Barney Softness, M.D.
Suzanne Rosenfeld, M.D.
Michael Rosenbaum, M.D.
Lisa Thebner, M.D.
Adina Rusakov, M.D.

Patient Registration Form

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name:	**First:**	**Middle:**
Birth date: _____ /_____/_____	**Sex at birth:** **M** / **F** **Gender Identity:** _____	**OB/GYN:** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____ **Home Phone:** ( ) _____ - _____

GUARANTOR INFORMATION

Person Responsible for the Bill:	**Billing Address (if different than above):**
_____ **Birth Date:** / /	_____ **Apt #:** **City:** **State:** **Zip:**

Cell Phone: ( ) _____ - _____ **Work / Home Phone:** ( ) _____ - _____

Email Address: _____ **Relationship:** Mother / Father / Other: _____

OTHER PARENT INFORMATION

Name:	**Home Address (if different than above):**
_____ **Birth Date:** / /	_____ **Apt #:** **City:** **State:** **Zip:**

Cell Phone: ( ) _____ - _____ **Work / Home Phone:** ( ) _____ - _____

Email Address: _____ **Relationship:** Mother / Father / Other: _____

FINANCIAL RESEPONSIBILITY & CLAIMS AUTHORIZATION

"I understand that the practice of West End Pediatrics, P.C. does not accept any form of insurance. Unless I have made prior alternative arrangements, I agree to make direct payment at time of service to the physician(s) of West End Pediatrics, P.C. for service furnished to me, regardless of compensation paid to me or my family by insurance carriers. I understand that all fees related to collection of past due fees for services rendered are also my responsibility."

Guarantor Signature:_____ **Date:** _____

CONSENT TO TREATMENT

"I, _____ give permission for West End Pediatrics to give medical treatment to the above named minor in accordance with New York State provision as deemed necessary by a licensed physican. **This authorization will remain in effect until revoked in writing."**

Signed_____Date_____

Print Name_____

Relationship to minor:
( ) Parent with legal custody
( ) Guardian with legal custody

NOTICE OF PRIVACY PRACTICES

"I have been provided with a copy of the Notice of Privacy Practices of West End Pediatrics and know that I can also access this document online at www.westendpedsnyc.com at any time in the future.

Parent/Guardian Signature:_____ **Date:** _____

PREFERENCE ON USE OF EMAIL

"I understand that patient information shared via email is not secure and that the patient portal can be used to access patient records in a secure and confidential manner. However, I may choose to share &/or request certain patient information via email and understand that using email to share patient information implies my consent to the risks."

Parent/Guardian Signature:_____ **Date:**_____

NOTICE OF CANCELLATIONS & AFTER-HOURS SERVICES

"I understand that additional charges will be incurred for medical services rendered on holidays and outside the working hours of the practice. These after-hour fees will be assessed on office visits, telephone calls and televisits. I also understand that cancellation fees will be assessed for missed appointments and appointments that are cancelled with less than 24 hrs notice."

Parent/Guardian Signature:_____ **Date:** _____

NOTICE OF TEENAGE PRIVACY PRACTICES

"I understand that when my child turns 18 years old, he/she will have the right to determine what information is shared to me/parents/guardians. My child will be able to specify what types of information can be disclosed and I will cooperate with the staff at West End Pediatrics in respecting those instructions."

Parent/Guardian Signature:_____ **Date:** _____