Patient Registration
Gettysburg Pediatrics
11 Hunters Trail • Gettysburg, PA • 17325

Patient's Information (Please complete for all children less than 18 years old)

Child 1 Name: ____ Date of Birth ______/______/______
First Middle Last

Address: ____

Gender: Male / Female / Transgender / Non-binary or Non-conforming / Prefer not to respond
Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Race: American Indian or Alaska Native / Asian / Black / Native Hawaiian or Pacific Islander / White

Child 2 Name: ____ Date of Birth ______/______/______
First Middle Last

Address: ____
(If different than above)

Gender: Male / Female / Transgender / Non-binary or Non-conforming / Prefer not to respond
Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Race: American Indian or Alaska Native / Asian / Black / Native Hawaiian or Pacific Islander / White

Child 3 Name: ____ Date of Birth ______/______/______
First Middle Last

Address: ____
(If different than above)

Gender: Male / Female / Transgender / Non-binary or Non-conforming / Prefer not to respond
Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Race: American Indian or Alaska Native / Asian / Black / Native Hawaiian or Pacific Islander / White

Parent/Legal Guardian's Information (Complete this section for a patient less than 18 years old)

Mother's Name: ____ Date of Birth_____/_____/_____
First Middle Last
Social Security Number ______-____-______ Phone ______-______-__________

Father's Name: ____ Date of Birth_____/_____/_____
First Middle Last
Social Security Number ______-____-______ Phone ______-______-__________

Is there a legal child custody agreement? Yes____ No ____

If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes____ No____

Please provide proof of parental custody orders or other legal agreements

How would you ideally prefer to be contacted: Patient portal _____ Phone_____

Emergency Contacts (Other than parents)

Name 1:___________________________________Relationship___________Phone number ______________
First Middle Last

Name 2:___________________________________Relationship___________Phone number ______________
First Middle Last

Person Responsible for Payment

Whom should receive billing statements? Mother _____ Father _____

Form Completed By:

____ ________________________
Parent/Guardian Signature Date

Gettysburg Pediatrics' Provider-Patient Agreement:

Patient Name: ___________________________ DOB: ________________

Our mission at Gettysburg Pediatrics is to provide our patients with the very best care in and around Adams County. We pledge to work with our patients and their family to achieve this goal. To meet our mission, we ask that our patients/family members attest to this agreement.

Code of Conduct:
The providers and staff at Gettysburg Pediatrics pledge to always treat our patients and family members with respect. We also ask our patients and their family members to treat us in a similar manner. This includes speaking kindly to our staff without threats or gestures, abstaining from vulgarities, stealing, or damaging items within the office. Failure to comply with this pledge by any member of your family will force our providers to ask you to seek care for your children at a different office.

Initial_______

No-Show Policy:
The providers and staff at Gettysburg Pediatrics pledge to do our very best to see every child that needs care. To accomplish that goal, it is vital that our patients keep every appointment that they make, for a missed appointment is a missed opportunity for us to provide care to another child. If you are unable to make a scheduled appointment, we respectfully ask that you notify the office 24 hours before the appointment time. If your family accumulates three or more No-Shows without notification, we will be forced to ask you to seek care for your children at a different office.

Initial_______

Vaccination Agreement:
Gettysburg Pediatrics believes immunizations are a vital part of keeping our children and our community healthy. We believe it is in the best interest of all our patients to be fully vaccinated according to the recommendations of the American Academy of Pediatrics. Therefore, Gettysburg Pediatrics can no longer accept patients that do not plan to be fully vaccinated by two years of age. This includes both newborns and new patients from other practices. However, this policy does not include the influenza or COVID vaccines, though both are still recommended by the office.

Initial_______

Signature of Parent/Guardian____________________________________Date______________

DELEGATED CONSENT FOR TREATMENT

Patient's Name: ____ Date of Birth _____ /_____ /_____
(First) (Middle) (Last)

Parent/Legal Guardian's Name_______________________________________
(First) (Middle) (Last)

If I can't bring my child to a medical appointment, I give permission for the person(s) listed below to accompany my child to visits at Gettysburg Pediatrics. He/she can also consent to the examination and/or treatment of my child, including testings, immunizations, and procedures.

Name: _____________________________________ Relationship to Patient:_________________

Name: _____________________________________ Relationship to Patient:_________________

This authorization is in effect until the minor reaches 18 years of age or until revoked in writing to Gettysburg Pediatrics.

______________________________________ ____________________________________
SIGNATURE OF PARENT/GUARDIAN DATE

_______________________________________ ____________________________________
SIGNATURE OF WITNESS DATE

AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
(MUST BE COMPLETED FOR INSURANCE BILLING PURPOSES)

Patient's Name: ____ Date of Birth _____ /_____ /_____
(First) (Middle) (Last)

Parent/Legal Guardian's Name_______________________________________

I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in the place of the original.

I also request that payment from my insurance company be made directly to Gettysburg Pediatrics. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or my insurance company at any time.

Parent/Guardian Signature: _____________________________ Date: _____________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Patient's Name: ____ Date of Birth _____ /_____ /_____
(First) (Middle) (Last)

Parent/Legal Guardian's Name____

I hereby give my consent for Gettysburg Pediatrics to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Gettysburg Pediatrics describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gettysburg Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the safety office at:

Gettysburg Pediatrics
11 Hunter's Trail
Gettysburg, PA 17325

With this consent, Gettysburg Pediatrics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Gettysburg Pediatrics may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

By signing this form, I am:

1. Consenting to allow Gettysburg Pediatrics to use and disclose my PHI to carry out TPO.
2. Acknowledging that I received and/or reviewed the Notice of Privacy Practices for Gettysburg Pediatrics.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Gettysburg Pediatrics may decline to provide treatment to me.

Parent/Guardian Signature: ______________________________ Date: ______________________