755 University Ave, Sacramento, CA 95825
Office (916) 924-8754 • Fax (916) 924-1739

American River Pediatric & Adolescent Medicine
Dr. Jonathan Thygeson M.D.
Dr. Marketa Leisure M.D
Dr. Philip Traquair M.D.

6357 Coyle Ave, Carmichael, CA 95608
Office (916) 903-7416 • Fax (916) 436-4126

Patient Registration Form

TODAY'S DATE _____

CHILD/PATIENT INFORMATION (PRINT CLEARLY)

FULL NAME _____ GENDER: M / F (circle one)

BIRTH DATE (mon/day/year) ____ / ____ / ____ AGE _____ BIRTH HOSPITAL _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE (_____) _____ EMAIL _____

SIBLINGS (if applicable)

NAME _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)
NAME _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)
NAME _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)

• **GUARANTOR:** Name of parent(s) to receive paper statements? ☐ Both parents
☐ Specific parent name _____

PARENTAL/GUARDIAN INFORMATION

FULL NAME _____

SSN _____ - _____ - _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)

☐ Check here if address is same as patient. If different, please fill out address below:
ADDRESS _____CITY, STATE, ZIP _____
CELL PHONE (_____) _____
EMAIL _____
EMPLOYER _____WORK PHONE (_____) _____

PARENTAL/GUARDIAN INFORMATION

FULL NAME _____

SSN _____ - _____ - _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)

☐ Check here if address is same as patient. If different, please fill out address below:
ADDRESS _____CITY, STATE, ZIP _____
CELL PHONE (_____) _____
EMAIL _____
EMPLOYER _____WORK PHONE (_____) _____

EMERGENCY CONTACT (when attempts to reach parents are not successful)

NAME _____ RELATIONSHIP TO CHILD _____

PHONE NUMBER (_____) _____

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OFFICE USE ONLY:
Claim Phone_____
Claim Address _____
_____
Effective date_____

PRIMARY **INSURANCE INFORMATION** (PRINT CLEARLY)

INSURANCE CARRIER _____

COPAY/DEDUCTIBLE _____

SUBSCRIBER ID _____ GROUP ID _____

PRIMARY POLICY HOLDER/SUBSCRIBER INFORMATION

SUBSCRIBER FULL NAME _____

RELATIONSHIP TO PATIENT _____

SSN _____ - _____ - _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)

☐ Check here if address is same as patient. If different, please fill out address below:

ADDRESS _____CITY, STATE, ZIP _____

EMPLOYER _____

SECONDARY **INSURANCE INFORMATION** (if applicable)

INSURANCE CARRIER _____ COPAY/DEDUCTIBLE _____

SUBSCRIBER ID _____ GROUP ID _____

PRIMARY POLICY HOLDER/SUBSCRIBER INFORMATION

SUBSCRIBER FULL NAME _____

RELATIONSHIP TO PATIENT _____

SSN _____ - _____ - _____ BIRTH DATE ____ / ____ / ____ GENDER: M / F (circle one)

☐ Check here if address is same as patient. If different, please fill out address below:

ADDRESS _____ CITY, STATE, ZIP _____

EMPLOYER _____

- We consider both parents to be 100% responsible for medical decisions and financial responsibility. If you have documentations that state otherwise, please provide us with a copy.
- Co-pay and deductibles are due at time of service.
- I understand that it is my responsible to be aware the policies, benefits, and limitations of my child's insurance plan(s). If I wish to receive medical treatment that is not covered by my insurance plan, I understand that I am responsible for the payment.
- I hereby authorize medical treatment and the release of any medical information pertinent to the treatment of my child. I also authorize payment of benefits to Jonathan E. Thygeson M.D., Inc.

Signature of Patient or Guardian **DATE**

_____

Printed Name of Patient or Guardian

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Patient Financial Responsibility Form

Thank you for choosing Jonathan E. Thygeson MD, Inc. as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is responsible to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patient (or patient's guardian, if a minor) is responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatments not covered by their insurance plan. Payment is due at time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patient (or patient's guardian, if a minor) may incur, and are responsible for the payment of additional charges at the discretion of Jonathan E. Thygeson MD, Inc. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without a 24 hour advanced notice.
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive form completion.
    - Any cost associated with collection of patient balances.

Patient Authorizations

- I hereby authorize Jonathan E. Thygeson MD, Inc. the physicians, staff, and hospitals associated with Jonathan E. Thygeson MD, Inc. to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize Jonathan E. Thygeson MD, Inc. personnel to communicate by mail, answering machine message, and/or email according to the information I have provided in the patient registration information.

