PEDIATRIC ASSOCIATES OF DURANGO

PLEASE PRINT CLEARLY

PRIMARY CONTACT Person for Family (this person will be the preferred contact person for Reminder calls)

Check One ☐ Birth Mother ☐ Step Mother ☐ Adoptive Mother ☐ Foster Mother ☐ Legal Guardian
☐ Birth Father ☐ Step Father ☐ Adoptive Father ☐ Foster Father ☐ Other _____

Name: _____ Date of Birth: ____ / ____ /_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Preferred Language: _____ E-mail:_____ Primary Phone:_____

SECONDARY CONTACT Person for Family

Check One ☐ Birth Mother ☐ Step Mother ☐ Adoptive Mother ☐ Foster Mother ☐ Legal Guardian
☐ Birth Father ☐ Step Father ☐ Adoptive Father ☐ Foster Father ☐ Other _____

Name: _____ Date of Birth: ____ / ____ /_____

Mailing Address:_____City:_____ State:_____ Zip:_____

Preferred Language: _____ E-mail:_____ Primary Phone:_____

Who Has Primary Physical Custody? (if applicable) _____

EMERGENCY CONTACT (in addition to individuals named above)

Name: _____Relationship: _____Phone#:_____

Person Authorized to Bring Patient for Treatment (in addition to individuals named above)

Name: _____Relationship: _____Phone #:_____

Best Phone Number to Call Regarding Patient Care_____ Relationship_____

PREFERRED PHARMACY:_____

List Only Children That the Above Information Applies To

	Patient/First Child	Second Child	Third Child	Fourth Child
First Name				
Last Name				
Sex	____ Female ____Male	____ Female ____Male	____ Female ____Male	____ Female ____Male
Date of Birth	/ / MM DD YYYY	/ / MM DD YYYY	/ / MM DD YYYY	/ / MM DD YYYY
Primary Language				
Ethnicity	____Not Hispanic ____Hispanic ____Refuse to Report	____Not Hispanic ____Hispanic ____Refuse to Report	____Not Hispanic ____Hispanic ____Refuse to Report	____Not Hispanic ____Hispanic ____Refuse to Report
Race	____Native American ____Asian ____Black/African American ____White ____Pacific Islander ____Refuse to Report	____Native American ____Asian ____Black/African American ____White ____Pacific Islander ____Refuse to Report	____Native American ____Asian ____Black/African American ____White ____Pacific Islander ____Refuse to Report	____Native American ____Asian ____Black/African American ____White ____Pacific Islander ____Refuse to Report
Can be seen w/out parent if under 18	_____Yes _____ No	_____Yes _____ No	_____Yes _____ No	_____Yes _____ No

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NOTICE OF PRIVACY AND CONSENT FOR CARE

PRIVACY PRACTICES: Pediatric Associates of Durango maintains a record of the health care services that are provided to our patients. We will share this information, as permitted by law, to provide medical treatment, run our organization, and bill for these services. You have the right to view, obtain a copy, or amend these records, if needed.

Our ***Notice of Privacy Practices*** describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include sending immunization records to our state registry, use of a Health Information Exchange (HIE) with other health care organizations involved in your care, and accessing your prescription history from pharmacy benefits. If you have questions or want to discuss options for decreased information sharing, please contact our Compliance Officer.

CONSENT FOR CARE: I hereby authorize Pediatric Associates of Durango to institute any necessary care in my absence, including hospitalization, for the patients above. Further I support an integrated approach to healthcare and authorize the behavioral health providers to share, review and discuss any information provided during conversations, informal meetings or therapy session with the providers in order that they are able to provide the most comprehensive plan of care.

PLEASE INITIAL THOSE THAT APPLY

Initial _____ I understand that both birth parents have access to full disclosure, even if they are not the custodial parent, and both can authorize care representatives, unless parental rights have been terminated by a court order. I understand that if there are custody orders in place, I must present current copies for my child's file.

Initial _____I authorize the people listed therein to bring my child to any appointments in the event of my absence, and give Pediatric Associates of Durango permission to call and leave a message regarding my child's clinical care, including lab and x-ray results, in my absence.

Initial _____I authorize Pediatric Associates of Durango to access information about medications I / my child/ my children have been prescribed in the past

Initial _____I authorize Pediatric Associates of Durango to fax any forms or immunization records to my child's school upon my request

THE UNDERSIGNED HEREBY CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE STATED CONDITIONS OF CONSENT AND HAS RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR ANY AND ALL PATIENTS LISTED ABOVE

_____

Responsible Party Printed Name

_____ _____

Responsible Signature Date