Kids First Pediatric Clinic, LLC
18676 Willamette Dr. Suite 300, West Linn, OR 97068
Phone: (503) 699-3313 Fax: (503) 699 – 3365
www.kidsfirstclinic.com

Registration Form

Today's date: _____

1. Patient Name_____ Date of Birth_____ Gender_____
2. Patient Name_____ Date of Birth_____ Gender_____
3. Patient Name_____ Date of Birth_____ Gender_____
4. Patient Name_____ Date of Birth_____ Gender _____

Address _____
Street City State Zip

Primary Home Phone _____ **Primary E-mail** _____

GIVE BOTH PARENTS INFORMATION

Parent Name _____ Other Parent Name _____

Soc Sec # _____ Soc Sec # _____

Date of Birth _____ Date of Birth _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Cell Phone Number _____ Cell Phone _____

Email Address _____ Email Address _____

Please provide the name of the person we will need to contact for the following: _____

Medical Issues, Reminders, and General Notices (Please circle only one)

Patient Email:_____Home PH:_____Work PH_____:

Please Circle one of the following:

Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino ☐ Not Specified

Preferred Language: _____

Race(s): American Indian or Alaska Native/ Asian, Black or African American/ Native Hawaiian or Pacific Islander/ White/ not specified

How did you hear about our office? _____

X _____ Initials

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Registration Form Continued…..

Insurance Information

Subscriber Name _____ Date of Birth _____ Gender _____

Address: _____

Primary Insurance _____ Effective Date _____

Ins. Identification _____ Group Number _____

Guarantor Name (if different from Subscriber _____ Date of Birth _____

Address _____

Secondary Insurance _____ Effective Date _____

Insurance Identification _____ Group Number _____

Guarantor Name (if different from Subscriber) _____ Date of Birth _____

Address _____

Do you have Active/ Pending OHP Insurance ☐ Y ☐ N

Child # 1 **□ Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

Child # 2 **□ Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

_____

Child # 3 **□ Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

Child # 4 **□ Check here if the insurance ID is the same as Card Holders**

Patients Name _____ Date of Birth _____

Relationship to child _____

I verify that this information is correct and up to date. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.

Responsible Party (print name) _____ Relationship to Child _____

Signature _____ Date _____

X _____ Initials

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Welcome to Kids First Pediatric Clinic

Office Policies

We are so happy that you have chosen to make us your child's medical home. We strive to create an atmosphere that is friendly and warm for our patients and look forward to taking care of your children for years to come. We hope the following information is helpful in informing everyone to our office policies and provides a more pleasant environment.

Appointment Policy

Sick and Well Waiting:
We have provided sick and well waiting areas for your convenience. If you come to the office with more than one child and one of your children is sick, then you must report to the sick waiting room. Children who are newborns and children here for a well exam, recheck, or follow up exam from a previous illness but are feeling much better should report to the well waiting room.

Sick Appointments:
We strive to accommodate sick appointments as same day appointments.

Well Child Appointments:
We follow American Academy of Pediatrics schedule of well child and teen check up visits. Please schedule your child visit 6-8 weeks in advance. This assures that your child will have their well visit and immunizations on time.

Cancellations:
If you should need to cancel a scheduled wellness or sick visit, please notify our office 24 hours in advance so that we may accommodate families who are on a waiting list for an earlier appointment.

No-Shows:
There may be a $25.00 no show fee to your account for every no-show appointment. Our office policy states that 3 or more no-shows are grounds for dismissal from the practice. This is not to be uncaring; it is an effort to continue consistent care to your child and prompt care throughout the day for other children.

Late for Schedule Appointments:
If you are going to be more than 15 minutes late, please call our office so we can reschedule your appointment for a more convenient time. If your child is sick, you may wait in the office and be worked in between patients. Please note there may be an extended wait time if you are late for your appointment.

After Hours Calls:
Dr. Jabbour is available to her patients 7 days a week for emergencies. For routine questions please call during office hours.

Release of Medical Records:
Medical records may be transferred to another physician at no charge for the first time. Each additional copy of records will be available for $25.00 charge for the first 30 pages, $0.25 for any additional page. Our office has 30 business days to release your child's medical records.

Shot Records/School Forms:
Immunization records will be released within 2-3 business days after request. Please allow 3-5 business days for your school, camp, and sports physical forms.

Medication Refills:
Please allow our office 72 hours for prescription refills. Medication refills will only be done during our normal business hours. For new prescriptions, the patient must be seen prior to any new prescriptions.

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Financial Obligation

Payments are due at the time of service.

For Billing Questions please call: (503) 810 - 8166

This office is contracted with many different insurance plans. All patients are expected to provide our office with current insurance information and to understand their benefits. For the convenience of our patients, our providers participate in a variety of managed care plans. Our office also acts as an advocate for our patients with their managed care plans. This may include completing pre-certifications, eligibility verification, or other similar paperwork on behalf of the patient. Ultimately, the patient is responsible for understanding their benefits and providing our office with current information so that we can handle this paperwork on their behalf in a timely manner.

Patient Financial Responsibilities

- The patient's guardian is ultimately responsible for the payment for the patient's treatment and care.
- Patients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash and most major credit cards at our office.
- Primary Care Physician: If you are required by your insurance company to select a primary care physician, this must be done prior to your child's appointment.
- Our mission as a practice is to provide for the health and well-being of our patients. Your health insurance is a contract between you and your health insurance company. You are financially responsible for any non-covered services.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payments from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that as part of my healthcare, Kids First Pediatric Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. By signing our Consent Acknowledgement Form, you acknowledge you agree and fully understand the Health Insurance Portability & Accountability Act.

X _____ Initials

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Consent Acknowledgement

1. Patient Name_____Date of Birth_____Gender_____

2. Patient Name_____Date of Birth_____Gender_____

3. Patient Name_____Date of Birth_____Gender_____

4. Patient Name_____Date of Birth_____Gender_____

1. **HIPAA (Health Insurance Portability and Accountability Act)** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Notice of Privacy. I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to Kids First Pediatric Clinic requested restrictions, but if parents agree, then parent is bound to abide by such restrictions.

   Parent/ Guardian Initials _____

2. Financial Obligation Policy. I understand that I am responsible for the charges accrued by my child/children regardless of insurance benefits. If in using the information I have provided today or on previous occasions, Kids First Pediatric Clinic is unable to collect from my child's insurance company, I accept full responsibility for the payment of child's bills.
   Parent/ Guardian Initials _____

3. **Appointment Policy/ Office Policies:** I hereby acknowledge that I have been presented with a copy of Kids First Pediatric Clinic Office/Appointment policies handout and understand my responsibilities. I have read and understand them.
   Parent/ Guardian Initials _____

The office policies and protocols will be updated periodically as the practice grows, and changes will be made accordingly.

I acknowledge that I have read this document in its entirety and fully understand it and will comply with all of Kids First Pediatric Clinic policies and protocols. I also acknowledge I have been given copies of all the policies mentioned above, and I was given the opportunity to ask any questions.

Today's Date: _____

Print Parent/Guarantor name:_____Signature: _____

X _____ Initials