Village Pointe Pediatrics, P.C.
18018 Burke Street
Elkhorn, NE 68022
Phone (402) 573-7337
Fax (402) 614-2314

Dundee Pediatrics
5018 Underwood Ave., Ste 200
Omaha, NE 68132
Phone (402) 991-5678
Fax (402) 991-5358

ADULT REGISTRATION, AUTHORIZATION & CONSENT FORM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Male: _____ Female: _____ Preferred Name (if different than above): _____

Street Address: _____

City: _____State: _____ Zip: _____ Primary Phone #: _____

Email: _____

PLEASE SELECT YOUR PRIMARY CARE PROVIDER				
☐ Dr. K. Anderson	☐ Dr. J. Andresen	☐ Dr. Byrne	☐ Dr. Christner	☐ Dr. Coffey
☐ Dr. Cohen	☐ Dr. J. Davey	☐ Dr. K. Davey	☐ Dr. Dek	☐ Dr. Larson
☐ Dr. Steinauer	☐ Dr. Wolfe	☐ Megan Kalil APRN	☐ Moe Garvin PA-C	

BILLING STATEMENTS (if left blank, statements will be sent directly to you)			
Name		Relationship to Patient	
Address			
City/State/Zip			

AUTHORIZATION TO SHARE YOUR HEALTH INFORMATION (leave this section blank if you do NOT want us to share your information with anyone)

AUTHORIZED INDIVIDUAL #1		AUTHORIZED INDIVIDUAL #2	
Name		Name	
Relationship to Patient		Relationship to Patient	
Phone		Phone	
This authorization is effective today and remains in effect unless an end date is listed below.			
End Date		End Date	

AUTHORIZATION TO SHARE MY HEALTH INFORMATION

I give Village Pointe Pediatrics and/or Dundee Pediatrics permission to use and share my health information as described below.

What this includes:
My health information may include details about my care and treatment, such as:

- Medical records, lab and imaging results, prescription history
- Billing statements and insurance information (EOBs)
- Hospital and clinic records
- This may also include sensitive information like mental health, genetic testing, HIV/AIDS status, substance use treatment, and reproductive health information (excluding psychotherapy notes).

Limits:
If there is anything you do NOT want share, list it here: _____

_____
Signature of Patient

_____ _____
Printed Name Date

STAFF ONLY

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CONSENT TO TREATMENT & NOTICE OF PRIVACY PRACTICES

CONSENT OF TREATMENT

I consent to receive medical care from Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics, including care provided by physicians, nurses, and authorized healthcare staff. This includes routine exams, preventive care, diagnostic testing, and treatment as medically necessary. I understand that I have the right to ask questions about my care at any time.

FINANCIAL RESPONSIBILITY & INSURANCE

I am responsible for payment of all services provided to me, regardless of insurance coverage. I understand my insurance benefits, including coverage limits and network requirements. I authorize insurance benefits to be paid directly to Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics. Any balance not covered by insurance is my responsibility and is due per office policy. If billing statements are sent to an authorized individual, I understand I remain responsible for payment if the balance is not paid. The full Financial Policy is available upon request.

HIPPA PRIVACY ACKNOWLEDGMENT

I understand that a copy of the Notice of Privacy Practices is available upon request. I authorize Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to use and share my health information as needed for treatment, care coordination, and billing.

COMMUNICATION AUTHORIZATION

I authorize Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to contact me by phone, voicemail, text, and/or email for appointments, test results, care coordination, and billing or account updates. I understand these communications may include personal health information as needed for my care.

PRESCRIPTION HISTORY REVIEW

I authorize providers at Village Pointe Pediatrics, P.C. and/or Dundee Pediatrics to access my prescription history through Surescripts or similar electronic systems. This may include medications prescribed by other healthcare providers and filled at pharmacies over time.

IMMUNIZATION POLICY

Our clinic requires patients to receive vaccinations against preventable diseases in accordance with recommendations from the American Academy of Pediatrics (AAP). We follow the Nebraska DHHS requirements for daycare and school participation and expect patients to remain up to date on immunizations by their next subsequent well visit. This policy helps protect you, as well as other patients in our clinic.

APPOINTMENT POLICY

To help us provide timely care to all patients, we ask that you arrive on time for your scheduled appointment. Arrivals more than 15 minutes late may need to be rescheduled at the discretion of the clinic to avoid delays for other patients.

By signing below, I acknowledge that I have read, understand, and agree to the policies outlined above.

Signature of Patient	Date of Birth
Printed Name	Date

STAFF ONLY	