ICAN, INC. & Paytons Place, LLC
409 E. Cook Road, Suite 100
Ft. Wayne, IN 46825
260-487-4226
Fax: 260- 490-5433

CHILD PATIENT REGISTRATION FORM

Date_____

Please complete the entire form. Thank you.

Child's name _____Gender_____

Age____ Date of birth _____ Grade _____ School_____

Child's Address_____

City, State, Zip Code_____

Home phone_____ Work phone_____ Cell phone_____ Mother's/ Father's

Referral source_____

Presenting concern(s)_____

Child's general medical condition_____ Physician _____

Current medications (names and dosage) _____

_____

Mother's name _____Father's name_____

Guardian's name_____Who has primary physical custody_____

Marital status of: Mother_____ Father_____

Address of either parent/guardian if different from child_____

_____

Siblings (names and ages) _____

_____

Name of person we may contact in case of an emergency_____

Relationship to child_____ Phone #_____

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

_____
Patient's date of birth

_____
Patient's name

Request that ICAN & Paytons Place handle the confidential health information in the following way: (Please check all the way (s) we may contact you).

_____U.S. Mail _____ Home phone

_____ Business phone _____ Cellular phone

_____ Fax _____Email_____

_____ Other_____

ASSIGNMENT OF BENEFITS AND HEALTH PROFESSIONAL-PATIENT AGREEMENT

I have received/read the Health Profession-Patient Services Agreement and agree to its terms and also I have received the HIPAA information contained therein.

_____
Initial

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered.

_____
Initial

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that if collection proceedings are necessary, I will pay all fees with collecting this bill.

_____
Initial

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. NO-SHOW OR CANCELLATIONS WITHIN 24-HOURS OF APPOINTMENT TIME MAY RESULT IN A SELF-PAY CHARGE AND THREE CONSECUTIVE CANCELLATIONS OR NO-SHOWS MAY RESULT IN TERMINATION OF SERVICES.

_____ _____
Patient's name Patient's date of birth

_____
Signature of parent/legal guardian

_____ _____
Printed name of parent/legal guardian Date

PATIENTS WITH MEDICAID COVERAGE

I request that payment of authorized Medicaid benefits be made to ICAN, INC & Paytons Place, LLC for services provided. I authorize the release of information regarding my treatment to the Health Care Financing Administration for determination of benefits for services provided.

_____

Patient's name

_____ _____

Date Signature of parent/legal guardian

RELEASE OF INFORMATION FOR PHYSICIAN

In order to provide the patient with the most effective care, I authorize an exchange of information for the following purpose(s): clinical evaluation, consultation, and/or coordination of care, between ICAN & Paytons Place and the following organization/person:

Name/Organization _____

Phone # _____ Fax #_____

Street Address_____

City, State, Zip _____

Patient's Name_____

Patient's Date of Birth _____

Street Address_____

City, State, Zip _____

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider at ICAN & Paytons Place has already acted in reliance upon the authorization. I understand that this authorization will expire in 365 days or when the patient turns 18 years old, or whichever comes first.

_____ _____

Signature of Parent/Guardian Witness Signature

_____ _____

Printed Parent/Guardian Witness Name Printed

_____ _____

Relationship to Patient Date Witnessed

_____

Date Signed