RIVERVIEW PLAZA 33 S. DELAWARE AVE., SUITE 103, YARDLEY, PA 19067
PHONE: 215.321.3600 / FAX: 215.321.3657 / www.arrowfamily.com

PEDIATRIC REGISTRATION/CONSENT FORM

First Name: ________________________ Middle Initial: _______ Last Name: ________________________________

Date of Birth: _____________________ Age: __________ Sex: M F SSN#: ______________________________

Race: White Hispanic Other_________________________________ Hispanic/Latino: Yes No

Address: ____

____

Home Phone:_________________________________ Contact Email: _____________________________________

Mother's Name:_____________________________________ Mother's Cell: ________________________________

Father's Name:_____________________________________ Father's Cell: _________________________________

INSURANCE INFORMATION

Do you have an HMO: Yes No If yes, have you made Dr. Robin Hurst your primary care physician? Yes No

Primary Insurance: __________________________________ Insurance ID #: ________________________________

Group # ____ Copay Amount: ________________________________

Subscriber: ____

Subscriber's Date of Birth : _____________________________ Subscriber's SS#: _____________________________

Patient's relationship to subscriber: Self _____ Dependant _____

Secondary Insurance (if applicable): _______________________________ *Insurance ID #:* _____________________

AUTHORIZATION TO RELEASE INFORMATION:

I / We authorize Arrow Family Medicine, PC to release any medical or incidence information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT:

I / We hereby authorize Arrow Family Medicine, PC to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT:

I / We understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature: ____
(SIGN HERE)

THIS IS TO CERTIFY THAT I UNDERSTAND THE HIPAA REGULATIONS:

In general the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Please check all that apply):

Home Phone Answering Machine: Yes No

Cell Phone: Yes No Cell # ____________________________________

Spouse Notification: Yes No Name: ____________________________________

Other (Please be specific) ____

Emergency Contact: Name/Phone # ____

Relationship ____

Signature: ____
(SIGN HERE)