KIDS CENTRAL PEDIATRICS REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name:______________________ First Name:______________________ Middle Name:______________________

Date of Birth: ____________________ Social Security Number:______________________ MALE [ ] FEMALE [ ]

Child's Address:____

City: ____ State: _______________ Zip Code:____________

Home Phone:____________________ Mother's Cell:_____________________ Father's Cell:_______________________

Mother's First & Last Name:____

DOB:____ SS#:____

Mother's Address:____ Mother's Cell #_________________________

Mother's Employer:____Mother's Work #_________________________

Father's First & Last Name:____

DOB:____ SS#:____

Father's Address:____ Father's Cell #__________________________

Father's Employer:____ Father's Work #_________________________

Are there any legal restrictions that would prevent the non-custodial parent(s) from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES [ ] or NO [ ]

If Yes, provide a copy of any legal paperwork that supports this restriction.

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE

Policy Holder Name:____ Relationship to Patient:_____________________

Policy Holder DOB:______________________________________ Policy Holder SS#:___________________________

Insurance Name:______________________ Policy/ Member #:__________________________ Group#:______________

SECONDARY INSURANCE

Policy Holder Name:____ Relationship to Patient:_____________________

Policy Holder DOB:______________________________________ Policy Holder SS#:___________________________

Insurance Name:______________________ Policy/ Member #:__________________________ Group#:______________

--- TURN OVER FOR POLICIES AND PROCEDURES ---

POLICIES AND PROCEDURES

FINANCIAL POLICY:
Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Therefore, financial responsibility for your child(ren)'s treatment is ultimately that of the parent/guardian. Parents/Guardians are responsible for all co-pays and deductibles prior to services being rendered. *You must present all insurance cards at the time of visit. Failure to notify us of insurance changes and/or new policies will result in dismissal from our practice*. You will be held responsible for the entire amount of the insurance claim if you knowingly fail to provide correct insurance information in a timely manner. A service charge of $35 will be added for any checks drawn on insufficient funds. For your convenience we accept cash, check, and Visa/MasterCard/Discover credit cards or debit cards. *Failure to notify the office of insurance changes or new policies will results in dismissal from the practice.*

MISSED APPOINTMENT POLICY:
We do realize that inadvertently missing appointments can sometimes happen. However, missed appointments often delay or prevent other patients from receiving timely care. Please arrive on time. If you are more than 20 minutes late for an appointment, you will be asked to reschedule. *If you miss more than three (3) appointments, you will be dismissed from our practice.*

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Kids Central Pediatrics physician or his or her designee. I consent for Kids Central Pediatrics to accept payment of benefits directly from my insurance company under the terms of my insurance. I allow the release medical records to my insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Kids Central Pediatrics Patient Information Privacy Policy. I hereby authorize Kids Central Pediatrics or the physician individually to release any of my or my dependent's medical or incidental non- public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA):
I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that Kids Central Pediatrics may share my health information for treatment, billing, and health care operations. I have been given a copy of the organizations notice of privacy practices that describes how my health information is used and shared. I understand that Kids Central Pediatrics has the right to change this notice at any time.

As legal custodian of the above listed child, I give Kids Central Pediatrics the right to examine and treat this child. I allow the release medical records to my insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters. I give Kids Central Pediatrics the right to treat my child if they are brought into the office in an emergency. I authorize Kids Central Pediatrics to release any of the information necessary to process insurance claims filed on my behalf. I authorize payment of medical benefits to be made directly to Kids Central Pediatrics or the physician for services performed. I acknowledge that the information listed above is current and correct and will notify Kids Central Pediatrics of any changes. I understand that I am responsible for charges not covered by my insurance contract and all charges related to misrepresentation of coverage. *In the event of divorce, if the responsible guarantor is not the one signing this consent, please provide court documents stating otherwise.*

GUARANTOR SIGNATURE:____ Date:________________________