Angels Pediatrics, Inc.
Enas F. Attia, M.D.
1515 E. Alluvial Ave., Suite 105
Fresno, CA 93720-3832
Phone: (559) 322-5515 Fax: (559) 322-5915

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle)_____

Address: _____

City_____ State_____ Zip_____

Social Security #: _____-____-_____ Date of Birth: _____ /_____ /_____ Age: _____ Sex of Patient: __ Male __ Female

RESPONSIBLE PARTY INFORMATION

Name: (Last) _____ (First) _____ (Middle)_____

Date of Birth: _____ Social Security #: _____-_____-_____

Address: _____ City: _____State: _____ Zip: _____

Telephone ( ) _____ Cell Phone: ( ) _____

E-Mail:_____Relationship to Patient: _____

Employer Name: _____

Work Phone: ( ) _____Occupation _____

BILLING INFORMATION

Please check one or more, as appropriate:

Bill my insurance company. Please provide card(s) to Patient Service Representative.

I will pay for my services, out-of-pocket.

Primary Insurance: I.D. #_____ Group # _____

Secondary Insurance: I.D. # _____ Group # _____

EMERGENCY NOTIFICATION

Name: (Last)_____ (First) _____ (Middle)_____

Address:_____

City:_____ State_____ Zip:_____

Telephone: ( ) _____ Relationship: _____

SPECIAL NEEDS

Angels Pediatrics, Inc. tries to meet your special needs. Please help us by circling or noting items you would like assistance with:

Sign Language: _____ Translator: _____ Financial: _____ Other:_____

HOW DID YOU HEAR ABOUT US **(Please complete, so we may thank them.)**

[ ] Physician _____ [ ] Friend _____ [ ] Other _____

CONDITIONS OF TREATMENT

NOTICE TO PARENTS OR GUARDIANS – The parent or guardian must accompany a child under the age of 18 years unless the parent or guardian has made prior written arrangements for care in their absence and the provider consents to this arrangement.

CONSENT FOR TREATMENT:
I authorize the employees of Angels Pediatrics, Inc., to render Medical treatment to my child. Further, I realize that among those who provide care to patients at Angels Pediatrics, Inc., are Physicians Nursing, and other healthcare personnel in training who, unless I direct otherwise in writing and may be present during patient care as part of their education.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Angels Pediatrics, Inc., for the purpose of diagnosing or providing treatment to my child, obtaining payment for my health care bills or to conduct health care operations of Angel Pediatrics, Inc. . I consent to the rendering of care by Angel Pediatrics, Inc. staff.

Notice of Privacy Practice: I understand I have a right to review Angel Pediatrics, Inc.'s Notice of Privacy Practices prior to signing this document. Angel Pediatrics, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Angel Pediatrics, Inc. . This Notice of Privacy Practices also describes my rights and Angel Pediatrics, Inc.'s duties with respect to my protected health information.

INSURANCE COVERAGE - I authorize any insurance company to pay benefits directly to Angels Pediatrics, Inc. .

FINANCIAL RESPONSIBILITY - I understand that I am financially responsible for all charges for services rendered by Angels, Inc. . I understand that all co-pays are due at the time of service. I further understand that if my insurance company has not paid within 120 days, I am responsible for the full amount due Angels Pediatrics, Inc. . If it becomes necessary for the account to be transferred to a collection agency for collection, I agree to pay all costs of collection including attorney fees.

I certify:

1. ***That I have read or have had this consent read to me;***
2. ***That I was given an opportunity to ask questions;***
3. ***That all questions were answered to my satisfaction; and,***
4. ***That I understand this consent and accept its terms and conditions.***

Signature of Patient (or Parent/Legal Guardian)	Date
Printed Name of Parent/Legal Guardian	Relationship to Patient
Witness	Date