Pediatric Patient Registration Form
Terra Linda Pediatrics, Inc (TLP)

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		
Date of Birth (DOB):	Sex:	SSN:
(2) Child Name (Last, First):		
DOB:	Sex:	SSN:
(3) Child Name (Last, First):		
DOB:	Sex:	SSN:

Home Address:	
Home Phone #:	**Email Address:**
What is the family's preferred language?	**Would you like an interpreter**? Yes No
How would you like to receive appointment reminders? Text Message Phone Call Do Not Remind	Is the **patient** employed? Yes No If yes**, Employer Name**:
Name of Pediatrician:	**Employment Status:** Full Time Part Time

Patient Contacts	
In **case of an emergency**, please provide the **names of individuals** (e.g. parent or grandparent) we should contact below:	
(1) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? Yes No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? Yes No	
Home and/or Cell Phone #:	**Relationship to Patient:** Mother Father Legal Guardian Foster Parent Aunt/Uncle Grandparent Other Relative Neighbor Caregiver
(2) Patient Contact Name:	
Is this emergency contact's address **the same** as the patient's address? Yes No	
*If no, please **enter address** here:*	
Is this person a **parent/legal guardian** of the patient? Yes No	
Home and/or Cell Phone #:	**Relationship to Patient:** Mother Father Legal Guardian Foster Parent Aunt/Uncle Grandparent Other Relative Neighbor Caregiver

Guarantor Information

Who is **financially responsible** for the patient's account if there are costs **not covered** by the health insurance plan?

(1) Patient Contact (2) Patient Contact Someone Else

If 'Someone Else' please provide their **name and address**:

Guarantor's Sex:	**SSN:**	**DOB:**

Relationship to Patient: Parent/Legal Guardian Foster Parent Grandparent Other Relative

Email Address:

Is this person **currently employed**? Yes No

If yes, complete below:

Employer Name:	Full Time Part Time Retired

Primary Insurance Information

Name of primary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the plan?

(1) Patient Contact (2) Patient Contact Guarantor Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

Secondary Insurance Information

Name of secondary health insurance coverage plan:

Policy ID #:	**Group #:**

Who is the primary subscriber of the secondary plan?

(1) Patient Contact (2) Patient Contact Guarantor Patient *(only select if patient has a Medi-Cal or Medi-Cal HMO plan)*

How Did You Hear About Us?

Family/Friend Referring Provider Internet/TV/Radio Health Insurance Provider Not Sure

Name of Referring Provider:

What is the Name and Address of Your Preferred Pharmacy and Lab?

Parent/Legal Guardian Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize Terra Linda Pediatrics, Inc (TLP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize TLP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. TLP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize TLP providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the TLP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	

Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**

Today's Date (Date of Authorization):

Phone Number(s) Authorized for Detailed Messages		
Phone Number	**Type**	**Parent/Legal Guardian**
	Home Cell Work	#1 #2
	Home Cell Work	#1 #2
	Home Cell Work	#1 #2

NOTE: ***Expiration of authorization automatically occurs on the patient's 18th birthday.***

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian **Today's Date**

Signature of Parent/Legal Guardian **Today's Date**

Signature of Witness (required if patient/parent/legal guardian unable to sign) **Today's Date**

Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the Terra Linda Pediatrics Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.terralindapediatrics.com

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Printed Patient Name Date of Birth (DOB)

____

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

____

Relationship to Patient

____

Signature of Patient or Parent/Legal Guardian Today’s Date (Date Noticed Received)

Terms and Conditions of Registration, Medical Services and Financial Agreement

1. Terra Linda Pediatrics, Inc (TLP)as an affiliate of UCSF Benioff Children's Physicians (UBCP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires TLP to provide the following information to individuals who supply information about themselves. As a patient of TLP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, TLP is authorized to maintain this information. As required by TLP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. TLP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see TLP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, TLP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay TLP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to TLP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for TLP, including emergency services, at a rate not to exceed TLP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to TLP by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

____

Printed Patient Name **Today's Date**

____

Signature of Parent/Legal Guardian or Financial Guarantor **Today's Date**

____

Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign) **Today's Date**

____

Relationship to Patient

____

Signature of Interpreter (if applicable) **Today's Date**

____

Language Used

Consent to Treatment of a Minor

I,____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

____, born on ____________________________________
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an TLP clinical facility. This authorization is effective from______________________________until
(Today's Date)
consent is withdrawn.

