WASHINGTON
VITAL VISION

PEDIATRIC REGISTRATION FORM

DATE:_____

Minor's Name: _____ Nickname: _____
Last *First* *MI*

Date of Birth: _____ M F Primary Language: _____

Referred by: _____Preferred Pharmacy:_____

Emergency Contact: _____ Relationship: _____
Last *First*
Telephone No.: _____

Parent/Legal Guardian 1:_____Relationship:_____
Last *First* *MI*
Lives with Minor: Y N Social Security #: _____ DOB:_____ E-mail:_____

Home Address: _____
Street *City* *St* *Zip*
Phone Numbers: _____
Home *Cell* *Work* *Other*

Employer: _____Employer Ph #: _____

Parent/Legal Guardian 2:_____Relationship:_____
Last *First* *MI*
Lives with Minor: Y N Social Security #: _____ DOB:_____ E-mail:_____

Home Address: _____
Street *City* *St* *Zip*
Phone Numbers: _____
Home *Cell* *Work* *Other*

Employer: _____Employer Ph #: _____

Parent/Legal Guardian 3:_____Relationship:_____
Last *First* *MI*
Lives with Minor: Y N Social Security #: _____ DOB:_____ E-mail:_____

Home Address: _____
Street *City* *St* *Zip*
Phone Numbers: _____
Home *Cell* *Work* *Other*

Employer: _____Employer Ph #: _____

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Insurance Information:

Primary Insurance Name: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Member ID No.: _____ Group No.: _____

Secondary Insurance Name: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Member ID No.: _____ Group No.: _____

Vision Plan: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Member ID No.: _____ Group No.: _____

If parents are divorced or separated who has custody?_____. Are there legal restrictions preventing custodial parent from consenting to medical treatment for the minor or obtaining minor's medical treatment? **Y** **N**. If yes, please explain and provide a copy of the legal paperwork supporting this restriction: _____

_____

Who should receive billing statements? Choose one only: Parent/Legal Guardian 1 2 3

Any documents to be picked up by non-legal guardians must have written consent.

I realize that I am responsible for payment for all medical services rendered to my dependent, regardless of the decision to reimburse or not reimburse made by my insurance carrier. I also understand that my insurance will be billed as a courtesy to me. It is my responsibility to know my coverage terms, including the need for prior authorization. I hereby assign benefits to which I am entitled for medical and/or surgical expenses relative to the services performed. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked in writing by me.

_____

Signature of parent or legal guardian. *Relationship to Minor* *Date*

If I refuse to sign the above, I understand that my insurance will not be billed and I am prepared to pay, in full, all services rendered to me at the time of service.

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I understand that I may be charged for a **REFRACTION** for my minor child. This is a specialized test that allows the doctor necessary information to properly diagnose visual acuity. At the time of the refraction, the physician may perform a routine refraction or may need, based on the medical condition of my minor, a more complex refraction. This fee will range between $75-$90 dollars. My insurance carrier may deem refractions as a non-covered benefit. This means, I will be responsible for payment in full for refraction services provided. I also understand that refraction payment will be collected at the time of service.

_____

Signature of parent or legal guardian. *Relationship to Minor* *Date*

I am aware of the privacy standards of Washington Vital Vision and my rights and responsibilities as the parent or legal guardian of my minor patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. All exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with Pacific Eye's policy. I am also aware that there are times when Washington Vital Vision will share the medical chart with other physicians who participate in the medical care process. By marking the appropriate box below, I give permission for Washington Vital Vision to share the medical records with others in the medical field to assist in over-all medical care.

☐ **I authorize** the practice to release any or all information concerning medical care to other physicians, insurance carriers, and other medical institutions who collectively care in my minor's healthcare.

☐ **I authorize** the practice to release any or all information concerning medical care to the individual listed above**.**

☐ **I authorize** the practice to release any or all information concerning medical care to the individual(s) listed below**:**

Name: _____ Relationship to Patient: _____

DOB: _____ Phone : _____

Name: _____ Relationship to Patient: _____

DOB: _____ Phone : _____

The above information is true to the best of my knowledge.

_____

Signature of parent or legal guardian. *Relationship to Minor* *Date*