Children's Healthcare Associates, LLP
P.O. Box 51570 • Amarillo, TX 79159 • Phone 806-468-4350 • Fax 806-468-4351

Date:_____

REGISTRATION FORM

Patient:_____ Date of Birth:_____ ❑ Male ❑ Female
Last First Middle

Street Address:_____ City:_____ State:_____ Zip:_____

County of Residence:_____ Phone #:_____ Social Security #_____

Patient Living With_____ Parent Responsible for Bill _____

Mother's Name:_____ Date of Birth:_____ Social Security #_____

Address (if different):_____ City:_____ State:_____ Zip:_____

Employer:_____ Department:_____ Work Phone:_____

Father's Name:_____ Date of Birth:_____ Social Security #_____

Address (if different):_____ City:_____ State:_____ Zip:_____

Employer:_____ Department:_____ Work Phone:_____

Person to contact in an emergency:_____
(MUST HAVE) (not living at home of patient)

Address:_____ Phone #:_____

PAYMENT DUE AT TIME OF SERVICE. Please check below which method of payment you will be using.

Cash_____ Check_____ Medicaid_____ CIDC_____ Champus_____ Medicare_____

INSURANCE INFORMATION:

1. Insurance Company:_____ SS#:_____ Group #:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Employer:_____ DOB:_____

2. Insurance Company:_____ SS#:_____ Group #:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Employer:_____ DOB:_____

MEDICAID #l:_____ Effective Date:_____ Cert. Date:_____

MEDICARE #l:_____ Effective Date:_____ Cert. Date:_____

CHAMPUS #:_____ Branch of Military:_____ Current Status: ❑ Active ❑ Retired

CIDC#:_____ Effective Date:_____ Cert. Date:_____

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CONSENT TO TREATMENT: The undersigned consents to rec eive medical and healthcare services provided by physicians, surgeons, advance practicing nurses, nurse clinicians, and other healthcare providers of the CHA group practice. Such services may include diagnostic procedures, examinations, treatments, or other services rendered un the general and special instruction of the physicians. Specific services may require informed consent.

This signed consent to treatment will be valid and remain in effect unless revoked by the undersigned with a written notice provided to CHA.

RELEASE OF INFORMATION: CHA may disclose all or any part of my medical recored including oral information and my provide bill/invoices to: (1) any person, orporation or agency (or their authorized representative) which is or may be liable under a contract to CHA, or to me or my family members for all or part of the clinic charges including, but not limited to, hospital or medical service companies, insurance or third party payors, workers' compensation carriers, or my employer; and (2) any individual or entity designated by me as a guarantor or party responsible for payment of fees for health care services provided to me.

The undersigned understands and agrees that the information authorized to be released my include (1) AIDS/HIV test results, diagnosis, treatment and related information; (2) information about drug and alcolhol use and treatment; and (3) mental health information.

The undersigned understands that this authorization for the release of information may be revoked at any time, by providing written notice CHA, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this authorization expires automatically ninety (90) days from the date signed or ninety (90) days after the last clinic visit or after all insurance or third part claims have been paid or satisfactorily resolved, whichever occurs last.

RELEASE FROM LIABILITY: The undersigned releases and agrees to hold harmless CHA employees from any and all liability associated with the release of confidential patient information i accordance with the authorization and understands that CHA cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, the undersigned hereby assigns righrts, title, and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services otherwise payable to me to Children's Healthcare Associates, LLP. Also authorized are direct payments to be made by Medicare/Medicaid and/or insurance companies or other third party payors, up to the tortal amount of the medical and healthcare charges, to Children's Healthcare Associates, LLP. The undersigned certifies that the information provided in connection with any application for payment by third party payors, including medicare/Medicaid, is correct.

The undersigned agrees to pay all charges for medical and healthcare services not covered by Medicare/Medicaid or which exceed the amount estimated to be paid or actually paid by an insurance company or other third party payor and agree to make payment as requested by CHA.

The undersigned certifies that this form has been fully examined and any question have been answered by CHA, and its content is understood and agreed to.

_____
Date Time

_____
Patient/Other Legally Authorized Person

_____
Witness/Translator*

_____
Print Name and Relationship to Patient

_____
Print Name and Translated Language