UCSF Benioff Children's Physicians

Pediatric Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	**Email Address:**
What is the family's preferred language?	**Would you like an interpreter**? ☐ Yes ☐ No
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	Is the **patient** employed? ☐ Yes ☐ No If yes**, Employer Name**:
Name of Pediatrician:	**Employment Status:** ☐ Full Time ☐ Part Time

Patient Contacts	
In **case of an emergency**, please provide the **names of individuals** (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? ☐ Yes ☐ No	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Aunt/Uncle ☐ Grandparent ☐ Other Relative ☐ Neighbor ☐ Caregiver

UCSF Benioff Children's Physicians

Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Someone Else

If 'Someone Else' please provide their **name and address**:

Guarantor's Sex:	**SSN:**	**DOB:**

Relationship to Patient: ☐ Parent/Legal Guardian ☐ Foster Parent ☐ Grandparent ☐ Other Relative

Email Address:

Is this person **currently employed**? ☐ Yes ☐ No

If yes, complete below:

Employer Name:	☐ Full Time ☐ Part Time ☐ Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the secondary plan?

☐ (1) Patient Contact ☐ (2) Patient Contact ☐ Guarantor ☐ Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy and Lab?

Parent/Legal Guardian Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

UCSF Benioff Children's Physicians

Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	

Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**

Today's Date (Date of Authorization):

UCSF Benioff Children's Physicians

Phone Number(s) Authorized for Detailed Messages		
Phone Number	**Type**	**Parent/Legal Guardian**
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2

NOTE: ***Expiration of authorization automatically occurs on the patient's 18th birthday.***

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian **Today's Date**

Signature of Parent/Legal Guardian **Today's Date**

Signature of Witness (required if patient/parent/legal guardian unable to sign) **Today's Date**

Relationship to Patient

UCSF Benioff Children's Physicians

We Ask Because We Care

Please complete this questionnaire. We use this information to review the treatment patients receive and to ensure that everyone gets the highest quality of care. Your individual responses are private and will not be shared outside the health care system.

1. Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to answer

2. How would you describe your Race? By race, we mean the major world group or groups from which your ancestors came. *Please check as many categories as you need to describe yourself.*

☐ American Indian/Alaska Native
☐ African American/Black
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ White
☐ Decline to Answer
☐ Other_____

3. How would you describe your Ethnicity? By ethnicity, we mean the group or groups with whom you share your cultural identity or customs. *Please check as many categories as you need to describe yourself.*

☐ African
☐ African American/Black
☐ Alaska Native
☐ American Indian
☐ Arab/North African
☐ Asian Indian
☐ Cambodian
☐ First Nation (Canada)
☐ Caribbean/West Indian
☐ Central American
☐ Chinese
☐ European/European Descent
☐ Filipino
☐ Guamanian
☐ Hmong
☐ Indigena - Maya
☐ Japanese
☐ Korean
☐ Laotian
☐ Mexican
☐ Middle Eastern
☐ Mongolian
☐ Native Hawaiian
☐ Pacific Islander
☐ Russian
☐ Samoan/American Samoan
☐ South American
☐ Thai
☐ Tibetan
☐ Tongan
☐ Vietnamese

☐ Decline to Answer ☐ Other_____

4. In which state and/or country were you born?_____

Please hand this form back to the front desk staff when completed. Thank you.

UCSF Benioff Children's Physicians

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.UBCP.org.

Printed Patient Name | Date of Birth (DOB)

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

Relationship to Patient

Signature of Patient or Parent/Legal Guardian | Today's Date (Date Noticed Received)

UCSF Benioff Children's Physicians

Terms and Conditions of Registration, Medical Services and Financial Agreement

1. UCSF Benioff Children's Physicians (UBCP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires UBCP to provide the following information to individuals who supply information about themselves. As a patient of UBCP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UBCP is authorized to maintain this information. As required by UBCP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UBCP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see UBCP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, UBCP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UBCP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UBCP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UBCP, including emergency services, at a rate not to exceed UBCP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UBCP by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name	**Today's Date**
Signature of Parent/Legal Guardian or Financial Guarantor	**Today's Date**
Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign)	**Today's Date**
Relationship to Patient	
Signature of Interpreter (if applicable)	**Today's Date**
Language Used	

UCSF Benioff Children's Physicians

Consent to Treatment of a Minor

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an UBCP clinical facility. This authorization is effective from _____ until
(Today's Date)
consent is withdrawn.

Signature of Parent/Legal Guardian **Today's Date**

Other Adult Consent to Treatment (Optional)

I,_____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize _____ to act as my agent to consent to any
(Printed Name Agent/Other Adult)
x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from _____ until consent is
(Today's Date)
withdrawn.

Signature of Parent/Legal Guardian **Today's Date**

UCSF Benioff Children's Physicians

UBCP MyChart Proxy Authorization Form

Authorization for Parent/Legal Guardian to Disclose Health Information & Grant Proxy Access to Patient's (Age 0 - 11 Yrs Old) UBCP MyChart Account

PATIENT'S NAME:_____ **PATIENT'S DATE OF BIRTH:**_____

PATIENT'S MEDICAL RECORD #:_____ **Last 4 of Patient Social Security #: _ _ _ _**

Important Reminder: UBCP MyChart displays certain health information from medical records, but **it does not display all health information** in your medical records.

Parent/Legal Guardian of Child: This authorization form is used for minors under the age of 12, in which an Attorney for Health Care, Advance Health Care Directive, or legal papers establishing parental or legal guardianship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 12th birthday.

AGREEMENT

The *UCSF Benioff Children's Physicians (UBCP) Terms and Conditions for UBCP MyChart,* and the UBCP MyChart *Proxy/Disclaimer* for access to *My Family's Record* in the UBCP MyChart section control this agreement between the patient's Parent/Legal Guardian and UBCP. Please refer to these documents when you signup online.

YOUR RIGHTS

This Authorization to release health information is voluntary. You may revoke proxy access at any time. For revocation, please contact the patient's practice. The revocation will take effect within two (2) business days upon notification of your request except to the extent UBCP or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, or ended by revocation, authorization for UBCP MyChart proxy access will expire automatically when the patient turns 12 years old. In order for revocation to be effective, it must be executed in writing.

Print Name of Parent/Legal Guardian: _____

If the Parent/Legal Guardian *is* an UBCP patient:

MRN: _ _ _ _ _ _ _ _ _

Last 4 of Social Security #: _ _ _ _

If the Parent/Legal Guardian *is NOT* an UBCP patient:

Full Social Security # : _ _ _ - _ _ - _ _ _ _ (optional)

Sex: Male ☐ Female ☐

Date of Birth:____/____/_____ (parent's date of birth)

Preferred Contact #: _____-_____-_____

Address:_____

Preferred Language:_____

I attest that the above information is true and correct.

Signature of Patient's Parent/Legal Guardian:_____ **Date:**____/____/_____

Practice representative who witnessed this proxy:

_____**(Print Name)**

_____**(Signature)** **Date:**____/____/_____

A copy is as valid as the original.