

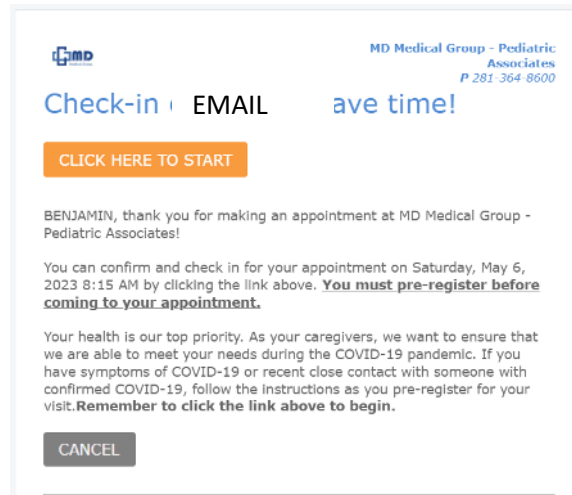
An email/text will be sent 2 days prior to your appointment.

Select click here to start

Or

Select the link

Your browser will open



TEXT

**+18668508384**

Tuesday 12:37

BENJAMIN, time to check in!  
8:15 AM Sat May 06  
MD Medical Group - Peditat 281-364-8600  
Txt STOP to opt out

Check in:  
<https://phresia.me/QECwzZX6hv>

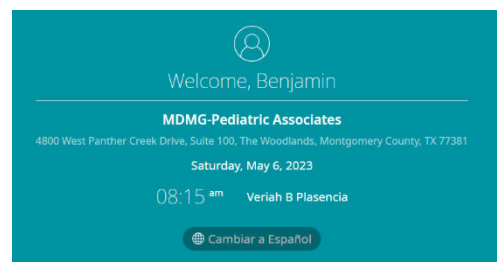
Cancel:  
<https://>

**IF YOU ARE FILLING OUT VIA TEXT LINK, YOU WILL BE ASKED TO TAKE A PICTURE OF YOUR ID AND INSURANCE CARD DURING THE REGISTRATION. THIS IS OPTIONAL**

The Welcome page will inform you of all the information that will be needed for your pre-visit registration.

Select **Get Started**

- Enter Patient's Date of birth and click verify
- Select which address is on file for the patient,
- Click verify
- *\*When filling out via email, you will be asked to have a security code sent by text. Confirm your phone number, select send security code, input code sent to your phone on the next window, select verify*



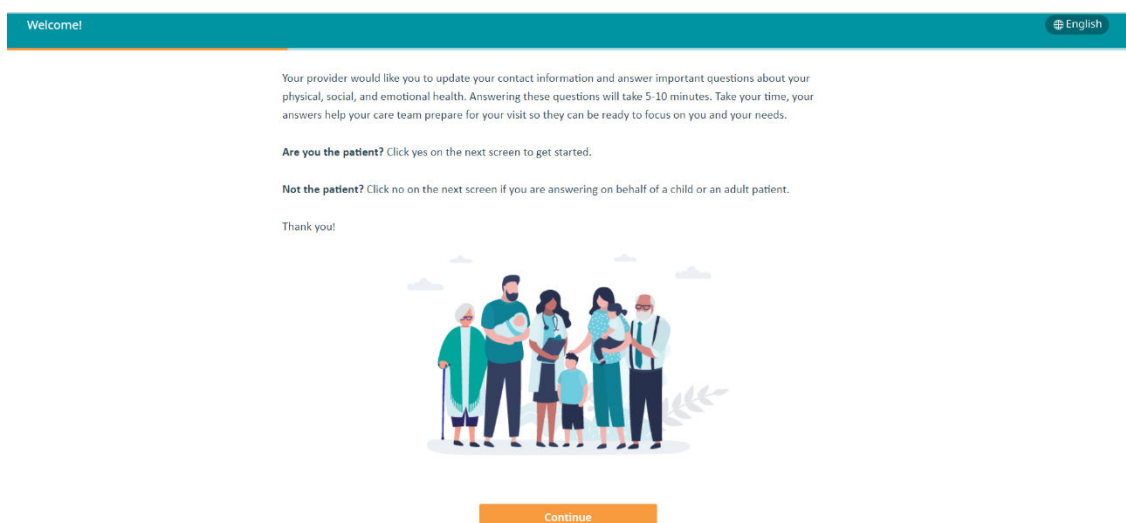
Here's what we need to do today:

- Verify who you are
- Review your information
- Update your insurance
- Store a card on file
- Make a payment
- Sign consent forms

Get Started

You will be directed to the Welcome Page:

Select continue



Select and enter applicable information on the Patient Information Page, select continue

Patient Information
English

\*Required

Are you the patient?\*

Yes
  No

If you are answering for a minor child patient, please let us know who you are. Please answer all following questions on behalf of the patient.\*

Patient's parent or step-parent
  Patient's legal guardian or representative
  Other relative authorized to act on behalf of the patient

Enter the first and last name of the person completing this information on behalf of the patient\*

Back
Continue

Verify or correct information on the Basic Patient Demographics Page, select continue

Basic Patient Demographics
English

\*Required

Street Address\*

Apartment Number

Enter your ZIP code (city and state entered automatically)\*

Home Phone Number

Cell Phone Number\*

E-mail Address\*

Preferred Contact\*

Home phone
  Cell phone
  Work phone
  Email

Primary Language Spoken\*

Select the Patient's primary language spoken

Select the Patient's marital status

Select the Patient's race. (More than one option may be selected.)

