

PATIENT REGISTRATION FORM  
PEDIATRIC & ADOLESCENT CARE OF MN  
(AFFILIATE OF CHILDRENS)  
2012

PRIVACY ACT FORM GIVEN

**PATIENT INFORMATION**

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
(First) (Middle) (Last)  
COUNTRY OF ORIGIN \_\_\_\_\_ SEX M \_\_\_ F \_\_\_ RACE \_\_\_\_\_ LANGUAGE \_\_\_\_\_ HOME( ) \_\_\_\_\_  
STREET \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**FATHER** \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ Email \_\_\_\_\_  
 PARENT  STEP PARENT  OTHER \_\_\_\_\_  
STREET \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**MOTHER** \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ Email \_\_\_\_\_  
 PARENT  STEP PARENT  OTHER \_\_\_\_\_  
STREET \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**RESPONSIBLE PARTY (BILLING INFORMATION)**

\*PERSON RESPONSIBLE FOR PAYMENT OF BILL

**NAME** \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ Email \_\_\_\_\_  
 PARENT  STEP PARENT  OTHER \_\_\_\_\_  
STREET \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY \_\_\_\_\_ EFF DATE \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
POLICY HOLDERS NAME \_\_\_\_\_  
POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_  
 PARENT  STEP PARENT  OTHER \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_ EFF DATE \_\_\_\_\_  
INSURANCE COMPANY ADDRESS \_\_\_\_\_  
POLICY HOLDERS NAME \_\_\_\_\_  
POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_  
 PARENT  STEP PARENT  OTHER \_\_\_\_\_

## PLEASE TURN OVER FINANCIAL/CREDIT INFORMATION

In compliance with the Federal Consumer Protection Act. Pediatric and Adolescent CarE of Minnesota, P.A. (Affiliate of Childrens) wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member of your family.

1. We will furnish you with a monthly statement of your account showing both the amounts billed to you and the payments or credits to your account. The monthly invoice/bill will also provide you with a detailed aging of how long balances have been outstanding.
2. We require the patient to be responsible for insurance filing and insurance payment problems. However, we do file many types of insurance forms for our patients. Please talk to our business office staff to determine your specific responsibilities in this area.
3. Payments for services rendered are considered due and payable at the time of service. Extended payment programs are available to you if arranged and approved by our business office. Ultimately the members are responsible for the payment.
4. Copays assigned by your insurance company are due at the time of service.

The undersigned hereby acknowledge to have read and agrees to the above financial credit and payment policies of Pediatric and Adolescent CarE of Minnesota P.A.

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Signature of Parent/Guardian

Date

## ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits due to me under the terms of my policy to Pediatric and Adolescent CarE of Minnesota, P.A. (Affiliate of Childrens) I understand the clinic's charge may exceed the insurance company/Medicaid payment, and if greater than such. I will be responsible for paying that additional allowable amount. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due on any bills if this is not done.

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Signature of Parent/Guardian

Date

## RELEASE OF INFORMATION

I hereby authorize Pediatric and Adolescent CarE of Minnesota, P.A. (Affiliate of Childrens) to furnish information regarding my child's health care and medical history to insurance carriers and to other medical care providers to whom I might be referred by Pediatric and Adolescent CarE of Minnesota P.A. and to furnish any information necessary to complete any health forms I might submit on behalf of my child's school camp, athletic organization or the like.

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Signature of Parent/Guardian

Date

## EMERGENCY CONTACT

\*Please list someone living outside of the home ex: grandparents, friend of family, aunt, uncle etc.\*

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Name

Relationship

Address

Phone

## NOTICE OF PRIVACY PRACTICES

This Notice describes how the medical information about you may be used and disclosed. Please review the attached form and sign the acknowledgment below. Please let us know if you would like a copy for your records.

I have read and understand the Notice of Privacy Practices.

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Signature of Parent/Guardian

Date