD **MEG A. WHELAN, MD** **R. CHRISTOPHER VAN WINKLE, MD**

MINOR PATIENT REGISTRATION SHEET

Patient Last Name_____First Name_____M.I._____
BIRTH DATE_____ GENDER (M/F)_____
Address_____
City_____State_____Zip Code_____
Phone #s H) ( )_____ C) ( )_____ W)( )_____
PREFERRED PHONE for Us to Contact You (circle one) Home Cell Work
*Primary Care Physician Name:*_____ *Referring Physician(if any)*_____

Preferred Pharmacy and Address_____

Race and Ethnicity Reporting

Please Circle Race: Hispanic White African American Asian American Indian Other Prefer not to report
Please Circle Ethnicity: Hispanic or Latino Not Hispanic Prefer not to report
Please Circle Language: English Spanish Indian Russian Other

Parent/Legal Guardian Information

Primary Contact Parent/Guardian	Alternate Contact Parent/Guardian
Name/Relationship_____	Name/Relationship_____
Date of Birth _____	Date of Birth_____
Address_____	Address_____
Primary Phone_____	Primary Phone_____
Alternate Phone_____	Alternate Phone_____
Email Address:_____	Email Address:_____

Emergency Contact (Not a parent):_____Relation:_____Phone #: _____

Primary Insurance Information

Insurance Company Name:_____Policy Holder Name:_____
Policy Holder Date of Birth:_____ Relationship to Patient_____

Authorization of Benefits

Prior to your appointment, you will be asked to pay unmet co-insurance amounts which your insurance company authorizes to be collected and of which we are aware at the time of service. Further, we automatically file insurance claims with your insurance company; therefore, please ensure that your primary and secondary insurance information is current and accurate. By signing below you agree to be responsible for satisfying any unpaid balance left by your insurance company for the services you receive from our office. Until further written notice, I hereby assign all medical and/or surgical benefits, to included major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to:
LeBauer Medical Center, PLLC Allergy, Asthma & Sinus Care.

E-Billing Authorization

I authorize LeBauer Medical Center to send me a monthly or periodic electronic billing notification by e-mail. This e-mail notification will provide a link to view and also pay your bill on a secure website.

Responsible Party Signature_____DATE:_____

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Authorizations

Patient Name:_____

Patient Date of Birth:_____

MISSED APPOINTMENT POLICY

I understand that LeBauer Medical Center does REQUIRE 24 hours advanced notice to cancel or re-schedule an appointment. I understand a fee may be charged to my account for missed appointments or appointments cancelled with less than the required notice.

FORM FEES

I understand that LeBauer Medical Center will charge for the completion of forms that require either staff or physician time to complete. The charge for this service will start at $20 depending on the complexity and time required. This includes, but is not limited to school forms, medication forms, letters, and FMLA forms. The fees may be waived (excludes FMLA) if the form is presented at an appointment to see the doctor or at a visit for the patient to receive an allergy shot and is picked up.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I authorize LeBauer Medical Center and its providers to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable to the staff here, and it may include prescriptions for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan. I understand the scope of my consent and that I authorize the access.

CONSENT TO CONTACT VIA EMAIL:

We may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare. I authorize LeBauer Medical Center to use the email address I provided above to contact me in regard to my healthcare. I consent that protected healthcare information may be transmitted to me via this email address.

CONSENT TO COMMUNICATE PROTECTED HEALTH INFO

I also authorize LeBauer Medical Center to communicate my protected health information (including appointment reminders) to me via the following methods:
Detailed message on my home answering machine or with an individual at that number, personally identifiable voicemail at work, and on a personally identifiable cell phone voicemail.

TEXT MESSAGING

It may be possible to contact you via text message for appointment reminders or other important communications. I agree to be contacted by this method.

I Acknowledge and Authorize, until further written notice, the above by signing below.

Responsible Party Signature_____
Today's Date:_____

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Designated Party Release

You may give LeBauer Medical Center, PLLC written authorization to disclose your protected health information to anyone that you designate. That may be a family member or personal representative. If you wish to authorize a person to receive information regarding your care and/or accounting, please complete the form below. I also understand that information released under this agreement is not protected from further distribution by the designated party.

Patient Name:_____Date of Birth:_____

Today's Date:_____

At my request, I authorize LeBauer Medical Center, PLLC to disclose my protected health information to (Enter below the name of person/entity who you designate to be eligible to receive your protected health information):

Name:_____Relationship:_____

Name:_____Relationship:_____
Name:_____Relationship:_____

AUTHORIZATION TO TREAT

If the patient is under 18 years of age, we must receive permission from the minor's parent or legal guardian before providing treatment or advice for an injury or illness that is non-life threatening. For any future visits to this office we must have permission from a Parent or Legal Guardian in order to provide treatment to a minor patient. **Please print the <u>name and relationship</u> of any adult, other than a parent, who has parental authorization to bring this child in for office visits.** Any person not on this list will be required to present a written note authorizing treatment.

I understand that I have the right to cancel this authorization at any time. If I wish to authorize cancellation I may request so in writing. However, if I cancel this authorization, I also understand that cancellation will not affect any action LeBauer Medical Center, PLLC took in reliance on this authorization before receipt of written notice of cancellation. I also understand that information released under this agreement is not protected from further distribution by the designated party.

Signature of Adult who brought the minor today_____