Registration Form
(Lactation & Feeding Services)

PATIENT LABEL HERE

REGISTRATION: LACTATION & FEEDING SERVICES

Name: ______________________________ DOB: ______/______/______
Last First MI

Birth Gender: ❑ Female ❑ Male | Preferred Pronoun: ❑ she/ her/ hers ❑ he/ him/ his ❑ they/ them/ theirs ❑ Other ____________

Address: ______________________________ SSN: ______________________

City/State/Zip: ______________________________

Primary Phone: (________)______________________ ❑ Cell **OR** ❑ Home

Email: ______________________________

Emergency Contact: ______________________________

Phone: (________)______________________

BILLING & INSURANCE INFORMATION *(check all that apply)*

❑ **No Insurance (Self Pay)**

PRIMARY INSURANCE

❑ Oregon Health Plan/ OHP/Medicaid
❑ Insurance through Employer or Private Policy

Company Name: ______________________________

Policy ID #: ______________________________

Group #: ____________________ Effective Date: __________

Policy Holder: ____________________ DOB: _____/_____/_____

SECONDARY INSURANCE

❑ Oregon Health Plan/ OHP/Medicaid
❑ Insurance through Employer or Private Policy

Company Name: ______________________________

Policy ID #: ______________________________

Group #: ____________________ Effective Date: __________

Policy Holder: ____________________ DOB: _____/_____/_____

PLEASE READ AND SIGN BELOW

Consent for Treatment: My signature below acknowledges that I, the patient or patient's legal representative, voluntarily request the healthcare practitioners and authorized personnel of Clackamas & Oregon Pediatrics to perform reasonable and necessary medical examinations, testing and treatment, including diagnostic and therapeutic procedures for the conditions(s) that bring me to seek care at this practice. I agree to permit laboratory tests, photographs for treatment and/or reporting purposes, routine medical treatment (such as medications, injections, immunizations & blood draws) and emergency procedures as necessary. Except in life threatening emergencies, when further treatment or procedures are recommended, I will be informed of the nature of the procedure, alternatives to and risks associates with treatment. I will have the opportunity to ask questions and receive answers, and additional consent may be required. I intend that this consent is continuing in nature and that it shall remain in effect until I revoke it in writing. I understand I have the right to discontinue services at any time.

Assignment of Benefits: My signature below acknowledges that in consideration of services received or to be received from healthcare practitioners and authorized personnel of Clackamas and Oregon Pediatrics I permit said personnel to bill all applicable insurance plans(s) for services received and assign all benefits for same to be paid directly to Clackamas & Oregon Pediatrics. I agree to pay for all services considered non-covered or ineligible. A photocopy of this Assignment shall be considered as effective and valid as the original.

Minors: My Signature below acknowledges my understanding that in most cases, patients less than 15 years of age must be accompanied by an authorized adult when seeking care at Clackamas & Oregon Pediatrics. Patients and legal representatives may authorize others to act on their behalf by completing an "Authorization of Delegate" form. Visits may need to be rescheduled until either of these conditions have been met.

Financial Policy: My signature below acknowledges I have received a copy of the Clackamas and Oregon Pediatrics Financial Policy and have read, understood and accepted its terms.

X______________________________ ______________________ _____/_____/_____

Signature of Parent / Legal Guardian **Relationship to Patient** **Date Signed**