MAGNOLIA
PEDIATRICS OF MARIN

Pediatric Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	**Email Address:**
What is the family's preferred language?	**Would you like an interpreter**? ☐ Yes ☐ No
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	Is the **patient** employed? ☐ Yes ☐ No If yes**, Employer Name**:
Name of Pediatrician:	**Employment Status:** ☐ Full Time ☐ Part Time

Patient Contacts	
In **case of an emergency**, please provide the **names of individuals** (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver

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Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Someone Else

If 'Someone Else' please provide their **name and address**:

Guarantor's Sex:	**SSN:**	**DOB:**

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other Relative

Email Address:

Is this person **currently employed**? ☐ Yes ☐ No

If yes, complete below:

Employer Name:	☐ Full Time ☐ Part Time ☐ Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the secondary plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy and Lab?

Parent/Legal Guardian Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.magnoliapediatricsofmarin.com.

Printed Patient Name Date of Birth (DOB)

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

Relationship to Patient

Signature of Patient or Parent/Legal Guardian Today's Date (Date Noticed Received)

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Terms and Conditions of Registration, Medical Services and Financial Agreement

1. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
2. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires Magnolia Pediatrics to provide the following information to individuals who supply information about themselves. As a patient of Magnolia Pediatrics, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, Magnolia Pediatrics is authorized to maintain this information. As required by Magnolia Pediatrics, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. Magnolia Pediatrics will obtain my written authorization to release information about my medical treatment, except in those circumstances when Magnolia Pediatrics is permitted or required by law to release information (see Notice of Privacy Practices for a description of the specific circumstances under which Magnolia Pediatrics may release this information). For example, Magnolia Pediatrics may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, Magnolia Pediatrics is required by law to report my diagnosis to the State Department of Health Services.
3. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay Magnolia Pediatrics for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
4. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to Magnolia Pediatrics of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for Magnolia Pediatrics, including emergency services, at a rate not to exceed Magnolia Pediatrics actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to Magnolia Pediatrics by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name	**Today's Date**
Signature of Parent/Legal Guardian or Financial Guarantor	**Today's Date**
Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign)	**Today's Date**
Relationship to Patient	
Signature of Interpreter (if applicable)	**Today's Date**
Language Used	

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Consent to Treatment of a Minor

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an Magnolia Pediatrics clinical facility. This authorization is effective from _____ until
(Today's Date)

consent is withdrawn.

_____
Signature of Parent/Legal Guardian **Today's Date**

Other Adult Consent to Treatment (Optional)

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize _____ to act as my agent to consent to any
(Printed Name Agent/Other Adult)

x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from _____ until consent is
(Today's Date)

withdrawn.

_____
Signature of Parent/Legal Guardian **Today's Date**