Pediatric New Patient Registration Form

Date: ____________________

Patient's Name: ______________________________ DOB: __________________ Male Female

Home Address: ______________________________ City: __________________ State: ____ Zip: __________

(For parents, use sections below)

Home Telephone #: ___________________________ Mobile #: _______________ Work #: ________________

E-mail: ____

Employer: __________________________________ Occupation: ____________________________________

Insurance Company: ____

Claim Mailing Address: ____

Insured Name: ______________________________ Relation to Patient: _____________________________

Insurance ID #: _____________________________ Group #: ____

Parent's Name: ______________________________ DOB: __________________ Male Female

(Complete the following if different from patient's information)

Home Address: ______________________________ City: __________________ State: ____ Zip: __________

Home Telephone #: ___________________________ Mobile #: _______________ Work #: ________________

E-mail: ____

Employer: __________________________________ Occupation: ____________________________________

Parent's Name: ______________________________ DOB: __________________ Male Female

(Complete the following if different from patient's information)

Home Address: ______________________________ City: __________________ State: ____ Zip: __________

Home Telephone #: ___________________________ Mobile #: _______________ Work #: ________________

E-mail: ____

Employer: __________________________________ Occupation: ____________________________________

Do both parents have legal medical decision making authority? ☐ Yes ☐ No

Are both parents supportive of alternative/integrative medical treatments? ☐ Yes ☐ No

Who has legal custody? ____

Who does the patient live with? ____

Patient's Name: ____

Siblings seen in this office: ____

Who may we thank for your referral? ____

Authorization for Integrative Medical Treatment

I authorize Jenn Gibbons to administer such medical and health care services, treatments and procedures for my child as she deems appropriate and necessary.

I understand that Jenn Gibbons will prescribe an integrative treatment program for my child, which may include acupuncture, traditional Chinese herbal medicine, nutritional therapies, homeopathy, and functional medicine. As a patient or parent seeking integrative medical treatment, I understand that I must decide, in conjunction with my child's practitioner, what course of treatment will best benefit my child. I understand that any or all of the above referenced treatment modalities may be considered unproven or experimental by other doctors, medical agencies, or third party payers and may not be reimbursable.

I understand that the benefits and/or risks and dangers of any treatment program prescribed by my practitioner will be explained to me to my full satisfaction. I understand that if any explanations as to the benefits and/or the risks and dangers of any of the prescribed treatment programs are unclear, it is my responsibility to ask for clarification before giving my consent to treatment. While I understand that there have been no warranties or assurances of successful outcome for my child, I nevertheless desire to pursue integrative medical treatment for my child after having considered all factors, including the information contained herein.

I understand that it is my responsibility to contact Jenn Gibbons to report any issues that my child is having with the treatment program, and to schedule consult time to make program adjustments and to conduct appropriate testing. I am responsible for seeking professional medical attention from Jenn Gibbons or another facility if my child experiences any unanticipated or unpleasant effects associated with treatment or a worsening my child's condition. If an emergency medical condition arises, I will seek treatment for my child immediately from the nearest emergency department or by calling 9-1-1.

Initial **Initial**

Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Additional Caregiver Authorization

I give permission to the following adults to seek medical care for my child when I am not present:

____

____

______ Initial ______ Initial

Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Patient's Name: ____

Authorization for Payment
I hereby authorize Jenn Gibbons to charge my account balance to the credit card indicated below. I authorize this credit card to be used as a guarantee against late cancellations and missed appointments, and for any and all balances including those relating to office visits, telephone, e-mail and portal consultations, missed/late appointments, miscellaneous fees, and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to Jenn Gibbons for the amount due. I understand that I may cancel this authorization in writing at any time.

☐ **Visa** ☐ **MasterCard** ☐ **Discover**

#: ____ **Exp Date**: ___________ **Security Code:** _______

Authorized signature: ____

Cancellation Policy
I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my child's treatment. I understand that the practitioner's time is reserved exclusively for my child's care for the duration of all scheduled visits, and that if I am late for my visit, the visit will end at the scheduled time and I will still be charged for the full visit time. If for some reason I cannot make an appointment, I will call at least **2 business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than 2 business days** prior to the scheduled time, I will be charged a fee that represents 50% of the cost of my scheduled appointment. I further understand that if I cancel **less than 1 business day** before my appointment, or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment.

______ **Initial** ______ **Initial**
Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Telephone and Electronic Communication Policy
I understand that non-urgent calls that occur after hours or on weekends, or telephone calls over 10 minutes that occur at any time, will be billed at the same consultation rate as in-person visits and charged to my credit card on file.

I further understand that e-mails which take over 10 minutes to read and reply will be billed at the in-person consultation rate and charged to my credit card on file. By sending an e-mail, I acknowledge and agree that a prompt reply is NOT required, expected, or contemplated. I acknowledge that I will not use e-mail communications to deal with emergencies or other time-sensitive issues. I understand that e-mail communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that Jenn Gibbons may keep copies of e-mail communications and that such messages may be included in my child's medical record.

Initial **Initial**
Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Patient's Name: ____

Receipt of Jenn Gibbons' Policies and Notice of Privacy Practices

I claim full financial responsibility for all services rendered by Jenn Gibbons. I understand that payment is required in full at the time of service. I understand that fees may change without notice.

I understand that Jenn Gibbons is not contracted with any insurance plans, and that my child's insurance plan may not reimburse for services rendered by Jenn Gibbons, including office visits, telephone and e-mail communications.

I understand that it is my responsibility to know my child's insurance plan benefits. I understand that Jenn Gibbons will file an insurance claim on my child's behalf as a courtesy, but that all pre-authorizations for visits and follow-up for insurance claims is my responsibility.

______ **Initial** ______ **Initial**
Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

Authorization to Release Information to Insurance Carrier
I authorize Jenn Gibbons to submit to my child's insurance carrier any information acquired in the course of my child's examination or treatment which may be required to process my child's claim for payment.

______ **Initial** ______ **Initial**
Please initial here and sign the last page to indicate you have read and accept the terms of this section.
If patient is a minor, both parents and/or all legal guardians must initial and sign.

____	____
Responsible Party's Signature	**Responsible Party's Signature**
Date: ______________________________	**Date:** ______________________________
Relation to Patient: ____________________	**Relation to Patient:** ____________________

If patient is a minor, both parents and/or all legal guardians must sign