SARHA
Southeast Alabama Rural Health Associates

PEDIATRIC REGISTRATION FORM

CHILD'S INFORMATION (Must have separate form for each child in family)

CHILD'S FULL NAME	CHILD'S DATE OF BIRTH	CHILD'S GENDER ☐ MALE ☐ FEMALE ☐ _____	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER

PRIMARY HOME ADDRESS	CITY	STATE	ZIP CODE

PATIENT/PARENT/GUARDIAN EMAIL ADDRESS	CHILD'S SOCIAL SECURITY NUMBER

PRIMARY CELL PHONE	PRIMARY WORK PHONE	PRIMARY HOME PHONE

WHAT IS THE BEST NUMBER TO REACH YOU?

RACE

- ☐ AMERICAN
- ☐ INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ ASIAN INDIAN
- ☐ JAPANESE
- ☐ WHITE
- ☐ FLIPINO
- ☐ KOREAN
- ☐ CHINESE
- ☐ NATIVE HAWAIIN/PACIFIC ISLANDER
- ☐ SAMOAN
- ☐ VIETNAMESE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ DECLINED TO SPECIFY
- ☐ OTHER RACE

IF HOMELESS, PLEASE SELECT:

- ☐ HOMELESS SHELTER
- ☐ DOUBLING UP
- ☐ STREET
- ☐ OTHER

ETHNICITY

- ☐ HISPANIC OR LATINO/SPANISH
- ☐ NOT HISPANIC OR LATINO/SPANISH
- ☐ DECLINE

VETERAN

- ☐ YES
- ☐ NO

FARMWORKER

- ☐ YES
- ☐ NO

IF YES TO FARMWORKER:

- ☐ SEASONAL
- ☐ MIGRANT

PHARMACY	PHARMACY PHONE	PHARMACY ADDRESS	
MEDICATIONS	ALLERGIES	SURGICAL HISTORY	HOSPITALIZATIONS

LEGAL GUARDIAN'S INFORMATION

FULL NAME	DATE OF BIRTH	PARENT/GUARDIAN EMAIL ADDRESS		
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE				
CELL PHONE				

EMERGENCY CONTACT

FULL NAME OF EMERGENCY CONTACT	EMERGENCY CONTACT'S RELATIONSHIP TO CHILD	EMERGENCY CONTACT'S PHONE NUMBER

BILLING INFORMATION (RESPONSIBLE PARTY/INSURANCE CARD HOLDER'S INFORMATION)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP TO CHILD	DRIVERS LICENSE #
PRIMARY INSURANCE NAME	POLICY #	GROUP #	EFFECTIVE DATE	
SECONDARY INSURANCE NAME	POLICY #	GROUP #	EFFECTIVE DATE	

_____

Patient/Parent/Guardian Signature **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Authorization for Medical and/or Diagnostic Treatment

I, the undersigned, a patient (or the parent and/or legal guardian of a patient) hereby authorize SARHA, its providers, and designated assistants to administer such treatment as is necessary and to perform medical and diagnostic treatment or tests and such additional procedures as are considered necessary. This includes but is not limited to Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STDs), Hepatitis A, B, and/or C, Urinalysis, Hemoglobin AIC, and X-rays. Tests may be performed via urine, blood, antibody test, and other means. STD's are notifiable diseases to the Department of Public Health. This authorization shall be effective for all times from this date forward unless revoked by the undersigned in writing. I also certify that no guarantee or assurance has been made as to the results that may be obtained. **The state of Alabama requires consent for treatment from the patient if he/she is 14 years of age or older. Please have your child sign below if applicable. The Parent/Legal Guardian may sign if given consent from the patient.

_____

Patient/Parent/Guardian Signature **Relationship to Child if applicable** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Consent to Treat a Minor (required for under 14 years of age)

If applicable, please check the appropriate box below:

_____My child ***may receive medical services*** at SARHA ***without me being present*****. HOWEVER**, I understand that I must be available by phone for my child to receive services. SARHA staff will attempt to contact me at the numbers provided.

