PATIENT REGISTRATION FORM

TODAYS DATE: _____

CHILD'S FULL LEGAL NAME: _____DOB_____SEX____

PRIMARY HOME ADDRESS: _____CITY_____

STATE_____ZIP_____*PRIMARY PHONE#_____HOME/CELL/WORK

*The primary phone # is used for messages and reminder calls, does not have to be home phone.

FATHER: _____DOB_____SS#_____

HOME ADDRESS: _____CITY_____

STATE_____ZIP_____CELL#_____WORK#_____

PLACE OF EMPLOYMENT & ADDRESS: _____

_____CITY/STATE/ZIP_____

MOTHER: _____DOB_____SS#_____

HOME ADDRESS: _____CITY_____

STATE_____ZIP_____CELL#_____WORK#_____

PLACE OF EMPLOYMENT & ADDRESS: _____

_____CITY/STATE/ZIP_____

CHILD RESIDES WITH:_____

BILLS MAILED TO :_____

WHOM MAY WE THANK FOR REFERRING YOU:_____

IN CASE OF EMERGENCY (IF PARENTS CANNOT BE REACHED)

NAME_____RELATIONSHIP TO CHILD_____

HOME & CELL #_____CITY_____

PERSON FILLING OUT THIS FORM_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____DOB_____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY_____EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____DOB_____

CONTRACT # _____ GROUP # _____

CONSENT TO TREAT

As the parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Merrillwood Pediatrics. I hereby authorize Merrillwood Pediatrics to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Merrillwood Pediatrics. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

Parent/Guardian Name & Signature

Name_____Child_____

Signature_____Date_____

FINANCIAL POLICY (Please initial below that you have read each statement)

___ I accept financial responsibility for all services rendered on my child's behalf whether or not I am present on the date of service. Please note that a divorce has no bearing on the responsibility for medical care as it affects third parties. **Whoever brings in the child(ren) is expected to pay the charges due for the service rendered that day. Merrillwood Pediatrics does not participate in payment disputes between parents.** Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balance.

___Patients with an outstanding balance of 90 days or more will be turned over to a collection agency and will be dismissed from the practice. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our billing dept. to request a plan before your account becomes delinquent. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 26%, or the maximum allowable rate, will be due on delinquent amounts.

___Occasionally during scheduled well child visits a physician will diagnose and treat a problem. When appropriate, problems addressed during preventative exams will be billed as routine care in addition to the well child visit. Some insurance policies do not cover both services. In the event that you schedule a well child visit and a problem is addressed, you may be responsible for additional copay or deductible.

___We are required by law to accurately report all services received by our patients. It is your responsibility to know if you have coverage before services are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis code in order to get paid.

___ If for any reason you must cancel or reschedule your appointment, a 24 hour notice is required to avoid a fee.

PATIENT CENTERED MEDICAL HOME- "PCMH provides care that is respectful of and responsive to individual patient preferences, needs and values; ensuring that patient values guide all clinical decisions."

___ I understand Merrillwood Pediatrics is a Patient Centered Medical Home. This means you have access to a single point of comprehensive care that addresses all of your child's healthcare needs. The PCMH is established to ensure all of their healthcare needs and goals are met. We would like for you to participate in this partnership optimize your child's wellness.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES FOR MERRILLWOOD PEDIATRICS

___I have received, or have been given the opportunity to receive, a copy of the HIPPA Notice of Privacy Practices for Merrillwood Pediatrics. *Please refer to HIPPA policy on website

AUTHORIZED INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD FOR MEDICAL CARE AND RECEIVE MEDICAL RESULTS.

Please list anyone who has your permission to bring your child to our office for medical care in your absence and /or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPPA requirements, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL_____

RELATIONSHIP TO CHILD_____PHONE #_____

NAME OF AUTHORIZED INDIVIDUAL_____

RELATIONSHIP TO CHILD_____PHONE #_____

PLEASE ARRIVE 15 MINUTES BEFORE APPOINTMENT TIME.

WE WILL NEED A COPY OF YOUR CURRENT INS CARD & LICENSE.

PLEASE MAKE SURE YOUR CHILD IS ACTIVE ON INSURANCE!