**Mercy Clinic**
**Pediatric Urology**
621 S. New Ballas Rd.
Suite 537A
St. Louis, MO 63141
phone 314-251-6990
fax 314-251-6998
mercy.net

Anand V. Palagiri, MD
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Dear Parent,

In order to ensure your child is seen as quickly as possible at their scheduled appointment, we ask that you complete the enclosed paperwork and present it to the receptionist. Parents that have scanner capability can e-mail completed paperwork to PediatricUrology@mercy.net. This will ensure our clinic populates this information prior to your appointment. If you have any questions, please contact our office.

Respectfully,

Mercy Clinic Children's Urology

*Every child. Every need. Every day.*

# Mercy Clinic Children's Urology

Phone: 314-251-6990 Fax: 314-251-6998

## Registration Form

Date and Time of Appointment: ____________

## PATIENT DEMOGRAPHICS

Name: ______________________ SS#: ____________

Sex: ☐ Male ☐ Female Birth date: ________ Aliases: ____________

____________

Permanent Address

Address: ______________________ Home phone: ____________

______________________ Work phone: ____________

City: ______________________ Mobile phone: ____________

State: ________ Zip code: ________ E-mail: ____________

Preferred communication method: ☐ Mail ☐ Phone ☐ E-mail ☐ MyChart

Language: ______________________ Interpreter needed: ☐ Yes ☐ No

Preferred Pharmacy

Pharmacy name: ______________________ Phone: ____________

Pharmacy address, if known: ______________________

## REFERRAL

How did you hear about us? ☐ Yellow pages ☐ Current patient ☐ Physician referral ☐ Internet

Who may we thank for referring you to us? ______________________

Pediatrician (if different from referring physician): ______________________

## EMERGENCY CONTACT INFORMATION

Contact 1

Name: ______________________ Home phone: ______________

Address: ______________________ Work phone: ______________

______________________ Mobile phone: ______________

City: ______________________ Relationship to patient: __________

State: __________ Zip code: __________ Legal guardian: ☐ Yes ☐ No

Contact 2

Name: ______________________ Home phone: ______________

Address: ______________________ Work phone: ______________

______________________ Mobile phone: ______________

City: ______________________ Relationship to patient: __________

State: __________ Zip code: __________ Legal guardian: ☐ Yes ☐ No

## INSURANCE COVERAGE INFORMATION

Who if financially responsible for the patient's account? ☐ Father ☐ Mother ☐ Other

