Kaplan Barron Pediatric Group

a division of ONE Pediatrics

Drs. Roth, Lehocky, Katz, Belza, Abrams, Newstadt, Baum & Slone

3333 Bardstown Road
Louisville, Kentucky 40218

Telephone: (502) 452-6337
FAX: (502) 458-5327

PATIENT REGISTRATION

(Patients 18 years & Older)

Patient's Name: _____ DOB: _____ Gender: M F

Address: _____

Preferred Contact Number: _____ Can we leave a message at this number? Yes No

Alternate Contact Number: _____ Can we leave a message at this number? Yes No

Patient's Email address: _____ Send Patient Portal Invite? Yes No

Health Insurance:

Primary Health Insurance: _____ Effective Date: ____/____/____

Policy Holder's Name: _____ DOB: ____/____/____ SSN: ____-____-____

Home/Mailing Address: _____

Relationship to policy holder (please circle one): Self Parent Other (list) _____

Secondary Health Insurance: _____ Effective Date: ____/____/____

Policy Holder's Name: _____ DOB: ____/____/____ SSN: ____-____-____

Home/Mailing Address: _____

Relationship to policy holder (please circle one): Self Parent Other (list) _____

Emergency Contact Information:

Name: _____. Relationship: _____ Phone Number: _____
Does this person have: __ Full Access __ Billing Info Only or __ No Access to your Medical Records?

Name: _____ Relationship: _____ Phone Number: _____
Does this person have: ____ Full Access ____ Billing Info Only or ____ No Access to your Medical Records?

Policy for Missed Appointments: I have been informed by KBPG, that the office requires a 24 hour notice for all appointment cancellations. I understand that I will be charged $25 (sick visit) - $40 (well visit) per missed appointment depending on the appointment type. Three missed appointments will result in discharge from the practice.

Patient's Signature: _____ **Date:** _____

Consent to Use & Disclose Health Information

Patients 18 years & older

This office is required by Federal Regulations to inform our patients in regards to the use of their health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPPA.

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my health care, KBPG, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures; I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.

I understand that KBPG is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Federal Regulations. I understand that KBPG reserves the right to change their *Notice of Privacy Practices.*

Patient's Name: _____ **DOB:** _____

I consent to the following uses of my medical information: (Please chose 1 option below & initial next to your choice)

_____ I allow the following people complete access to my medical records.

Full Name	Relationship

OR

_____ I allow the following people access to my diagnosis and treatment information *as it appears to any charges I incur at KBPG.*

Full Name	Relationship

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax. **I fully understand and accept the terms of this consent.**

Patient's Signature: _____ **Date:** _____

Declination to Use or Disclose Information

Patients 18 years & older

Patient's Name: _____ **DOB:** _____

I do not wish for any of my medical (medical records, diagnosis, treatment, etc.) or financial information to be discussed with or released to anyone other than myself. I understand that I will be listed as the Responsible Party on my account with KBPG and will be financially responsible for all charges incurred. I also understand that no one will be allowed to schedule appointments or receive medical advice on my behalf.

Financial Guarantee: I guarantee personal payment of any charges I incur for services rendered by KBPG. In case of default of payment in accordance with the policies of KBPG, I agree to pay all costs associated with account collections proceedings, including, but not limited to a collection processing fee of 30% of the balance plus postage cost.

Patient's Signature: _____ Date: _____