PATIENT REGISTRATION FORM

PATIENT NAME: _____ SEX M or F
Last First Middle

DATE OF BIRTH _____ PATIENT SS# _____ RESIDES WITH _____

HOMEADDRESS _____
Street City State Zip

MAILING ADDRESS (if different from above) _____

HOME PHONE: _____ EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US? _____

FAMILY INFORMATION (IF PT IS A MINOR)

Mother/Guardian
NAME _____

ADDRESS _____
(If different from patient)
HOME PHONE: _____

CELL PHONE _____

WORK PHONE _____

SS# _____ DATE OF BIRTH _____

Father/Guardian
NAME: _____

ADDRESS _____
(If different from patient)
HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

SS# _____ DATE OF BIRTH _____

EMERGENCY CONTACT (OTHER THAN PARENT)

NAME: _____ TEL _____ RELATIONSHIP _____

LIST ALL CHILDREN: (Including any children not being seen today, and any children not being seen in this office)

Last Name	First	Middle	Date of Birth	Female/Male (circle)

INSURANCE INFORMATION:

NAME OF INSURANCE _____ NAME OF SUBSCRIBER: _____

ID NO# _____ DOB: _____

INSURED SS# _____ EMPLOYER _____

RELEASE AND ASSIGNMENT:
The information that I have given is correct to the best of my knowledge. I understand that it will be held in strictest confidence. I understand that it is my responsibility to inform the office of any changes in this patient's information or medical status. I certify that my child is covered by the insurance named above and assign directly to All Pediatric Care, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize All Pediatric Care, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on insurance submissions whether manual or electronic. I agree to pay for charges not covered by insurance when they are billed to me. I understand collection proceedings may be initiated if I do not pay my bills on time and that I may be held responsible for fees incurred in the attempt to collect outstanding debts.

_____ _____
SIGNATURE OF RESPONSIBLE PERSON – PARENT/GUARDIAN DATE

INITIAL & DATE IF INFORMATION ABOVE IS CORRECT AT EACH VISIT

INITIALS								
DATE								

Authorization For Medical Treatment of Minors

I, _____, parent or legal guardian of:

_____ _____

(Child's Full Name) (Childs Date of Birth)

do hereby authorize the following individuals (must be over the age of 18) to schedule appointments and/or accompany my children to medical appointments. Please list anyone other than the child(ren)'s biological mother or biological father who may be accompanying the child(ren) to appointments. This may include siblings over the age of 18, babysitters, step parents, grandparents, neighbors, friends of the family, etc... I understand that only my child(ren)'s biological mother and father and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen age 16 and above, in my absence. Authorized individuals include: *(Please print name & relationship):*

Name: **Relationship:**

_____ _____

_____ _____

Please inform the above listed individuals to bring photo identification to appointments

I have read all of the information above and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify All Pediatric Care any changes in my health status, my child (ren)'s health status, or the above information. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

Privacy Statement Acknowledgement

I acknowledge All Pediatric Care has provided it's Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my child's protected health information if I desire a copy of the Notice of Privacy Practices is available to me to keep. If revisions are made, I understand that it is my responsibility to request a copy.

_____ _____

Signature of Parent/Guardian/ Personal Representative Printed Name of Parent/Guardian/Personal Representative

Authorization to Leave Messages on Voice Mail/Machines

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and/or

answering machine. This authorization can only be revoked in writing.

Yes, please leave me a message:_____ Date:_____

No, don't leave any specific messages:_____ Date:_____

Acknowledgement of "Abuse Free Zone"

At All Pediatric Care we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect each one of you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your discharge from the practice.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

_____ _____

Signature of Parent/Guardian/ Personal Representative Printed Name of Parent/Guardian/Personal Representative

FINANCIAL POLICY ACKNOWLEDGMENT

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

All Pediatric Care has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with your insurance company. Any financial portion that is the "member's responsibility" such as a co-pay, deductible or a non-covered percentage will be collected **at the time of service**. _____(initial). Remember, your insurance coverage is a contract between you and your insurance company. All Pediatric Care is not responsible for services denied by your insurance company._____(initial)

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

HMO INSURANCE PLANS: All co-pays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

NON-CONTRACTED INSURANCE PLANS: If we are not contracted with your insurance company you will be asked to pay in full at the time of service. We can supply you with a billing copy to attach to a claim form (should be supplied by your insurance broker or Human Resources department) to send to your insurance company to request that payment be sent to you.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit you for your balance.

MEDICAID: We accept Medicaid. Newborn children must have a Medicaid Identification No# available at the time of the exam. If you do not provide us with the Medicaid billing information we will change the account to "Self-Pay" at that point you are required to make payment within 30 days.

DIVORCE DECREE: We are not a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, MasterCard, Discover, and personal checks (with photo id only). Any outstanding balances are due within 30 days of the statement. The second and each subsequent statement will be assessed a $5 rebilling fee. If you experience circumstances beyond your control, please call our office and we will be happy to make payment arrangements. All balances reaching 90 past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed at $30 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of one hours notice in order for another child to be scheduled. If you do not cancel by the deadline, a $25 missed appointment fee will be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment.

I authorize medical care and accept the financial responsibility for my children, my step children, and/or the child(ren) that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims.
I have read and fully understand the financial policies of All Pediatric Care, and agree to the terms. I also understand that the terms of these financial policies may be amended by the Practice at any time without prior notification. I authorize medical care and accept the financial responsibility for my children, my step children, and/or child(ren) that I am accompanying. I am responsibility for all fees and will assure the charges paid in a reasonable time.
I authorize the release of medical or other information necessary to process any claims.
I have read and fully understand the financial policy of All Pediatric Care, and agree to the terms. I understand that the terms of these financial polices may be amended by the practice at any time without prior notification.

_____ _____

Parent/Guardian/Personal Representative Date