Adult Registration Form
1315 Burro Avenue Cloudcroft, NM 88317
Office: 575-682-2002 Fax: 575-682-2003

How did you hear about us?_____

Last Name: _____First Name: _____MI:_____

D.O.B.: _____/_____/_____ Gender: Male Female

Cell Phone: (____) _____ - _____Work Phone: (____) _____ - _____

Employer_____Preferred Email:_____

Mailing Address:_____

Physical Address:_____

Insurance Information

Primary Policy: Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Insurance Carrier: _____

Policy ID#: _____ Group #:_____

Assignment of Insurance and Privacy Policy

- I understand that I am financially responsible for all the professional charges that may be billed
- All copayments and non-covered charges are due at the time of service. All costs not paid by insurance are due upon receipt of statement
- I hereby authorize payment of medical benefits direct to Bloom and Grow Pediatrics, LLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.
- Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices.

_____ _____ _____

Patient Signature if over 18 **Printed Name** **Date**

Bloom and Grow Pediatrics COVID-19 Testing: Informed Consent

Please carefully read and sign the following Informed Consent:

a. I authorize this COVID-19 testing unit to conduct collection through a nasal swab for COVID-19

b. I authorize my test results and other information to be disclosed to any governmental entity as may be required by law.

c. I acknowledge that a positive test result is an indication that I must self-isolate and wear a mask or face covering as directed in an effort to avoid infecting others.

d. I understand the Bloom and Grow Pediatrics testing unit is not acting as my medical provider. This testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care, and treatment from my medical provider if I have questions or concerns or if I become ill or my condition worsens.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Patient Signature if over 18	**Printed Name**	**Date**