Signature of Patient or Guardian **Date**

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian **Date**

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Notice of Privacy Practices
Patient Acknowledgement

Our practice recognizes and respects the fact that all patients of Jonathan E. Thygeson MD, Inc. have the right to inspect and obtain a copy of his/her protected health information (PHI).

With my consent, Jonathan E. Thygeson MD, Inc. may use and disclose to any healthcare provider or healthcare facilities or affiliated operations and corresponding business or public entities any PHI about myself (if emancipated or of legal age) or my child in order to provide care and treatment for my child or myself, and to bill insurances for the resulting charges and to collect payment from all responsible parties.

I have the right to review the Notice of Privacy Practices at any time.

With my consent, Jonathan E. Thygeson MD, Inc. may call my home or other designated location and leave a message on my voicemail, cell phone, message exchange, or answering machine or in person in reference to any items that assist in the practice of carrying out treatment, payment, and other healthcare operations, such as appointment reminders, insurance items, payment items, and any call pertaining to my (if emancipated or of legal age) or my child's clinical care, including laboratory results and information, among others.

With my consent, Jonathan E. Thygeson MD, Inc. may send mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as patient statements and other information regarding my (if emancipated or of legal age) or my child's healthcare as long as they are marked "Personal and Confidential."

With my consent, Jonathan E. Thygeson MD, Inc. may email any information regarding my (if emancipated or of legal age) or my child's healthcare, treatment, payment, and appointment to me. I have the right to request that Jonathan E. Thygeson MD, Inc. restrict how the practice uses and discloses my or my child's healthcare information in order to carry out treatment or payment. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting Jonathan E. Thygeson MD, Inc. to the use and disclosure of my PHI to carry out treatment, payment, and other healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jonathan E. Thygeson MD, Inc. may decline to provide treatment to my child.

Signature of Patient or Guardian **Date**

Printed Name of Patient or Guardian

Child/Patient Name **Birth Date**

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Sutter Health

Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Sutter Health and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Sutter Health or its affiliates under my cell phone plan.
My text/mobile phone number is: (___)_____ ☐ Patient Initials

I know that I am under no obligation to authorize Sutter Health or its affiliates to send me text messages. I may opt-out of receiving these communications at any time by calling the Service Desk @ (877) 607-6484, or by responding STOP to 622622. Please allow 2-3 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Sutter Health and its affiliates to the phone number that I have provided.

Patient Name: _____DOB:_____

Signature:_____, _____
(Patient/legal representative) *(Relationship if other than Patient)*

Printed Name:_____, Date: _____
(Legal representative)

Fax: Patient Services Contact Center
Attn: My Health Online, (877) 607-6484

Mail: Patient Services Contact Center
Attn: My Health Online
P.O. Box 255386
Sacramento, CA 95865-5386

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Medical Records Release Authorization Form

PATIENT NAME _____ BIRTH DATE _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

I hereby authorize/request the release of my medical records:

Receiving From:
Name of Institute/Doctor's Name

_____

Address _____

_____

Office Number (_____) _____

Fax Number (_____) _____

Send To:
Name of Institute/Doctor's Name

_____

Address _____

_____

Office Number (_____) _____

Fax Number (_____) _____

Type of Information:
Dates of Treatment _____

Information to be released: ☐ Immunization Records ☐ Full Medical Records

☐Mail ☐Pick-up

Comments for Physician:

_____

_____

Signature of Patient or Guardian **Date**

_____

Printed Name of Patient or Guardian

Fees for Medical Records:
***Charts exceeding 30 pages, send via CD or mail**

- $50.00 – for full chart (not a current patient)
- $10.00 – for immunization records only in storage
- $25.00 – for full chart in office (10-100 pages)
- $10.00 – epic charts/Current patients

Office Use Only:
Paid $_____
Date _____
Payment Type ☐ Cash
☐ Check
☐ Credit card
Reference # _____

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DTaP Agreement

Date: _____

Patient(s) Name: _____

DOB: _____

_____Parent Name(s) understand that American River Pediatrics requires that patients get the **DTaP Vaccines** in accordance with the CDC pediatric vaccine schedule. We agree to look for a new Pediatrician if we decide to change to an alternative vaccine schedule that does not include the DTap vaccine during the appropriate intervals.

X_____

(Parent Signature)