Hispanic or Latino
  Not Hispanic or Latino
  Decline to Answer

Continue

Enter Pharmacy where you would like any prescriptions to be sent, select continue

Additional Demographics
English

\*Required

Pharmacy Name\*

Enter the name of the Patient's preferred pharmacy.

Pharmacy Phone\*

Enter the preferred pharmacy's phone number

Pharmacy Address

Enter the street address of the Patient's pharmacy, including the unit or suite number, if applicable

Back
Continue

## Input/Verify Emergency Contact information, select continue

*\*This can be a parent/guardian's information*

Emergency Contact English

\*Required

**Emergency Contact Name\***  
Enter the name of the patient's emergency contact:

M:  B:

**Emergency Contact Phone Number\***  
Enter the emergency contact's primary phone number:

(986) 758-4214

**Emergency Contact Relationship\***  
Select the emergency contact's relationship to the Patient:

Parent

**Emergency Contact Address\***  
Enter the address of the Patient's emergency contact person:

**Emergency Contact City, State, ZIP\***  
Enter the emergency contact's ZIP code (city and state entered automatically):

Zip Code:  State:  City:

**Emergency Contact Cell Phone Number\***  
Enter the emergency contact's cell phone number:

(986) 758-4214

**Emergency Contact Work Phone Number\***  
Enter the emergency contact's work phone number:

## Input/Verify Primary Insurance information (if insured), select continue

Primary Insurance English

\*Required

**Does the patient have health insurance?\***

Yes  No

**Select the patient's insurance provider\***

Aetna

**Enter the patient's policy ID\***  
Name examples include: ID No., Policy No., Identification No., Member ID or Subscriber ID

W10093845948729384

**Is the patient the policy holder?\***

Yes  No  I don't know

**Enter the policy holder's full name\***

Danielle Smith

**Enter the policy holder's date of birth\***

12/23/1983

**Select the policy holder's gender\***

Male  Female

**What is the patient's relationship to the policy holder?\***

Spouse  Life Partner  Child

Other

Select if patient has Secondary Insurance

If yes, Input information then select continue

If no/I don't know, select continue

Secondary Insurance English

\*Required

Does the patient have secondary health insurance?\*

Yes
  No
  I don't know

Input/Verify Legal Guardian information.

- Add other parents/guardians by selecting **yes** to the question “Are there any other legal buardian’s that you would like to include for the patient?”
- Select how many other legal guardians you may like to include (Other parent/step-parents)
- Input all requested information for all legal guardians
- Select continue

Legal Guardians English

\*Required

Enter the name of the legal guardian that is accompanying the patient today\*

Danielle  Smith

Enter the legal guardian's relationship to the patient\*

MOTHER

Are there any other legal guardian's that you would like to include for the patient?\*

Yes
  No

Select how many legal guardian's would you like to include\*

One
  Two
  Three

Enter the full name of the first legal guardian\*

Michael  Smith

Enter the first legal guardian's relationship to the patient\*

FATHER

Enter the primary phone number of the first legal guardian\*

(935) 999-9999

Select if there are any non-custodial adults who may bring the patient to visits (other family members, babysitters, family friends)

If you select no, then select continue

If you select yes, select how many others you would like to add, input all information, then select continue

Non-Custodial Adults English

\*Required

Are there any non-custodial adults who may bring the patient to visits & receive patient's health information?\*

Yes
  No

You will be directed to the General Consent for Treatment, Financial Agreement, & Release Form

- Review the form
- Select I accept/I decline
- Enter full name in textbox
- Click the box below textbox
- Select Continue

I accept
  I decline

Please enter your full name in the textbox below to accept the policy

I understand that by typing my name and clicking on "Continue", I am electronically signing this document

Back

Continue

*Please note- if declined, you will have a chance to discuss the consent form with your office staff, and fill out at your arrival. If consent is not given at check-in, services will not be rendered.*

If your appointment is for a well visit, the next page(s) will be your wellness questionnaires

Please select all applicable answers, then select continue on each subsequent pages

The next page will be the Compliance Statement

- Review the statement
- Select I accept
- Enter Full Name in textbox
- Click the box below the textbox
- Select Continue

Compliance Statement English

Please sign the below: Scroll to bottom

Date Completed: 05/04/2023 15:01

I certify that by typing my full legal name below and clicking "Continue", I have completed the clinical questionnaires to the best of my ability and have given truthful information about myself or my child's identity, clinical, and demographic information.

I give Pediatric Associates consent to provide, solicit, and arrange for health care services, treatment, and prescribed medications) when necessary to myself or child.

I certify that the clinical questionnaires were completed following any instructions that the patient should complete themselves, or used best effort to have them completed by patient.

I accept

Please enter your full name in the textbox below to accept the policy

I understand that by typing my name and clicking on "Continue", I am electronically signing this document


Continue

The last and final page is the Thank You page, you may exit out of the browser

Thank you! English


Thank you for registering with us!

[+ Add appt to calendar](#)

 **Check-in**


When you arrive for your appointment, let the front office know that you've registered online.

Depending on the reason for your visit, you may be asked to answer some additional questions or sign some additional paperwork before seeing a provider.

 **Insurance**

Please bring your insurance card(s) with you to your appointment.

The receptionist may need to make a copy of this card. This card has information that tells us who is responsible for paying the bill for your appointment.

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