GRANGER MEDICAL CLINIC

GRANGER MEDICAL
REGISTRATION FORM FOR MINOR CHILDREN

FAMILY INFORMATION* (FOR ALL PATIENTS) - *Please Use Full LEGAL Names* DATE:

Legal Guardian 1: ____________________ Date of Birth: ____________ Social Security #: __________

Gender: ❑ Male ❑ Female Relationship To Child(ren): ❑ Parent ❑ Step-parent ❑ Grandparent ❑ Other: ____________

Mailing Address: ____________ City ____________ State_____ Zip ________ Employer: ____________

Phone (primary): ____________ Phone (alternate): ____________ Email: ____________

Preferred Language: ____________ Do you require an interpreter? ❑ Yes ❑ No

Legal Guardian 2: ____________________ Date of Birth: ____________ Social Security #: __________

Gender: ❑ Male ❑ Female Relationship To Child(ren): ❑ Parent ❑ Step-parent ❑ Grandparent ❑ Other: ____________

Mailing Address: ____________ City ____________ State_____ Zip ________ Employer: ____________

Phone (primary): ____________ Phone (alternate): ____________ Email: ____________

Preferred Language: ____________ Do you require an interpreter? ❑ Yes ❑ No

***Please note that the information provided in this section will be used to contact you regarding appointment reminders, account balances, and any other medical or billing issues regarding your account. Calls to the number(s) provided may be made via pre-recorded messages.**

CHILDREN INFORMATION (We participate in several state and federal programs that require data on race and ethnicity.)

IF 18 OR OLDER, SKIP THIS SECTION AND FILL OUT "PATIENTS 18 OR OLDER" SECTION BELOW.

Child's Legal Name: ____________________ Date of Birth: ____________ Goes by: ____________
Sex: ❑ Male ❑ Female **Race**: ❑ Am. Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ White ❑ Other: ________

Child's Legal Name: ____________________ Date of Birth: ____________ Goes by: ____________
Sex: ❑ Male ❑ Female **Race**: ❑ Am. Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ White ❑ Other: ________

Child's Legal Name: ____________________ Date of Birth: ____________ Goes by: ____________
Sex: ❑ Male ❑ Female **Race**: ❑ Am. Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ White ❑ Other: ________

Child's Legal Name: ____________________ Date of Birth: ____________ Goes by: ____________
Sex: ❑ Male ❑ Female **Race**: ❑ Am. Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ White ❑ Other: ________

Child's Legal Name: ____________________ Date of Birth: ____________ Goes by: ____________
Sex: ❑ Male ❑ Female **Race**: ❑ Am. Indian ❑ Asian ❑ Black or African American ❑ Hispanic ❑ White ❑ Other: ________

PATIENTS 18 OR OLDER ONLY* (THIS SECTION TO BE COMPLETED BY PATIENTS 18 YEARS OR OLDER) DATE: ____________

Full Name: ____________________ Goes by: ____________ Date of Birth: ________ Sex: M F

Social Security # ____________ Race: ________ Preferred Language: ____________ Do you require an interpreter? Yes No

Mailing Address: ____________ City ____________ State_____ Zip ________ Employer:

Phone (primary): ____________ Phone (alternate): ____________ Email:

Marital Status: Married Single Other

***Please note that the information provided in this section will be used to contact you regarding appointment reminders, account balances, and any other medical or billing issues regarding your account. Calls to the number(s) provided may be made via pre-recorded messages.**

PERSON RESPONSIBLE FOR INSURANCE (PRIMARY)

Name of Primary Insurance:

Policy Holder:

Home Address:

City: State: Zip:

Phone:

DOB: Relationship to patient:

PERSON RESPONSIBLE FOR INSURANCE (SECONDARY)

Name of Secondary Insurance:

Policy Holder:

Home Address:

City: State: Zip:

Phone:

DOB: Relationship to patient:

EMERGENCY CONTACT (This person should live in the same state, but not in the same household)

Name: ____________________ Phone: ____________ Relationship: ____________

Name: ____________________ Phone: ____________ Relationship: ____________

(CONTINUED ON BACK)

GRANGER
MEDICAL CLINIC

PHARMACY INFORMATION

Name of Preferred Pharmacy: _____ Location:_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Granger Medical's NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my or my child(ren)'s Protected Health Information (PHI) may be used.

I understand that no authorization is required from me in order for Granger Medical to use my or my child(ren)'s PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

Patient (If 18 years or older) / Legal Guardian Signature:_____**Date**:_____

NOTIFICATION OF APPOINTMENTS/TREATMENT

Granger Medical makes every effort to use your preferred method of communication for appointment/treatment reminders and/or any other issues regarding your account with us. Contact with you may be made using the information you have provided, and may consist of text messages, voicemail, e-mail, letters, etc. If you choose not to be contacted via one of the methods listed above you must notify Granger Medical in writing. Every effort will be made to respect your request.

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

In my absence, I authorize Granger Medical to release all or portions of my, or my dependents, medical record(s) to those as indicated below (i.e. lab results, prescriptions, etc.). This authorization is in effect until I revoke it in writing. (Please consider others who may bring your children in for care, or your parents, if you are 18 or older). **Please consider Schools and/or Daycare Providers**

Name: _____ Name: _____

Name: _____ Name: _____

Patient (If 18 years or older) / Legal Guardian Signature: _____ **Date**:

CONSENT FOR TREATMENT

I hereby consent to medical treatment, diagnostic tests, laboratory or other procedures, which the physician(s) or other health care provider(s) of Granger Medical may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient (If 18 years or older) / Legal Guardian Signature: _____**Date**:_____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I agree to be financially responsible for costs incurred in my, or my dependent's care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by Granger Medical on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to Granger Medical (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.
A finance charge (1.5% per month/APR 18%) will be added to any amount for which payment has not been received within **30 days** from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $15.00 for each check or other instrument tendered by me but returned to this facility. In the event any amounts are referred to a third party debt collection agency, I agree that in addition to any other amounts allowed by law (interest, court costs, attorney's fees, etc.) I will also be responsible for a collection fee of up to 30% of the principle amount owing as allowed by Utah Code Annotated section 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Granger Medical's financial policy and agree to pay for said medical services according to such terms.

Patient (If 18 years or older) / Legal Guardian Signature:_____ **Date**:_____

AUTHORIZATION TO TREAT IN ABSENCE OF PARENT OR GUARDIAN (OPTIONAL)

If my child(ren) is/are brought to the office by _____, I consent for my children to be treated and agree to be financially responsible for the cost of such care.

I UNDERSTAND THAT BY NOT SIGNING THIS SECTION MY CHILD(REN) CANNOT BE SEEN AT GRANGER MEDICAL WITHOUT MYSELF OR ANOTHER LEGAL GUARDIAN PRESENT.

Legal Guardian Signature: _____ **Date**:_____

OFFICE USE ONLY:

Verify ID _____ Type: _____ (Driver's License, Passport, etc.)

Employee Signature:_____ Date: _____