PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM

PRIMARY CARE PHYSICIAN **(Circle)**

Wood ♦ Brannon ♦ Blakeney ♦ Diebel ♦ Mukkamala
McNally ♦ Speight ♦ Hooper ♦ Sabrina, CRNP

PATIENT INFORMATION

First | *Middle* | *Last* | *Preferred Name* | *Social Security #*

Date of Birth | *Sex* (M F) | *Race* | *Ethnicity* | *Religion* | *Preferred Language*

ALLERGIES: **Does your child have any known Drug/other Allergies?** _____

Do we see any of your other children in your family? Yes No List Each: _____

FAMILY INFORMATION

Child lives with:

Parents Mother Father Grandparent Foster Parent Other:

MOTHER

First | *Middle* | *Last*

Street Address | *City,State,Zip*

Home Phone | *Cell Phone*

Authorization to Contact by Cell Phone and/or Text Yes No

DOB | *Social Security #*

Employer | *Work #*

Drivers License # | *State*

Email (Best Email for Reminders, Notices and Information)

FATHER

First | *Middle* | *Last*

Street Address | *City,State,Zip*

Home Phone | *Cell Phone*

Authorization to Contact by Cell Phone and/or Text Yes No

DOB | *Social Security #*

Employer | *Work #*

Drivers License # | *State*

Email (Best Email for Reminders, Notices and Information)

Parent/Guardian Status **(Circle) Single Married Divorced Separated Widowed Foster Other:** _____

If divorced, who has legal custody of child: _____

Legal Documents: If yes please provide: Divorce Custody Foster Court Orders Other:

EMERGENCY CONTACT & AUTHORIZED PERSON(S)

List Person(s) to contact in case of an emergency and person(s) authorized to bring child to visits and have access to "ALL" patient medical and financial information.

Name/Phone Number: _____

Name/Phone Number: _____

Name/Phone Number: _____

Name/Phone Number: _____

PARTNERS IN PEDIATRICS, LLC

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

PRIMARY INSURANCE	***SECONDARY INSURANCE***
Insurance Company	***Insurance Company***
Member ID # ***Group ID #***	***Member ID #*** ***Group ID #***
Insurance Holder's Name ***DOB***	***Insurance Holder's Name*** ***DOB***
Employer	***Employer***

POLICIES & PROCEDURES
PLEASE READ CAREFULLY, INITIAL AND SIGN AUTHORIZATION BELOW

Initial ____ ***INSURANCE:*** *Partners in Pediatrics, LLC accepts assignment of insurance benefits from most major insurance companies for payment of services on your behalf. It remains your responsibility to verify coverage with our physicians and your specific policy before treatment. Our business office is ready to assist you with your coverage questions.*

Initial ____ ***CO-PAY:*** *Your insurance policy and the agreement between your physician and the insurance company requires that we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay is not made at the time of service, then an additional $10.00 service charge is added to your account.*

Initial ____ ***SELF-PAY:*** *If your child does not have medical coverage or is out of the network, then you must see the business office before treatment. You are responsible for all charges incurred at the time of service. The business office will assist you with the amount due. You may receive a copy of your itemized billing statement for insurance or tax purposes.*

Initial ____ ***NO SHOW:*** *As a courtesy, we will provide reminders for your appointment. If you are unable to make your scheduled time, then you must notify our office 24 hours prior to that time. Missing three (3) scheduled appointments will result in dismissal from the practice.*

Initial ____ ***HOSPITALIZATION:*** *In the event of hospitalization we will file the hospital charges incurred for the physician treating your child. If newborn patient charges are incurred, then it is your responsibility to add the newborn to your policy or another acceptable policy within 30 days of date of birth. If no insurance is acquired, then you will be responsible for all newborn hospital charges and all subsequent office visit charges if any.*

Initial ____ ***AGREEMENT TO PAY:*** *In case of default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect monies you may owe, Partners in Pediatrics, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.*

Initial ____ ***PRIVACY:*** I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Portability & Accountability act of 1996 (HIPAA) and have been offered a copy of it.

PARTNERS IN PEDIATRICS, LLC

AUTHORIZATION AND PERMISSION FOR TREATMENT

I acknowledge I have read and understand the disclosures, billing policies of Partners in Pediatrics, LLC and I am responsible for payment. I, as the parent, guardian or legal personal representative, give my permission to Partners in Pediatrics, LLC and their employees to provide medical care to my child. I realize I am responsible for accompanying my child or children while on the premises.

According to HIPAA law, I shall update this information at least ANNUALLY or sooner if any change occurs.

Signature of Parent or Guardian *Date*

OFFICE USE ONLY