



Ptarmigan Pediatrics, LLC



950 E Bogard Rd, Ste 233

Wasilla, AK 99654

Phone: 907-357-4KID (4543) Fax: 907-357-4533

The Patient Protection and Affordable Care Act signed into law by President Obama in March 2010 altered the requirements for information collected by medical practices. We ask that you kindly fill out this form in its entirety so we can update our files and comply with these new regulations. Thank you for understanding.

Patient Registration Form; updated 1/1/2011 to comply with PPACA

Name of Mother/Guardian _____ SSN _____ Date of Birth _____

Mailing Address _____

Primary Phone _____ Secondary Phone _____

Name of Father/Guardian _____ SSN _____ Date of Birth _____

Mailing Address (if different than above) _____

Primary Phone _____ Secondary Phone _____

Email _____ Preferred Pharmacy _____

Preferred Contact Method: Home Phone Cell Phone Work Phone Email

Family's Preferred Language (although we cannot guarantee we can communicate with you!): English | Other: _____

1. Child's Name _____ Date of Birth _____ Gender: M F

Primary Race: African American, Alaska Native, American Indian, Asian, Caucasian, Hispanic, Pacific Islander

Ethnicity: (Your active culture, such as: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

2. Child's Name _____ Date of Birth _____ Gender: M F

Primary Race: African American, Alaska Native, American Indian, Asian, Caucasian, Hispanic, Pacific Islander

Ethnicity: (Your active culture, such as: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

3. Child's Name _____ Date of Birth _____ Gender: M F

Primary Race: African American, Alaska Native, American Indian, Asian, Caucasian, Hispanic, Pacific Islander

Ethnicity: (Your active culture, such as: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

4. Child's Name _____ Date of Birth _____ Gender: M F

Primary Race: African American, Alaska Native, American Indian, Asian, Caucasian, Hispanic, Pacific Islander

Ethnicity: (Your active culture, such as: American, Inuit/Eskimo, Canadian, Russian, Ukrainian, Iraqi, etc.): _____

NAME OF OTHER PERSON(S) I AUTHORIZE TO CONSENT TO MEDICAL CARE FOR MY CHILDREN LISTED ABOVE:

Full Name: _____ Phone: _____ Relationship _____

Full Name: _____ Phone: _____ Relationship _____

This consent serves as permission for non-emergency treatment at PTARMIGAN PEDIATRICS, LLC. The above named caregiver(s) is/are acting in loco parentis and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, diagnostic tests, etc.), for the above named child(ren), which may be required in my absence. I agree to pay for all services provided to my child. This authorization shall be effective for a period of one year from the date signed, or if earlier on this date: _____. I may revoke this authorization by submitting written notice to the address above at any time prior to the termination date.

Signed: _____ Date: _____ Witness: (required for treatment consents) _____

How did you first hear about our clinic? _____

If you are submitting this remotely, please mail / fax this completed form with a copy of Insurance ID card(s) to the address at the top of this page.



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HIPAA Acknowledgement, Office Policies, Assignment of Benefits

Revised 1/11

By signing below, I, _____, hereby...

(printed name of parent or legal guardian)

1. ...acknowledge **receipt of or access to Ptarmigan Pediatrics, LLC's, HIPAA / Privacy Notice** and recognize that changes to this policy may occur at any time without notice. I will always have access to the most recent Notice at the clinic website: www.ptarmiganpediatrics.com, or posted in the clinic office waiting room. **I may request a written copy at any time.**
2. ...believe that Ptarmigan Pediatrics, LLC, is **committed to providing the highest quality medical care** for my family members aged birth through 17 years. Doctors are available by phone 24/7 to answer any pressing medical questions I may have.
3. ...recognize that while Ptarmigan Pediatrics, LLC, strongly supports the use of **childhood vaccines**, receiving vaccines is NOT a condition of care at this clinic.
4. ...commit to **canceling appointments** with as much notice as possible, and understand that failure to notify this office of my inability to keep any appointment will result in a "no-show." Repeated no-shows are serious and may involve a fine which must be paid prior to the child being seen again in this clinic, acceptance at the clinic on a walk-in basis only (as time allows), or both. Insurances do NOT cover no-show charges. Patients **over 15 minutes tardy** may be asked to reschedule.
5. ...understand that Ptarmigan Pediatrics, LLC, is proud to be a **mentoring / training facility** for certified medical assistants and nursing students, who may provide care to my child under the supervision of the licensed medical staff.
6. ...agree that **my child cannot be seen in this clinic without a parent or legal guardian** (or my representative designated in writing) being present. "Guardianship agreement" forms are available in our office or via download on our website.
7. ...authorize Ptarmigan Pediatrics, LLC, to **submit claims to my child's insurance company(s)** on my child's behalf, and my child's insurance company(s) to pay benefits directly to Ptarmigan Pediatrics, LLC.
8. ...understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay over these funds to Ptarmigan Pediatrics, LLC.
9. ...understand that an **"out-of-network" insurance carrier may limit payments** for any or all services provided by Ptarmigan Pediatrics, LLC, regardless of the advertised benefits package. (i.e., they may pay less than our standard charges, even if they advertise "100% benefit").
10. ...agree that upon acceptance of services provided by Ptarmigan Pediatrics, LLC, **I assume responsibility for any deductible, co-pay and coinsurance, as well as any other balance not covered by my child's insurance carrier. Copays and estimated coinsurances are due at the time of service.** If my account is turned over to **Cornerstone Credit Services** for collections, **I agree to pay any resulting collection and legal fees.**
11. Furthermore, I understand that if I personally pay all billed charges in full at the time of service, I am eligible for a **20% "prompt-pay/self-pay discount."** (School/sports physicals not included).
12. **VACCINE ADMINISTRATION RECORD:** Patient immunization records may be released to any school, any day care program, any physician office, any medical clinic, any hospital, and to the State of AK DHHS offices.

Name(s) of Children / Patients: _____

Signature of parent or legal guardian: _____

Date: _____

A photocopy of this assignment is considered to be as valid as the original.