

20380 Town Center Lane Ste 215  
Cupertino, CA 95014  
408.996.7950  
408.996.7997 (fax)



Date: \_\_\_\_\_

## Patient Registration and Consent for Treatment

Patient Information	
Patient Last Name _____	First Name _____ MI _____
Street Address _____	Apt# _____
City _____	State _____ Zip _____
Telephone (Mobile) _____	Telephone (Home) _____
Date of Birth _____	E-mail _____
If parents not married,, Custody status: Joint <input type="checkbox"/> Sole <input type="checkbox"/> Describe: _____	
Parent Information (complete if patient is under 18 or on parent's insurance or parents are paying)	
Father's Last Name _____	First Name _____ MI _____
Date of Birth _____	Telephone (Home) _____
Telephone (Work.) _____	Telephone (Mobile) _____
Street Address _____	Apt# _____
City _____	State _____ Zip _____
Father's Employer & Address _____	
E-mail _____	
Mother's Last Name _____	First Name _____ MI _____
Date of Birth _____	Telephone (Home) _____
Telephone (Work.) _____	Telephone (Mobile) _____
Street Address _____	Apt# _____
City _____	State _____ Zip _____
Mother's Employer & Address _____	
E-mail _____	
Insurance Information	
Is there more than one insurance through which the patient has coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Insurance Name _____	Insurance Phone _____
Policy ID# _____	Group # _____
Policy Holder _____	Policy Holder DOB _____
Relationship to Patient: _____	SS#(if insurance ID) _____
Employer of Policy Holder _____	
Employers Address: _____	

### Referral Source

How did you hear about the Bay Area Children's Association? \_\_\_\_\_

Primary Care Physician Information		
Doctor's Name _____	Telephone: _____	Fax: _____
Street Address _____		
City _____	State _____	Zip _____

Guarantor Information	
Whether paying via insurance, sliding-scale or out-of-pocket, please enter guarantor information. This is the person who will assume financial responsibility for payments:	
Guarantor Name _____	Phone # _____
Relationship to Patient _____	

Emergency Contact	
Emergency Contact (other than parent): _____	
Relationship to Patient _____	Phone # _____ Phone Type: <input type="checkbox"/> Mobile <input type="checkbox"/> Home

Authorization to Release Medical Information and Assign Benefits
I hereby authorize the release of any medical information necessary to process an insurance claim and in the case of assigned benefits, do hereby authorize payment to be sent directly to the physician.
Signature of Patient (if over 18) or Parent/Guardian _____

Assumption of Financial Responsibility and Consent for Evaluation and Treatment
I understand that I (unless a different person is specified as the guarantor above) am financially responsible to BACA for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom the Bay Area Children's Association has a participating contract, or unless arrangements for monthly billing have been established. I also understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. In the event collections proceedings are instituted to enforce payment of fees due to the Bay Area Children's Association, I, the undersigned agree to pay the additional sum of twenty-five percent (25%) of the principal due as attorney fees, plus all associated court fees.
I give consent for the Bay Area Children's Association to conduct an evaluation and make treatment recommendations for myself or my dependent. I understand that before treatment commences there will be a thorough discussion of all treatment options, and that it is my decision as to whether or not I want to proceed with treatment.
Signature of Patient (if over 18) or Parent/Guardian _____
Signature of Second Parent/Guardian (in cases of joint legal custody) _____

Receipt of Office Policies
I have reviewed a copy of the Bay Area Children's Association Office Policies including the policy for Cancellations, Confidentiality, HIPAA rules, Patient Rights, Phone-Calls, E-mails, Emergencies, and Discontinuation of Treatment. I understand that these policies are posted on the website ( <a href="http://www.bayareachild.org">www.bayareachild.org</a> ) and can be modified at any time.
Signature of Patient (if over 18) or Parent/Guardian _____

**IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE IMMEDIATELY OF ANY CHANGES TO THE ABOVE INFORMATION**