FASTER CARE CHILD'S PATIENT REGISTRATION

Child's Last Name:	First Name:
Middle Initial:	Sex:
Date of Birth:	SSN:
Address:	

Mother/Guardian's

Mother's Last Name:	First Name:
DOB:	SSN:
Address (if different from child):	
Phone:	

Father/Guardian's

Father's Last Name:	First Name:
DOB:	SSN:
Address (if different form child):	
Phone:	

Insurance

1	Primary Insurance:
	Policy Holder's Name:
2	Secondary Insurance:
	Policy Holder's Name:

Both parents will be granted access to seek medical treatment and acquire confidential health information for the designated child at Faster Care. If I wish to object, I am aware that I must express such an objection in writing. It is also within my knowledge that the objection will be disregarded if the opposing individual provides court documentation establishing their legal entitlement to access the information.

Additional individuals authorized to bring child in for treatment and to retrieve HIPPA Protected Health Information (Medical Records):

All information and authorizations provided will remain in effect unless otherwise revoked in writing.

Full Name: _____Relationship_____Phone: _____

Full Name: _____Relationship_____Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Faster Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of Faster Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of Faster Care's notice of privacy practices.

I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultrasounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at Faster Care will also require a separate payment. The patient will be responsible for these charges, not Faster Care.

Payment for the patient portion will be collected at the time of service, including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a $50.00 charge on all unpaid balances. Bounced checks will receive a $30.00 charge.

Patient Signature OR Signature of parent if the patient is a minor: _____ Date: _____