Pediatric Associates, LLP

Patient Registration

Date:_____/_____/_____ Acct #: _______________

Last Name: ________________________ First Name: ________________________ MI: _____
Nickname: ________________________ D.O.B.: _____/_____/_____ Sex: Male / Female
Primary Language: _________________
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Additional Siblings:
Last Name: ________________________ First Name: ________________________ MI: _____
Nickname: ________________________ D.O.B.: _____/_____/_____ Sex: Male / Female
Primary Language: _________________
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Last Name: ________________________ First Name: ________________________ MI: _____
Nickname: ________________________ D.O.B.: _____/_____/_____ Sex: Male / Female
Primary Language: _________________
Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Mailing Address:
Address: ____
City: ______________________________________ State: ____________ Zip Code: __________
Best Contact #: (______) ________ - ___________

Father:
Last Name: ______________________________ First Name: __________________________
Date of Birth: ____ /____ /____ Lives with patient? Yes / No
Cell Phone: (____) ______ - ___________ Home Email:_____________________________________
Work Phone: (____) ______ - ___________ Work Email: ____________________________________
Employer: ______________________________ Occupation: ________________________________

Mother:
Last Name: ______________________________ First Name: __________________________
Date of Birth: ____ /____ /____ Lives with patient? Yes / No
Cell Phone: (____) ______ - ___________ Home Email: ____________________________________
Work Phone: (____) ______ - ___________ Work Email: ____________________________________
Employer: ______________________________ Occupation: ________________________________

Emergency Contact: (other than parents)
Name: ______________________________________ Phone: (______) ________ - _________

Insurance:
Primary Policy: Policy Holder's Name: ____
Policy Holder's Birth Date: ____ /____ /____ Policy Holder's SSN_______-_______-_______
Policy Holder's Sex: Male / Female Insurance Carrier: ____________________________
ID# _______________________________________ Group # ___________________________

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Secondary Policy: *Policy Holder's Name*: ______________________________
Policy Holder's Birth Date: ____/____/____ *Policy Holder's SSN*_______-_______-_______
Policy Holder's Sex: Male / Female *Insurance Carrier:* ______________________________
ID# ______________________________ Group # ______________________________

If parents are divorced or separated, please fill out this section:
Who has custody? ______________________________
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes / No**
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

How would you ideally prefer to be contacted? (circle one):

Home Phone / Cell Phone / Work Phone / Home E-mail / Work E-mail

Additional Questions:

Who should receive billing statements? ______________________________
List address to send billing statements. (If different from residential address)
Name: ______________________________
Address: ______________________________
City: ______________________________ *State:* __________ *Zip Code:* __________
Home Phone: (______) _______ - __________

Vaccine Policy:

Pediatric Associates has carefully reviewed our approach to vaccinations within our practice. We want to ensure that all of our patients, as well as our patient community, are as healthy as possible. One of the most important public health advancements has been the development of vaccinations, by which many diseases have been eliminated or become uncommon. Scientific research has consistently and overwhelmingly shown that vaccines are effective and safe.

Effective March 19, 2018, the Physicians at Pediatric Associates have revised our vaccine policy for new patients. Pediatric Associates follows the recommended immunization schedule of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

1. **Pediatric Associates will allow alternate vaccine schedules under the following guidelines:**
    a. **Vaccinations are started by age 12 months.**
    b. **Mandatory vaccinations for public school attendance are completed by age 5.**
2. **Families with questions and concerns regarding vaccinations are encouraged to speak with their primary pediatrician. Families who are unable or unwilling to follow the above guidelines may be asked to find another health care provider.**

As pediatricians, we partner with parents to make the best decisions for their children and their health. We understand that the choice to vaccinate can be an emotional one for some families. We will do everything we can to provide education and information on all vaccines.

______________________________ ______________________________
Signature of Parent or Guardian **Date**

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Thank you for choosing Pediatric Associates as your child's primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have created this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. Please contact your insurance carrier to confirm that Pediatric Associates is an in-network provider. If we are not an in-network provider, payment in full is expected at time of service. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

2. Co-payments. Insurance carriers require all co-payments must be paid at the time of service. For high deductible plans without co-payments, a $80.00 payment will be required. If these payments are not paid at time of service, a $25.00 fee will be added to your account.

3. Self Pay Patients. Patients who are self pay are required to pay the total amount for a visit at the time of service. If these payments are not paid at time of service, a $25.00 fee will be added to your account.

4. Non-covered services. Non-covered services are deemed by your contract with your insurance carrier. Please be aware that some of the services your child receives may be non-covered including but not limited to labs, developmental testing, hearing and vision screenings, etc. You will be responsible for all non-covered services.

5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card annually. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance carrier may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance carrier pays your claim. Your insurance benefit is a contract between you and your insurance carrier; we are not party to that contract.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and all your children will be dismissed from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat your child on an urgent basis.

8. Missed appointments. Our policy is to charge $25.00 for missed appointments not canceled within 24 hours of the scheduled time.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party ______________________ **Date** __________

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Due to patient confidentiality, please list below if you wish to allow any family member or any close friends to bring your child(ren) into the office for medical care. Also, we may communicate with the following individuals regarding appointments and medical information or course of treatment. I understand that this will remain in effect until I give written notice to Pediatric Associates to remove any of the persons listed below. (If left blank, parents will be the only ones authorized.)

________________	________________	(____) ______ - ______
(Name)	*(Relationship)*	*(Telephone)*
________________	________________	(____) ______ - ______
(Name)	*(Relationship)*	*(Telephone)*

(1) Pediatric Associates utilizes SureScripts National prescribing system. We are required to obtain your authorization, which will allow us to obtain prescription benefits as well as formulary guidelines from your insurance carrier. This consent will also allow us to obtain any prescription activity from the national database to assist us in obtaining very important information, which includes drug interactions, etc...

(2) You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any phone 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 e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

(3) Some insurance companies have determined that annual physical exams must be billed separately from the treatment of any active problems encountered at the same time. We are required by this rule to bill your annual exam as a physical and not by any active diagnosis you may have. For example, if there is an active problem that requires treatment/ medication and/or a new test to be performed (i.e. ADHD or strep throat), you may be charged in addition to your annual exam an appropriate level of service charge. Therefore, it is possible you will receive two office visit charges for services rendered at the time of your appointment. I understand that I am responsible for any amount not covered by health insurance.

(4)I authorize Pediatric Associates to provide medical care to my child(ren). I herby consent for Pediatric Associates to use or disclose information about my child(ren) (or another person for whom I have authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and healthcare operations. I also authorize Pediatric Associates to furnish my child's immunization information to medical facilitates, schools, and daycares.

(5)I acknowledge that I have received the Notice of Privacy Practices and Notices of Individual Rights. A copy of this notice is available at www.pediassoc.com.

BY SIGNING BELOW, YOU AGREE AND CONSENT TO STATEMENTS 1 THROUGH 5 LISTED ABOVE.
YOU MAY REFUSE TO SIGN THIS CONSENT FORM.

FATHER/GUARDIAN
SIGNATURE: ________________________________ DATE: ____/____/____

MOTHER/GUARDIAN
SIGNATURE: ________________________________ DATE: ____/____/____