Associated Pediatric Partner S.C **PLEASE PRINT CLEARLY**

Patient Name: _____ M / F D.O.B._____
Last First Middle

Patient Name #2: _____ M / F D.O.B._____

Patient Name #3: _____ M / F D.O.B._____

Patient Name #4: _____ M / F D.O.B._____

Child/Children's Address

Street Address: _____

City, State, Zip: _____

Your Preferred Contact Number: _____ **Email:** _____

Parent/Guardian #1_____ D.O.B._____
Last First Middle

Relationship to Patient: _____

Address (if different than above): _____

City/State/Zip:_____

Home Phone:_____ Cell Phone: _____

Email:_____ Employer:_____

Are you the primary insurance carrier? (circle one) Yes No

Parent/Guardian #2: _____ D.O.B._____
Last First Middle

Relationship to Patient: _____

Address (if different than above): _____

City/State/Zip:_____

Home Phone:_____ Cell Phone: _____

Email:_____ Employer:_____

Are you the primary insurance carrier? (circle one) Yes No

Marital Status of Parent/Guardian (circle one): Married Divorced Separated Widowed Single

Child Resides With: _____

Party Responsible For Payment of Medical Services_____

Emergency Contact Information (Not Living with Patient)

Name: _____ Phone Number: _____

Address: _____ City/State/Zip:_____

Relationship to Patient: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. It is agreed that payment for services will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon, and that all proceeds of the insurance for services rendered in the practice are assigned to ASSOCIATED PEDIATRIC PARTNERS SC but without the clinic's assuming sole responsibility for the collection thereof. I authorize the physician to release any medical information required to process this claim and I authorize access to my medication history. I authorize group, its physicians, practitioners, independent contractors, business associates, agents and/or affiliates to contact me using email, and autodialed calls, texts, and artificial voices or prerecorded voices at the telephone numbers provided with regard to billing, collections, and other account and patient activities. I understand that I am not required to provide this call consent, and I may revoke it at any time. A $50.00 fee for no shows may apply.

Signature: _____ Date: _____ 07/19

Associated Pediatric Partner S.C **PLEASE PRINT CLEARLY**

Patient Registration Page 2 of 3

Patient Name: _____
Last First Middle

Patient Name #2: _____

Patient Name #3: _____

Patient Name #4: _____

PRIMARY INSURANCE INFORMATION

Policy Holder Information

Policy Holder Name: _____
Last First Middle

Street: _____

City: _____State: _____ Zip: _____

Policy holder date of birth:_____

Insurance Plan Name:_____

Policy ID No: _____

Policy Group: _____

Patient's relationship to policy holder: _____

Initial box(es) and sign below is you authorize care for you child(ren) in your absence.

[ ] I hereby authorize that my child(ren) under 18 may be treated without a parent or guardian being present, provided they are accompanied by one the following individuals:

Person #1 _____ Person #2_____

Person #3 _____ Person #4_____

[ ] I hereby authorize that my child(ren) 16 years of age and older may be treated without any adult in attendance.

Signature: _____ Date: _____

Printed Name: _____

All THREE registration pages (with signatures) must either be faxed to 847-520-6091 or emailed to frontdesk@associatedpediatricpartners.com Please remember that email isn't 100% secure, and should not be used for Protected Health Information.

Vaccination Policy

As medical professionals, we feel very strongly that vaccinating your child according to the schedule recommended by the CDC and American Academy of Pediatrics is absolutely necessary to protect all children and young adults. When you do not vaccinate, you take a significant risk with your child's heath and the health of others around them. At Associated Pediatric Partners, we firmly believe in the effectiveness of vaccines to prevent serious illness and save lives, and we firmly believe in the safety of vaccines. Delaying or spreading out vaccinations goes against expert recommendations, and can put your child at risk of serious illness or even death.

If, without a valid medical contraindication, you feel that you cannot stay within the recommended time frame for vaccination based on the schedules published by the CDC and American Academy of Pediatrics, we will ask that you find another healthcare provider.

By signing below, I acknowledge that I have read and understand Associated Pediatric Partners Vaccination Policy.

Signature of Parent/Guardian: _____

Date: _____

Review our full Vaccination Policy Statement and Vaccination Schedule below

VACCINATION POLICY STATEMENT

ASSOCIATED PEDIATRIC PARTNERS

Because we are committed to protecting the health of your children and the community, we require all of our patients to be vaccinated. As medical professionals, we feel very strongly that vaccinating your child on schedule is absolutely the right thing to do. We recognize that the choice may be an emotional one for some parents and we will do everything we can to help you understand the schedule and be comfortable. However, should you have doubts, please discuss these with one of our doctors IN ADVANCE of your visit. In RARE cases we may alter the schedule to accommodate parental concerns, but ONLY if there are medical reasons to do so.

Please be advised, however, that such additional visits will require additional co-pays on your part. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays. If you should absolutely refuse to vaccinate your child despite all our efforts, we may ask you to find another healthcare provider who shares your views.

We firmly believe:

- in the effectiveness and safety of vaccines to prevent serious illness and to save lives.
- all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.
- based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- that thimerosal, a preservative that has been in vaccines for decades is safe in minute quantities and only remains in multi-dose influenza vaccine. We do stock preservative-free in small quantities upon request only.
- vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccines and the vaccine schedule are the results of years and years of scientific study and data gathering on millions of children.
- parents together with our expertise will make safe decisions for their children.
- giving one vaccine at a time, delaying or "breaking up the vaccines" goes against expert recommendations, and can put your child at risk for serious illness (or even death) and in fact causes more days of discomfort for them.
- **We do NOT sign** religious exemptions for vaccinations. Currently the state of Illinois does NOT provide philosophical exemptions, and religious exemptions must be legitimized by the school.

VACCINATION SCHEDULE OVERVIEW

1) All Infants will receive all PRIMARY SERIES (2,4,6 MONTHS) recommended vaccines by 6 months of age. Additional recommended booster vaccines will be received BEFORE their second birthday.

2) PRESCHOOL BOOSTERS MUST BE RECEIVED BY 5TH BIRTHDAY.

3) 11-12 YEAR VISITS WILL RECEIVE Tdap, Menactra and HPV vaccines. They must complete their series by the time they are 13 years old.

4) All teens must receive Menactra #2 on or after 16 years of age.

5) We will also give your child/teen an annual influenza vaccination unless they receive it at a school clinic or pharmacy, or unless they have an EGG allergy or other medical contraindication. If you receive a flu vaccine, or any other vaccine, elsewher please note it down and inform us so we can keep an accurate immunization record.

6) We highly recommend Meningococcal b vaccination (2 dose series) prior to leaving for college.

Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.