Date____/____/_____

PATIENT INFORMATION

Patient Name:_____ Date of Birth____/_____/ ____ ☐ Male ☐ Female

Patient's SSN: _ _ _- _ _ -_ _ _

Allergies to Medications: 1._____ 2._____ 3._____
☐ None

Pharmacy Name:_____Phone_____Fax _____

How did you hear about us? ☐ Other Patients ☐ Insurance Co ☐ Internet ☐ Provider Referral
For Provider Referrals, Please Specify ☐ PCP ☐ Specialist
Name _____ Address _____

POLICY HOLDER /GUARDIAN INFORMATION

Mother's name:_____ DOB:____/_____/ ____

Father's name:_____ DOB:____/_____/ ____

Address: _____

City:_____State:_____Zip Code: _____

Primary Insurance : _____

Insurance ID: _____ Group #: _____

Policy Holder:_____Patient Relationship: _____

Secondary Insurance: _____

Insurance ID: _____ Group #: _____

Policy Holder:_____Patient Relationship: _____

Policy Holder SSN (**REQUIRED**): _ _ _- _ _ -_ _ _ Email: _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Emergency Contact: _____ Phone _____

CONSENT FOR DISCLOSURE under HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

Your signature below represents consent for Pediatrics and Genetics, LLC to use and / or disclose information about yourself and the patient (or another person you have authorized to sign on your behalf) that is protected under federal law, for the sole purposes of treatment, payment and health care. You also agree to have patient's medication history from the pharmacy or Rx exchange.

You understand your rights under HIPAA. You may request a copy of this document at our office or view it on our website www.pediatricsgenetics.com.

Privacy will be protected based on the Guardian / Guarantor details in this registration form. Any exceptions to these needs to be requested in writing.

We LOVE delivering quality pediatric and genetics care and enjoy the personal relationships we have with our patients and families. We must however recover charges for these services so we can continue to survive and thrive. We strive to keep insurance and financial arrangements as simple as possible and summarize our policies below. **Your signature below indicates that you have read these policies.**

- All co-payments, co-insurance, and deductibles are due at time of service, as per our contract with insurance providers.
- We will file insurance as a courtesy, but you are ultimately responsible for charges incurred. This document confirms that you assign agreed upon insurance contracted fees for the services to our clinic and will commit to any remaining co-payments that the insurance company declares as a balance. In the event payment balances become delinquent, you agree to be responsible for any additional recovery fees that the clinic incurs to collect such balances (balances 60 day past due typically accrue an additional fee of $12.25 for accounts recovery. Collection Services fees will be added to balance due on delinquent accounts)
- If you do not have valid insurance credentials at time of visit, we will have to collect the fees in full before care and you will have to adjust this payment with your insurance provider. It is also your responsibility to get confirmation from your insurance provider that our practice is 'In Network' as well as get any prior authorization for any tests ordered.
- It is your responsibility to keep us up to date with your current contact information for us to contact you in a timely manner for follow ups, test results or billing updates that we get from your insurance provider.
- It is also your responsibility to provide appropriate legal documentation relating to any change in Guardian / Guarantor relationship with the patient. Pediatric visits will only be undertaken in the presence of one or more registered guardian(s).
- As time permits, we will contact you to confirm your appointment. We rely on you to keep track of appointments.
- We understand that in certain Sick Visit circumstances, you will have to walk-in without an appointment. We will make every attempt to accommodate you. But in some situations, you may have a longer than normal wait as we serve previously scheduled patients.
- Inability to make an appointment should be confirmed with our office at least 24 hrs ahead of the appointment, so we may provide this slot to someone else that may need it. Otherwise, the appointment is considered a 'No Show' and we reserve the right to bill you $25 for each such incident. Three no shows will be considered clinic disruptive and we reserve the right to transfer care out of our office.
- Brief phone consults may be scheduled based on time availability and will be billed to your account (since insurance does not cover them). Disability form, Katie Beckett forms, and Notary Services are $20.

Guarantor / Guardian Signature_____Date____/____/ _____