____
Signature of Parent/Legal Guardian **Today's Date**

Other Adult Consent to Treatment (Optional)

I,____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

____, born on ____________________________________
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize____to act as my agent to consent to any
(Printed Name Agent/Other Adult)
x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from____________________________until consent is
(Today's Date)
withdrawn.

____
Signature of Parent/Legal Guardian **Today's Date**

UBCP MyChart Proxy Authorization Form
Granting Proxy Access to Parent/Guardian on behalf of an ADOLESCENT (Age 12 - 17 years)

PATIENT'S NAME:_______________________ **PATIENT'S DATE OF BIRTH:**____________________

PATIENT'S MEDICAL RECORD #:______________ **Last 4 of Patient Social Security #:** _ _ _ _

Important Reminder: UBCP MyChart displays certain information from medical records, but **it does not display all health information** in medical records.

Parent/Legal Guardian of Adolescent: This authorization form is used to establish UBCP MyChart accounts for both the Parent/Legal Guardian and the adolescent patient. This authorization form serves as acknowledgement and permission for my adolescent to have a UBCP MyChart account. Legal papers establishing parental or guardian relationship may be requested. A renewal of this authorization may be requested as well. Expiration of proxy access automatically occurs on the patient's 18th birthday.

I would like to (please circle one) grant / decline my child access to their own individual MyChart account.

AGREEMENT
The *UCSF Benioff Children's Physicians (UBCP) Terms and Conditions for UBCP MyChart,* and the UBCP MyChart *Proxy/Disclaimer* for access to My *Family's Record* in the UBCP MyChart section control this agreement between the patient's Parent/Legal Guardian and UBCP. Please refer to these documents when you signup online.

YOUR RIGHTS
This Authorization to release health information is voluntary. You may revoke proxy access at any time. For revocation, please contact the patient's practice. The Revocation will take effect within 2 business days upon notification of your request except to the extent UBCP or others have already relied on it.

REVOCATION/EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, or ended by revocation, authorization for UBCP MyChart proxy access will not expire unless the relationship between the legal guardian and the patient changes.

Print Name of Parent/Legal Guardian: ____

If the Parent/Legal Guardian *is* an UBCP patient:

MRN: _ _ _ _ _ _ _ _

Last 4 of Social Security #: _ _ _ _

If the Parent/Legal Guardian *is NOT* an UBCP patient:

Full Social Security # : _ _ _ - _ _ - _ _ _ _

Sex: Male ☐ Female

Date of Birth:____/____/__________Preferred

Contact #:___________-______-___

Address:____

Preferred Language:______________________________

I attest that the above information is true and correct.

Signature of Child's Parent/Legal Guardian:________________________________ **Date:**____/____/______

Practice representative who witnessed this proxy:

____**(Print Name)**

____**(Signature)** **Date:**____/____/______

A copy is as valid as the original.

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UCSF Benioff Children's Physicians

UBCP MyChart

Parent/Legal Guardian Proxy – ADOLESCENT (Age 12-17 years)

Dear Parent/Legal Guardian,

Thank you for signing the *UBCP MyChart Proxy Authorization* form. This is the first step in allowing you to view some of your adolescent's health information online through UBCP *MyChart* patient portal.

UBCP *MyChart* patient portal is offered to you free of charge as an online resource for routine health care needs. For patients age 12-17, UBCP requires signed approval from the parent or guardian in order for the parent/guardian to view some of the child's health information on MyChart. Proxies would have access to adolescent test results, allergies, and immunizations; they can message their adolescent's providers and request appointments on their adolescent's behalf. **Parents/guardians will not have access to information related to sensitive services**, such as reproductive health (i.e. pregnancy testing, contraception, testing and treatment for sexually transmitted diseases), and certain mental health and substance use screening and treatments. Because certain sections may contain sensitive information, parent proxy access will be limited as follows:

Content	Adolescent (12-17 yrs)	Parent Proxy (≥ 12 yrs)	Parent Proxy (0-11 yrs)
Labs	YES	YES	YES
Immunizations	YES	YES	YES
Allergies	YES	YES	YES
Growth Chart	YES	YES	YES
Messaging to and from Provider*	YES	YES	YES
Appointment Request	YES	YES	YES
Appointment View	YES	NO	YES
Problem List/Summary	YES	NO	YES
Medications/Refill Request	YES	NO	YES

* Parent and teen can send private messages to the provider.

Once your child turns 18, you will be removed from their account and will not see any of their health care information. If you have any questions, please call the patient's practice or UCSF MyChart Customer Service at 415-514-6000 (M-F 8 am -5 pm) or email us at UCSFMyChart@ucsfmedctr.org.