_____My child ***may receive medical services*** at Southeast Alabama Rural Health Associates (SARHA) ***only if I am present***.

Assignment of Insurance Benefits

I hereby authorize payment of insurance benefits to the above-named center and/or provider under the terms of my policy. I hereby authorize the center and/or provider to release any information acquired during my examination or treatment so that my insurance benefits may be promptly and correctly filed.

_____

Patient/Parent/Guardian Signature **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Payment Policy

Full payment is required at the time of service for all patients covered by insurance plans that are under contract with SARHA and patients on the sliding fee scale. Patients in these insurance categories are required to pay all applicable copayments, deductibles, co-insurances, and sliding fee percentages at the time of service. Failure to comply with the payment policy may result in patient dismissal. Charges for patients with insurance plans that are not under contract with SARHA will be filed upon request, at no charge, as a service to the patient. Since full payment at the time of service is required, SARHA cannot accept the assignment of non-contract insurance plans. The patient, not the insurance company, is therefore responsible for payment of the entire bill. The insurance company may then pay the patient directly. This payment policy enables SARHA to control billing costs and thus maintain reasonable fees. Financial assistance is available for those who qualify.

I agree to pay all costs of collecting or attempting to collect any charges for this patient, including a reasonable attorney's fee and all/any collection agency fees and court costs. I hereby waive all rights of any exemption under any law or Constitution. I, the undersigned, give SARHA, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers, which could result in charges to me. SARHA may also contact me by sending text messages or email, using any email address I provide. Methods of contact may also include using prerecorded/artificial voice messages and/or the use of automatic dialing devices, as applicable, for the purpose of insurance or payment.

_____

Patient/Parent/Guardian Signature **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Authorization for Health Information Exchange and Prescription Formulary

By signing this consent form, you are agreeing that your provider at SARHA may request, share, and use your prescription medication and medical history from other healthcare providers, facilities, and/or third-party pharmacy and insurance benefit payors for treatment purposes. I also authorize SARHA to contact me with automated appointment reminders by phone or text message with the phone numbers I have provided.

_____

Patient/Parent/Guardian Signature **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Authorization of Disclosure of Personal Health Information (PHI)

I permit my Protected Health Information to be disclosed for the purposes of communicating results and care decisions to the family members and others selected for PHI disclosure.

You have chosen to permit the selected members on your contact profile to give access to your Protected Health Information (PHI).

Name:_____ Contact Number:_____ Relationship:_____

Name:_____ Contact Number:_____ Relationship:_____

Name:_____ Contact Number: _____Relationship:_____

_____

Patient/Parent/Guardian Signature **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

Household Income

To assist us in reporting requirements, please see the following table and determine what category you fall into: This information is confidential, Individual information will not be shared.

Household Size	Household Income				
	Category A: Less than	Category B: Less than	Category C: Less than	Category D: Less than	Category E: Equal to or more than OR chooses not to disclose
1	$14,580	$19,391	$21,870	$29,160	$29,160
2	$19,720	$26,228	$29,580	$39,440	$39,440
3	$24,860	$33,064	$37,290	$49,720	$49,720
4	$30,000	$39,900	$45,000	$60,000	$60,000
5	$35,140	$46,736	$52,710	$70,280	$70,280
6	$40,280	$53,572	$60,420	$80,560	$80,560
7	$45,420	$60,409	$68,130	$90,840	$90,840
8	$50,560	$67,245	$75,840	$101,120	$101,120

Please write in the letter of the category that best describes your household, with your name on the signature line, or discuss with the receptionist at check-in. If your household is greater than 8 people, please discuss this with the receptionist.

_____

Patient/**Parent/Guardian Signature** **Relationship to Child** **Date**

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**

About our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I,_____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____
Patient/Parent/Guardian Signature

_____
Description of Legal Authority to Act on Behalf of Patient

_____

Student's Last Name **Student's First Name** **Middle Initial** **Student's Date of Birth**