Amarillo Pediatric Clinic PLLC
1901 Medipark, Suite 65
Amarillo, TX 79106
Phone: (806) 468-4333
Fax: (806) 468-4334
www.apcamarillo.com
Erica Leathers, FNP-C ● Julie Reel, FNP-C ● Paula Saunders, FNP-C

Patient Registration Form

Patient Information

	Sex ☐M ☐F	DOB:
Last Name First Middle	Email:	SS#:

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

Home Phone:_____ Cell Phone:_____ Preferred: ☐Cell ☐Home

Parent Information

Mother	Father
Last Name First Middle	Last Name First Middle
DOB: SS#:	DOB: SS#:
Mailing Address:	Mailing Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Employer:	Employer:
Occupation:	Occupation:
Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Custody?
Both ☐ Mother ☐ Father ☐ Other ☐_____

Party Responsible for Payment?
Mother ☐ Father ☐ Guardian ☐ Other ☐_____

Emergency Contact(s)

Contact name (not living in home of patient)	Relationship	Home Phone	Work Phone	Cell Phone
Individuals who can give treatment consent	**Relationship**	**Home Phone**	**Work Phone**	**Cell Phone**

Authorization

The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to Amarillo Pediatric Clinic. I understand that my insurance carrier may pay less than the actual bill of service and I agree to be financially responsible for any balance and for all services rendered. I authorize Amarillo Pediatric clinic to release information including diagnosis and records of treatment or examinations during the period of such care to third party payers and / or other health practitioners.

_____ _____
Patient / Other Legally Authorized Person Date

_____ _____
Print Name and Relationship to Patient Witness

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Date:_____

CONSENT TO TREATMENT: The undersigned consents to receive medical and healthcare services provided by the healthcare providers of the APC group practice. Such services may include diagnostic procedures, examinations, treatments, or other services rendered under the general and special instruction of the providers. Specific services may require informed consent. I also authorize APC to obtain medication information and history from Surescripts.

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

RELEASE OF INFORMATION: APC may disclose all or any part of my medical record including oral information an may provide bill/invoices to: 1) any person, corporation, or agency (or their authorized representative) which is or may be liable under a contract to APC, or to me or my family members for all or part of the clinic charges including, but no limited to, hospital or medical service companies, insurance or third party payers, workers' compensation carriers, or m 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 release may include 1) AIDS/HIV test results, diagnosis, treatment, and related information; 2) information about drug and alcohol 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 to APC, 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 party claims have been paid or satisfactorily resolved, whichever occurs last.

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

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, the undersigned hereby assigns rights, title, and interest in all insurance, Medicaid, or other third party payer benefits for medical or health care services otherwise payable to me to Amarillo Pediatric Clinic, PLLC. Also authorized are direct payments to be made by Medicaid and / or insurance companies or other third party payers, up to the total amount of the medical and healthcare charges, to Amarillo Pediatric Clinic, PLLC. The undersigned certifies that the information provided in connection with any application for payment by third party payers, including Medicaid, is correct.

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

The undersigned certifies that this form has been fully examined and any questions have been answered by APC, 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