1901 Medi Park, Suite 110
Amarillo, TX 79106
Phone: (806) 468-4310
Fax: (806) 468-4311

REGISTRATION FORM

Date: ______________________

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#:___________________________

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Date: ______________________

CONSENT TO TREATMENT: The undersigned consents to receive medical and healthcare services provided by physicians, advance practicing nurses, nurse clinicians, and other healthcare providers of the Pediatric Wellness Center of Amarillo (PWCA) 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.

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

RELEASE OF INFORMATION: PWCA may disclose all or any part of my medical record including oral information and provide my bill/invoices to: (1) any person, corporation, or agency (or their authorized representative) which is or may be liable under a contract to PWCA, 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 healthcare services provided to me.

The undersigned understands and agrees that the information authorized to be released 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 PWCA, 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 signed date 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 PWCA employees from any an all liability associated with the release of confidential patient information in accordance with the authorization and understands that PWCA cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or healthcare services, the undersigned hereby assigns rights, title, and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or healthcare services otherwise payable to Pediatric Wellness Center of Amarillo. Also authorized are direct payments to be made by Medicare/Medicaid and/or insurance companies or other third party payors, up to the total amount of the medical and healthcare charges, to Pediatric Wellness Center of Amarillo. 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 PWCA.

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