

**Children's Heart Center of Central Oregon
Patient Registration**

Patient information

Name: LAST _____ FIRST _____ MIDDLE _____
DOB: _____ Gender: Male Female Other
Pronoun: he/him she/her they/them other, please specify: _____
Patient address: _____
Cell phone (if applicable): _____

Parents/Guardians

- 1) Name: LAST _____ FIRST _____
Relationship: mother father other (please specify _____)
Cell phone: _____ Other phone: _____
Address (if different from above): _____
Email: _____
 Primary contact (the person we should contact with appointment confirmations, test results, etc.)
- 2) Name: LAST _____ FIRST _____
Relationship: mother father other (please specify _____)
Cell phone: _____ Other phone: _____
Address (if different from above): _____
Email: _____
 Primary contact (the person we should contact with appointment confirmations, test results, etc.)
- 3) Name: LAST _____ FIRST _____
Relationship: mother father other (please specify _____)
Address (if different from above): _____
Email: _____
Cell phone: _____ Other phone: _____
 Primary contact (the person we should contact with appointment confirmations, test results, etc.)
- 4) Name: LAST _____ FIRST _____
Relationship: mother father other (please specify _____)
Address (if different from above): _____
Email: _____
Cell phone: _____ Other phone: _____
 Primary contact (the person we should contact with appointment confirmations, test results, etc.)

For primary contact:

If we are unable to reach you by cell phone, please select all that apply:

- We may text you
- We may send an email to you
- We may leave a message on your answering machine at home
- We may leave a message with another parent/guardian

Responsible Party

Name: LAST _____ FIRST _____
DOB: _____ Gender: Male Female Other
If not listed above:
Address: _____
Cell phone: _____ Other phone: _____

Insurance Information

Insurance	ID Number	Subscriber Name	Subscriber DOB
Primary			
Secondary			

Emergency Contact, if not listed above:

Name: LAST _____ FIRST _____

Relationship: _____

Address: _____

Cell phone: _____ Other phone: _____

Any individuals not listed above who are permitted to seek medical care for my child:

Name	Relationship to child

FINANCIAL AGREEMENT

I, the undersigned,

do not have insurance coverage

have insurance coverage and authorize direct payment to the Children’s Heart Center of Central Oregon

I acknowledge that I will be financially responsible for all charges, whether or not paid by insurance. **A 10% annual charge will be assessed for invoices not paid within 30 days.** Invoices not paid within 90 days may be sent to collections. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. In addition, I authorize CHCCO to release information, as necessary, in order to facilitate treatment, payment, or other healthcare operations.

I understand that a fee of \$100 will be charged for missed appointments (“no shows”) and appointments that are not cancelled within a 24-hour advance notice.

Signature: _____ Date: _____

Print Name: _____

Patient Name: _____ DOB: _____



MISSED APPOINTMENT (NO-SHOW) POLICY

Patient Name: _____ DOB: _____

Please **read carefully**, and **initial** below:

At CHCCO, our goal is to provide excellent service in a timely manner, and we need your help.

Canceled appointments, missed appointments, and arriving late for an appointment all affect our ability to stay open, on schedule, give timely appointments to patients who need them, and provide an excellent level of care. We make an effort to be accommodating in our scheduling, so that the needs of our patients can be met. Although we have always asked our patients and their families to notify us if they will be unable to make their appointment, circumstances have made it necessary for us to implement a Missed Appointment Policy. We want to make certain that appointments are kept available for those patients who need and desire them.

_____(initial) If I am unable to come to my appointment, I will notify CHCCO as soon as possible, and no later than **24 hours** before the appointment.

_____(initial) If I don't show for an appointment, or if I reschedule within 24 hours of my appointment, I will be charged a fee of \$100, and this will not be covered by my health insurance plan.

_____(initial) If I am more than 15 minutes late for an appointment, the appointment may need to be rescheduled.

_____(initial) Patients with multiple no-shows will not be rescheduled, so that appointment times can be made available to those who need and desire them.

I, (print) _____ (patient or responsible party),
acknowledge that I have read and understand the statements above, and that I am responsible for charges to my account.

Signature

Date

Children's Heart Center of Central Oregon

HIPAA ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____

The Privacy Act of the Health Information Portability and Accountability Act (HIPAA) of 1996 was placed into effect to protect your Personal Health Information (PHI) from being disclosed to unauthorized persons.

The HIPAA Notice available on our website (hard copies available at our clinic location) is our privacy policy, and explains how your PHI may be used or disclosed as well as your rights for access and control of your PHI. This Notice is effective going forward. A new acknowledgement form will be reissued if there are significant changes to this policy.

Please sign this form to acknowledge that you have received and read a copy of our privacy policy, or that you have declined to read a copy. If you have any questions regarding the privacy policy, please ask a member of our staff.

Form completed by (print) _____ for the above patient.

Signature: _____ Date: _____