18+ PATIENT REGISTRATION

Last Name: _____ First Name: _____ Middle name: _____

Preferred name (if different than legal name)*: _____

Date of Birth: _____ Sex assigned at birth: F / M Preferred pronouns: _____

Ethnicity: Unknown / Hispanic or Latino / Not Hispanic or Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African-American / Native Hawaiian or Other Pacific Islander / White / Decline to specify / Other Race

** Please note that while staff is happy to use your preferred name in the office, patients are listed by legal name in our system and on all medical paperwork. If you wish to update your legal name, please present staff with documentation such as birth certificate, court document, or ID card.*

Patient's mailing address:

_____

(Street or PO Box) (City) (State and Zip)

Patient's contact information:

Phone number: (_____) _____ - _____ Email Address: _____

➔ Receive automatic text reminders to cell phone number listed above? Yes / No

Emergency contacts - please list both name *and* relationship:

1. _____ _____ Phone: (_____) _____ - _____

2. _____ _____ Phone: (_____) _____ - _____

PLEASE NOTE: If you would like to share your medical health information with a third party, such as a parent, you will need to complete our 18+ privacy and release of information form (attached).

Alger Pediatrics 18+ privacy and release of information form

**Please note: this form must be completed and signed by the patient.*

Patient's name: _____ **Patient's date of birth:** _____

I understand and acknowledge that as of my 18th birthday, my parent/guardian will no longer be permitted access to my medical records and information without my specific written permission.

Alger Pediatrics will not release any medical information to my parent/guardian or permit my parent/guardian to schedule appointments without my written consent in accordance with this document.

- ☐ I do not wish to grant a third party access to my medical information. Alger Pediatrics will share medical information only with me, the patient.
- ☐ I wish to grant the below person(s) access to some or all of my medical information.

Name: _____

Relationship: _____

Phone number: _____

I wish to grant the person(s) named above access to the following medical information:

- ☐ All medical information, including all records listed below.
  - ☐ Office notes
  - ☐ Lab results; pathology reports
  - ☐ X-rays
  - ☐ Financial history report
  - ☐ Nursing home, home health, hospice, and other physician records
  - ☐ Mental health records
  - ☐ Record of communicable disease testing (including HIV)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Only share the following information:

    _____

This authorization is valid for one year from the date signed, unless an earlier termination date is specified. This authorization may be revoked in writing at any time. Alger Pediatrics does not require this authorization as a condition for the delivery of healthcare or treatment. There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA).

Patient signature: _____ **Date signed:** _____

To allow a parent/guardian access to your patient portal account, please complete back side of form.

→

Patient name: _____

ALGER PEDIATRICS, P.C.

ACKNOWLEDGEMENT

I acknowledge receipt of this notice of information practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or additional confidential treatment of communication.

I, _____, have received a copy of Alger Pediatrics' notice of privacy practices.

Signature: _____

Date: _____

Alger Pediatrics **05/01/2025**

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for health care services with our practice. Specifically, PHI is information about you, including demographic information (i.e. name, address, phone, etc.), that may identify you and relates to your past, present, or future physical or mental health condition and related health care services.

Alger Pediatrics is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other health care professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI and purposes for which we may use and disclose your PHI. Regarding use of information for health care law, be aware that our office records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges (HIE's) and clinically integrated networks (CIN's) and these HIE's and CIN's have strict rules on how this information is accessed.

Alger Pediatrics may disclose your medical information for the following purposes, as well as other purposes that are permitted or required by law. Any information pertaining to treatment related to reproductive health care **cannot** be used or disclosed to investigate or impose liability for seeking lawful reproductive health care.

Treatment – We may share information about you to providers and other office personnel who are involved in providing your health care treatment.
Payment – We may share information about you in order to bill and collect payment from your insurance carrier, a third party or to obtain authorization for payment.
Health Care Operations – We may share information about you in order to manage our health care operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care.

Your Rights Under The Privacy Rule - Following is a statement of your rights, under the Privacy Rule, in reference to your PHI, please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice.

You have the right to authorize other use and disclosure - This means you have the right authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your health care provider, or our practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medication matters using an alternative method (i.e. email or telephone), and to a destination (i.e. cell phone number, alternative address, etc.) designated by you, You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. We have the right to charge a reasonable fee for paper as established by professional, state, or federal guidelines.

You have the right to request restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. If we agree to the requested restrictions, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of you PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure of accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, or would like a more in depth copy of our privacy policy please feel free to contact our Compliance Officer.

You may file a complaint with us by notifying our Compliance Officer at ***616.243.9515 or lauren.dekruyter@algerpediatrics.com.*** *We will not retaliate against you for filing a complaint.*