Ptarmigan Connections
3505 E Meridian Park Lp, Ste 200
Wasilla, AK 99654
Phone: (907) 357-4400
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PTARMIGAN CONNECTIONS

Patient Registration

Child's Full Name _____ Also known as: _____

Date of Birth _____ **Sex:** □ M □ F □ Other
Race: □ African American □ Alaska Native □ Caucasian □ Declined □ Other_____
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Parent ☐Bio-mother ☐Stepmother ☐Guardian ☐Other:_____
Full Name_____ **SSN** _____ **DOB** _____
Mailing Address _____ **Zip code** _____
Physical Address _____ **Zip code** _____
Home/Work (circle one) Phone _____ **Cell Phone** _____
Email: _____**Preferred Contact Method:** ☐ **Home Phone**☐ **Cell Phone**☐ **Work Phone**

Parent ☐Bio-father ☐Stepfather ☐Guardian ☐Other:_____
Full Name_____ **SSN** _____ **DOB** _____
Mailing Address (if different than above) _____ Zip code _____
Physical Address _____ Zip code _____
Home/Work (circle one) Phone _____ **Cell Phone** _____
Email: _____**Preferred Contact Method:** ☐ **Home Phone**☐ **Cell Phone**☐ **Work Phone**

Preferred Pharmacy _____ **Preferred Language** (if other than English): _____

***** CHILD'S INSURANCE INFO** (present card(s) to front desk) ☐ **Self Pay** ****THIS SECTION MUST BE FILLED OUT****

Primary Insurance Company:_____ Policy#:_____ Group#:_____
Policy Holder's Name: _____SSN: _____ DOB: _____

Secondary Insurance Company: _____Policy#:_____ Group#:_____
Policy Holder's Name: _____SSN: _____ DOB: _____

Informed Consent

By signing below, we, the legal guardians of the above named child hereby…

☐ …**consent to all medical and/or any other clinical services** (including, but not limited to, speech-language, psychiatric evaluations, medication management, counseling, medical services, neuropsychological evaluations, etc.) deemed medically necessary by a licensed staff member at this facility for the child named above.

☐ …understand that **I have the right to ask questions** about risks, discomforts, and benefits of any service. I also understand I have the **right to discontinue service** at any time.

☐ …acknowledge **receipt of or access to Ptarmigan Connections, HIPAA / Privacy Notice** and recognize that changes to this policy may occur at any time without notice. I will always have access to the most recent Notice at the clinic website: *www.ptarmiganconnections.com*, or posted in the clinic office waiting room. **I may request a written copy at any time**.

☐ …commit to **canceling appointments** with as much notice as possible. I understand the clinic policy is 1 week for neuropsychological or FASD evaluations and 24 hours for all other appointments. Extenuating circumstances will be considered before assigning a "no-show." Repeated no-shows are serious and may involve dismissal from the clinic, loss of regular appointment spot, or acceptance at the clinic on a walk-in basis only (as time allows). Patients **over 10 minutes tardy** may be asked to reschedule.

☐ …understand that Ptarmigan Pediatrics / Ptarmigan Connections is proud to be a **mentoring / training facility** for students in health related fields, who may provide care to my child under the supervision of the licensed clinical staff.

☐ …agree that **my child cannot be seen in this clinic without a parent or legal guardian** (or my representative designated in writing) being present, unless I complete the "Permission to Treat a Minor without Parent/Guardian Present".

☐ …authorize Ptarmigan Connections, to **submit claims to my child's insurance company(s)** on my child's behalf, and my child's insurance company(s) to pay benefits directly to Ptarmigan Connections.

☐ …understand that should any insurance payment be made directly to me for monies due on this account, I agree to immediately pay over these funds to Ptarmigan Connections.

☐ …understand that **telemedicine appointments** may be billed differently than in-person appointments. I agree that it is my responsibility to preauthorize this service and pay for any sessions not covered by my insurance.

☐ …understand that **an "out-of-network" insurance carrier may limit payments** for any or all services provided by Ptarmigan Pediatrics / Ptarmigan Connections, regardless of the advertised benefits package. (i.e., they may pay less than our standard charges, even if they advertise "100% benefit").

☐ …agree that upon acceptance of services provided by Ptarmigan Connections, **I assume responsibility for any deductible, co-pay and coinsurance, *as well as any other balance not covered by my child's insurance carrier*. Copays and estimated coinsurances are due at the time of service.** If my account is turned over to **Cornerstone Credit Services** for collections**, I agree to pay any resulting collection and legal fees**.

☐ Furthermore, I understand that if I personally pay all billed charges in full at the time of service, I am eligible for **"prompt-pay/self-pay discount."**

***Both biological parents must sign for mental health services with Ptarmigan Connections

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ **Date:** _____

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ **Date:** _____