Corner Pediatrics, PSC

Registration for **Minor Children** (Please Print) – Updated June 2022

Mother's Name	Date of Birth	
Address, City, State, & Zip		
Cell Phone Number	May we text this number with appointment reminders?	□Yes □No
Email		
Father's Name	Date of Birth	
Address (if different from above)		
Cell Phone Number	May we text this number with appointment reminders?	□Yes □No
Email		

List all Minor Children In Your Custody Who Come Here for Care:

Child's Full Name		SS# req'd
Date of Birth		Gender
Ethnicity	□ Hispanic	□ Non-Hispanic
Race	□ American Indian or Alaskan Native	□ Asian
	□ Black or African American	□ Native Hawaiian or Other Pacific Islander
	□ Other	□ White

Child's Full Name		SS# req'd
Date of Birth		Gender
Ethnicity	□ Hispanic	□ Non-Hispanic
Race	□ American Indian or Alaskan Native	□ Asian
	□ Black or African American	□ Native Hawaiian or Other Pacific Islander
	□ Other	□ White

Child's Full Name		SS# req'd
Date of Birth		Gender
Ethnicity	□ Hispanic	□ Non-Hispanic
Race	□ American Indian or Alaskan Native	□ Asian
	□ Black or African American	□ Native Hawaiian or Other Pacific Islander
	□ Other	□ White

Child's Full Name		SS# req'd
Date of Birth		Gender
Ethnicity	□ Hispanic	□ Non-Hispanic
Race	□ American Indian or Alaskan Native	□ Asian
	□ Black or African American	□ Native Hawaiian or Other Pacific Islander
	□ Other	□ White

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance and that Corner Pediatrics reserves the right to dismiss patients with delinquent accounts. I also authorize Corner Pediatrics, PSC and/or my insurance company to release any information required to process my claims.

Parent/Guardian Signature Date **OVER→**

Corner Pediatrics, PSC

Consent to Treat **Minor Child(ren)**/Medical Care Authorization/HIPAA

Until notified in writing, Corner Pediatrics, PSC (CPeds) assumes that a child's biological and/or legal parents both have access to treatment options and medical information for their child.

_____
Initials

I, _____, hereby authorize and consent to the examination and/or
Printed Name of Parent/Legal Guardian
treatment of my child(ren), listed on the previous page, by the physicians and clinical staff of CPeds.

_____
Initials

I give permission for the following person(s) to bring my child(ren) to CPeds in my absence and to act in my behalf in authorizing medical care.

Name & Cell	Relationship
Name & Cell	Relationship

(Anyone not mentioned above who brings your child into the office must have a signed authorization from you.)

_____
Initials

In the event of an emergency or other illness, I understand that the physicians and staff of CPeds will deliver any medical care deemed necessary regardless of the accompanying adult.

_____
Initials

At CPeds, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of CPeds, kept in a secure location, and accessed only for purposes outlined in the HIPAA Notice of Privacy Practices. Records may be released or shared with other healthcare providers for treatment of your child. Patients are entitled to one free copy of their medical records after an authorization for release is signed. Additional copies may be made for a fee of $1.00 per page.

- I have been given a laminated copy of the HIPAA Notice of Privacy Practices to read, and I understand that I may request my own personal copy at any time.
- CPeds may call my home and place of employment for healthcare reasons, appointment reminders, and to resolve billing issues. CPeds may mail bills and informational postcards to my home.
- CPeds may leave messages on my answering machine, voicemail, or via text message regarding appointments and limited lab results.
- At my request, CPeds may forward immunization certificates and/or school forms to me via personal email, personal or work fax, or US mail. At my request, CPeds may forward immunization and school forms directly to the school via the same methods.
- I authorize CPeds to discuss patient information with adults or other minors present during the visit regardless of whether I am present.
- I understand that if I send a picture of myself or my child(ren), CPeds may display it within the office.
- I understand I may edit any of the above items by striking through them and writing the word, "no."

_____

Parent/Guardian Signature Date