Name: ______________ DOB: __________ SS#: ______________

Address: ______________________________________________

Primary Insurance Coverage

Who is the subscriber? ______________________________________

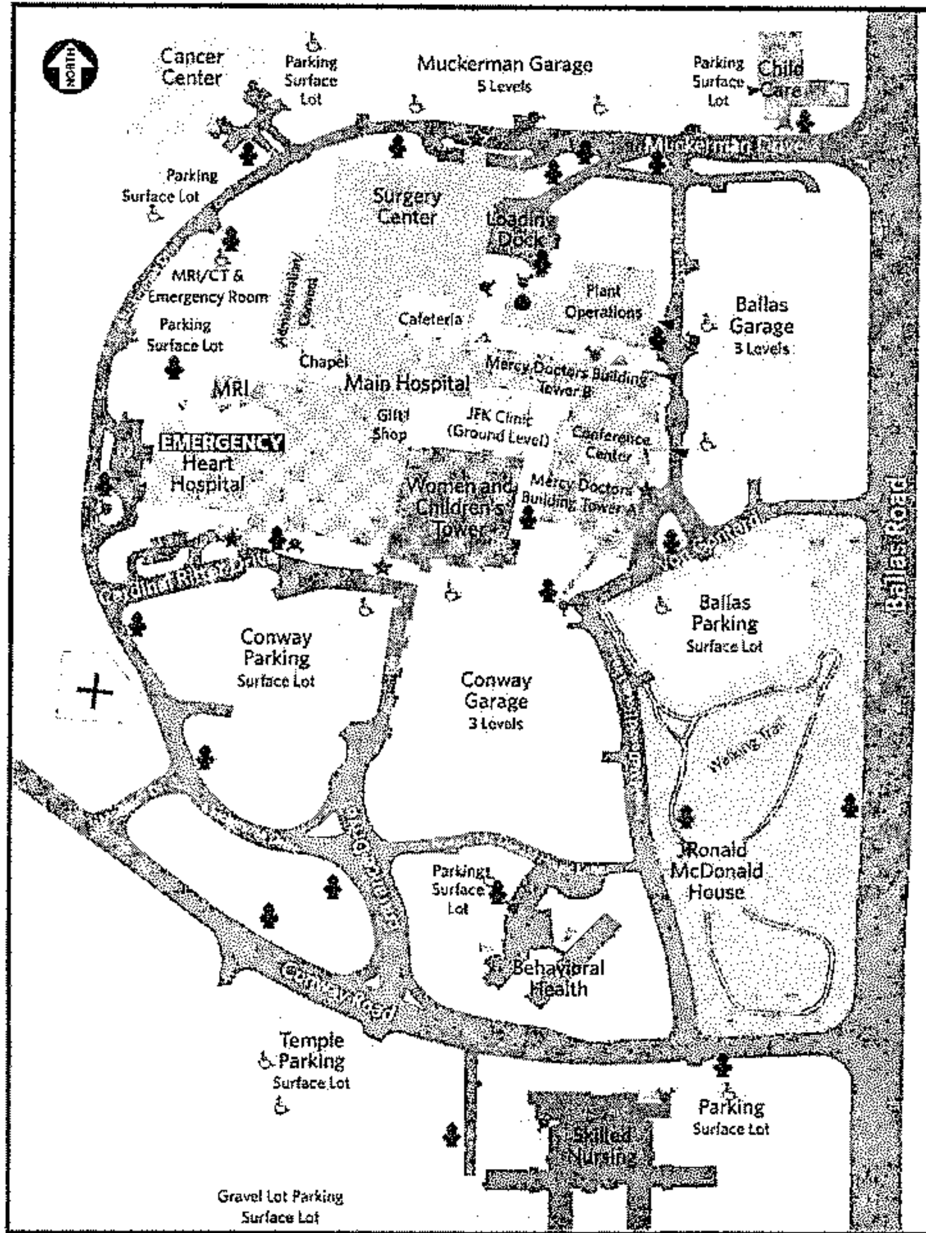
Address: ______________________________________________

DOB: __________ SS#: __________ Employer: ______________

Coverage name: ______________________________________

Group #: __________ Subscriber #: __________ Member ID #: __________

PO BOX #: __________


NORTH
Cancer Center
Parking Surface Lot
Muckerman Garage
5 Levels
Parking Surface Lot
Child Care
Parking Surface Lot
Surgery Center
Loading Dock
MRI/CT & Emergency Room
Parking Surface Lot
Cafeteria
Plant Operations
Ballas Garage
3 Levels
Chapel
Main Hospital
MRI
Mercy Doctors Building Tower B
Gift Shop
JFK Clinic (Ground Level)
Conference Center
EMERGENCY
Heart Hospital
Women and Children's Tower
Mercy Doctors Building Tower A
Ballas Parking
Surface Lot
Conway Parking
Surface Lot
Conway Garage
3 Levels
Walking Trail
Ronald McDonald House
Parking Surface Lot
Behavioral Health
Conway Road
Temple Parking
Surface Lot
Parking
Surface Lot
Skilled Nursing
Gravel Lot Parking
Surface Lot
Ballas Road

Name:________________________________________

Date of Birth:__________ MRN#: __________ CSN: __________

# Consent and Agreement
## Physician Services and Hospital Services

1. **Annual Consent for Services:** I consent to the services that may be performed by a Mercy Health ("Mercy") physician or non-physician provider ("provider") or facility. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location.

2. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy's Charge Description Master as of the date of treatment, unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

3. **Assignment of Insurance Benefits:** I assign my (or the patient's) rights under all insurance and benefit plan documents and authorize direct payment to Mercy of all insurance and plan benefits payments for services provided by Mercy. By paying Mercy, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

4. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

5. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

6. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.

7. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Consent and Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy's website.

Name:________________________________________

Date of Birth:__________ MRN#: __________ CSN: __________

**Consent and Agreement**
**Physician Services and Hospital Services**
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8. **Personal Valuables**: I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of unusual value, Mercy is not responsible for the loss or damage to these items.

9. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.

10. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.

11. **Phone Calls:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Mercy and its collection agencies may monitor and/or record any communication.

12. **Notice to Mercy Co-workers:** As a co-worker employed by an entity owned or controlled by Mercy, I agree to payment of outstanding balances(s) due for medical services rendered to me, or any dependents for whom I am financially responsible, after all applicable insurance payments are received for such services. In the event I do not make reasonable attempts to resolve the outstanding balances, I understand Mercy may initiate payroll deduction, in accordance with Mercy's Co-worker Payroll Deduction Policy.

13. **Patient Self Determination Act:**

    I have an Advance Directive? ☐ Yes ☐ No

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Date:________________Time: ________________Signature: ________________________

If signed by other than patient, indicate relationship: ______________________________

Witness:______________________________

**SISTERS OF MERCY**
**HEALTH SYSTEM**

**Caregiver Child Proxy Enrollment** – To Become a Proxy and Have Access to a Child's MyChart Record

*To request online access to the MyChart electronic health record of a child whose medical care you help manage, please complete this form. The patient must sign this form and provide additional authorization for release of medical information through his or her MyChart record on the Child Proxy Authorization form. Please note, that as a proxy, you will access the patient's medical information through your MyChart online record. Completing this form will establish a MyChart record for you (if not already established) and for the patient. Return forms to the patient's physician office.*

**Your Information** (all sections required)
*About the individual requesting access to the patient's MyChart record.*

Name:________________________________ Date of Birth: __________

Last 4 digits of Social Security Number: ________ E-mail: ____________________

Street Address: ________________ City: ________ State: ____ Zip: _______

Phone Number: ________ Primary Physician: ______________________

**Patient Information** (all sections required)
*About the patient whose MyChart record you're requesting to access.*

Name:________________________________ Date of Birth: __________

Last 4 digits of Social Security Number: ________ E-mail: ____________________

Street Address: ________________ City: ________ State: ____ Zip: _______

Phone Number: ________ Primary Physician: ______________________

*Please check the authorized party's relationship to the patient:*

- ☐ *Custodial Parent***
- ☐ *Legal Guardian / Next Friend ***
- ☐ *Non-Custodial Parent***
- ☐ *Durable Power of Attorney for Healthcare (DPOA)***

*Is there a court order or other documents limiting the requesting individual's access to this child's medical records?*

________________
***Please Write: Yes / No***
*If yes, please provide legal documents.*

** This request MUST be accompanied by a certified copy of legal paperwork verifying the authority of the patient's personal representative.

**MyChart Terms and Agreement**

- I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view my health information or that of someone who has authorized me as a MyChart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it many have been compromised in any way.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand a paper copy of a portion of the patient's medical record may be requested by the patient's medical provider with proper release.
- I understand that my activities within MyChart may be tracked by computer audits and that entries I make in my MyChart record or communications I send to my physician may become part of my medical record.
- I understand that access to MyChart is provided by physician office as a convenience to its patients and that the physician has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Enrollment Form and I agree to its terms.

________________________ / ______________ / __________
Your (Proxy) Signature – required | Relationship to Patient | Date

I acknowledge that I have read and understand this MyChart Enrollment Form. I agree to its terms and choose to designate the person named above as my MyChart Proxy, thereby allowing them access to MyChart medical record.

________________________ / ______________ / __________
Patient Signature (or authorized person) – required | Relationship to Patient | Date