Steel City South Pediatrics Inc.

PATIENT REGISTRATION

** FORM MUST BE FILLED OUT COMPLETELY **

Patient's Name: (Last, First, Middle Initial) | Sex: M F | Date of Birth: | Preferred Language: English/other

Home Phone#:

Address: | Mobile Phone #:

Apart # | Mobile Phone #:

City: State: Zip: | E mail :

Your Child's Guarantor's Information

Father's / Guarantor's Name: Date of Birth: | Mother's / Guarantor's Name: Date of Birth:

Phone #: Ext #: Work place: | Phone #: Ext #: Work Place:

Your Child's Health Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Name on ID Card: (Parent's or Child's)	Name on ID Card: (Parent's or Child's)
Relationship to Patient: Parent: Other:	Relationship to Patient: Parent: Other:
Insurance ID #	Insurance ID #
Group #:	Group #:
Co-pay amount: ________ Effective Date: ____________ Is patient covered on your insurance policy? Yes : NO:	Co-pay amount: ________Effective Date: ______________________ Is patient covered on your insurance policy? Yes:____________ No:________

Your Child's Health Information

Hospital:_________________Normal /C-section delivery: __________Full /Preterm(____weeks) Birth weight: ___lb____Oz Breast/ Formula Feeding:___________

Past Med /Surgical History: Prenatal complication/ NICU/Hospital Admission:______________________________

Developmental History: Appropriate /on time /Delay:(Speech/Psycho social/Potty training)______________________

Allergy (Drug/food/environmental) :______________________________

Mediaction:___________________Dose____________How long _______Reason:______________________________Prescriber____________

Mediaction:___________________Dose____________How long _______Reason:______________________________Prescriber____________

Your Child's Pharmacy Information

Name:______________________________Address:______________________________City:____________Zip: ___________Phone#______________

Your Child's Previous PCP

Previous PCP Name/ Facility:______________________________

Address:______________________________City:______________________State:_____________Zip :________________

Phone #:______________________ Fax#:__________________________ Reason of transfer:______________________________

Your family's Health Information

Asthma:________Diabetes:__________Cancer:___________High Cholestreol:__________Heart disease:___________ Anemia(G6PD/Sickle cell)________TB: ___

other:______________________________

House Hold family #:________Smoker: Y/N Pets: Y/N___ House Built: Before 1970 Y/N/Unknown___ Paint peeling: Y/N ___ Travel outside USA(IN 3 MONTHS):Y/N

Emergency Contact Information

IN CASE OF EMERGENCY, Please provide us with the NAME and PHONE number of nearest relative not living with you:

Name;______________________________Relationship______________________Phone #______________

Authorized Personal Information

Name: ____________________________ Relationship:_________________________Phone#:______________________

Name: ____________________________ Relationship:_________________________Phone#:______________________

Name: ____________________________ Relationship:_________________________Phone#:______________________

Were you referred to our practice? Yes: ______ No: ______ If yes, by whom? ______________________________

If No, how did you hear about our practice? ______________________________

I hereby authorize the office of *Steel City South Pediatrics* to release any medical information required in the course of examination and treatment, and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but not limited to co-insurance, co-payment, deductible, and non-covered service.

Date: ________________________________ Signature: ____

Revised 7/21/2017

Steel City South Pediatrics,Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

Steel City South Pediatrics has a Notice of Privacy Practices which describes how we may use and disclose your protected health care information (PHI) or your child's PHI, and how you can access PHI and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: **STEEL CITY SOUTH PEDIATRICS, INC.**
3911 Saw Mill Run Blvd.
Pittsburgh, PA - 15227

Telephone: (412) 885-2000
Fax: (412) 885-5641

Acknowledgement of Receipt

I acknowledge that I have received the Notice of Privacy Practices for Steel City South Pediatrics.

____
Name of Patient

______________________________ ______________________
Signature of Patient (or personal representative) Date

Personal Representative Name and Relationship:______________________________

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above named patient/personal representative with the Notice of Privacy Practices.

Describe how the notice was provided:

- □ Offered copy and individual refused to accept delivery
- □ Offered copy and individual accepted delivery
- □ Other:______________________________

Describe efforts to obtain signature on acknowledgement of notice form:

- □ Patient/personal representative was asked to sign form and refused
- □ Other:______________________________

______________________________ ______________________
Signature of staff member Date

Authorization of Release Patient Health Information to SCSP

Release of Information to: Steel City South Pediatrics
3911 Saw Mill Run Blvd
Pittsburgh, PA 15227
412-885-2000 (phone) 412-885-5641 (Fax)

Individual Name: ______________________________ D.O.B________________________
(Please Print)

Attending Physician/Facility: ____

(All of the information below must be completed)

1. I authorize the use and/or release of the above named individual's health information as specified in number "3" for the reason listed below. If applicable the time period of information to be released.

____

____

2. I authorize the following individual and/or organization to use and/or release the information

Steel City South Pediatrics Inc.

3. I authorize the following types and dates of health information to be used and/or released. (Cross out and initial below any information you do not want released
   a. Entire Medical Record
   b. Allergy list
   c. Discharge Summary
   d. History and Physical
   e. Immunization record
   f. Laboratory test results
   g. Medication List
   h. Problem list
   i. Referral and consultation notes (May list specific doctor)
   j. X-ray results
   k. Other:_________
4. Information on sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency , behavioral or mental health services, and treatment for alcohol or drug abuse can be in medical records. This information may be released to the following individual(s) or organization:______________________ For the purpose of ___________________________
5. I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present that request to the Privacy Officer or the Administrator of my facility who will deliver it the Privacy Officer. I understand that the revocation will not apply to the information that has already been released or to the information that is required by law by my insurance company. This revocation will expire in 6 months from the date or earlier as I have specified here: Month: Day: Year:
6. I understand that authorizing the disclosure or this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may see of copy the information to be used or disclosed. I understand that once my information is disclosed it may not be protected by the same high confidentiality standards as required by HIPAA and enforced by this facility. I understand that any question that I have concerning this can be answered by calling this facility's Privacy Officer

________________________________ ________________
Signature of Individual or Legal Proxy Date

________________________________ ________________
Proxy Relationship to Individual Date