URGENT CARE of Holden

5 Shrewsbury St, Holden MA 01095-1960
Phone 508-829-3800 – Fax 508-829-3802

EXISTING PEDIATRIC REGISTRATION FORM

Time of Arrival: _____ : _____

PATIENT INFORMATION [*Please print NEATLY & LEGIBLY*]

FIRST	LAST & Suffix (Sr, Jr, III, IV etc)	DOB
		/ /

REASON FOR BEING SEEN TODAY (*In only a few brief words*)

	Is the visit related to a(n)?:
	☐ Assault ☐ Motor Vehicle Accident ☐ Workplace injury

PHARMACY: *If a prescription is needed today,* which pharmacy do you want us to electronically send it to?

Name:	Location: (Street & City)

AUTHORIZATION FOR TREATMENT

- I hereby authorize medical treatment by the provider, the clinical staff and technical employees assigned to care for the minor.
- I authorize the treating providers to order any ancillary services deemed necessary for the care and treatment of the minor.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with the provider or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand that Urgent Care of Holden utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that the providers and appropriate staff will have access to the healthcare information across the continuum of caring for the minor.
- I understand that Urgent Care of Holden utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to the pharmacy of my choosing.
- I consent to the release of the minor's prescription history from any pharmacy or drug monitoring agency to the provider/practice.
- I authorize the release of Protected Health Information (PHI) to the minor's primary care provider (PCP) listed for continuum of care.
- In the event that a healthcare worker is exposed to any blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of the minor's blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Massachusetts law.

PAYMENT FOR SERVICES & GUARDIAN RESPONSIBILITIES

- I agree to be responsible for payment of all services rendered, to me and/or my dependents.
- I authorize the assignment to Urgent Care Specialists, PC d/b/a Urgent Care of Holden of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (medical, workers' compensation, motor vehicle personal injury, or any other insurance or benefit plan).
- I authorize the release of Protected Health Information (PHI) to my insurance companies or other third party payers, including their representatives, as necessary to determine coverage or as required for review, quality improvement, and/or management.
- **I agree to pay, at the time of service, any required co-payments.**
- I agree to pay any co-insurances or deductibles, as well as charges for services not covered by insurance, including those deemed NOT a medical necessity for treatment, either at the time of service or later determined by an insurance provider.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a $25 fee charged for returned checks and any future payment must be made by alternate methods.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.

By signing this document, I attest that the information provided is true and accurate; *I have read, understand and agree to the above terms:* and that reproductions are as legally binding as the original.

X _____ _____ _____

Parent / Guardian Signature **Relationship** **Date**

XPM BARCODE LABEL

Office Use: ___ *Ins. Verified* ____ *Care360* ____*XPM Entered & Scanned* *PSR Initials:* _____

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EXISTING PEDIATRIC DEMO UPDATE FORM

If there are any changes necessary — fill *only* that section.

If no changes are needed, do not complete.

CHILD

PATIENT'S INFORMATION [*Please print NEATLY & LEGIBLY*]

FIRST	MI	LAST	Suffix (Sr, Jr, III, IV etc)

DOB	Sex	GENDER IDENTITY	*Preferred* First Name *(if different)*
/ /	☐ Male ☐ Female	☐ Other ☐ Male ☐ Trans-male (FTM) ☐ Female ☐ Trans-female (MTF)	

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other or Unknown

Ethnicity ☐ Hispanic or Latino ☐ *Not* Hispanic or Latino

Lives with ☐ Both Parents ☐ Mom ☐ Dad ☐ Other

MOM / GUARDIAN

MOTHER'S or LEGAL GUARDIAN INFORMATION ☐ Insurance Policy Holder ☐ Guarantor / Responsible for Bill

FIRST	LAST	DOB	Marital Status
		/ /	☐ S ☐ M ☐ D ☐ W

Primary Phone	Secondary Phone
☐ Cellphone ☐ Leave Messages? ( ) -	☐ Cellphone ☐ Leave Messages? ( ) -

Home Address: **City**: **State**: **Zip Code**:

Mailing Address: (*if different from above*) **City**: **State**: **Zip Code**:

Employer:	Occupation:	Veteran?
		☐ Y ☐ N

DAD

FATHER'S INFORMATION ☐ Insurance Policy Holder ☐ Guarantor / Responsible for Bill

FIRST	LAST & Suffix (Sr, Jr, III, IV etc)	DOB	Marital Status
		/ /	☐ S ☐ M ☐ D ☐ W

Primary Phone	Secondary Phone
☐ Cellphone ☐ Leave Messages? ( ) -	☐ Cellphone ☐ Leave Messages? ( ) -

Home Address: ☐ Same as Mom / Guardian above **City**: **State**: **Zip Code**:

Mailing Address: (*if different from above*) **City**: **State**: **Zip Code**:

Employer:	Occupation:	Veteran?
		☐ Y ☐ N

PCP

Your Pediatrician / Primary Care Provider's Name:	Office Location:

Office Use: ____ *Care360 Updated* ____*XPM Entered & Scanned* *PSR Initials:* _____