CHILD NEW PATIENT REGISTRATION Phone:_____

Name_____ DOB_____
Last First MI

Address _____ City_____ State_____ ZIP_____

SS# _____ E-Mail Address_____

Age_____ Sex_____ Race_____ Ethnicity_____ Language_____

Mother's Name_____ Mother's DOB_____
Last First MI

Mother's Employer _____ Mother's SS#_____

Father's Name_____ Father's DOB_____
Last First MI

Father's Employer _____ Fathers SS#_____

Please list reliable phone numbers that we may reach you on:
In the event that you are set up for any tests/procedures, we may disclose these numbers for said facilities to contact you.

Home phone:_____ Mobile phone: _____

Work phone: _____ Alternate: _____ Contact Name_____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company_____ Policy Number_____ Group_____

Policy Holder Name_____ DOB_____ SS#_____

Place of Employment: _____ Relationship to Patient_____

I, _____ hereby give my permission for the doctor or the doctor's nurse to give the results of my child's lab tests, x-ray reports, and any other medical information that I may need to know to the persons listed below or to leave such information on my answering machine. I also authorize these said people to pick up prescriptions and/or correspondence from the office in regards to my child's medical care.

_____ _____

I hereby give authorization to Kids and Tummies, LLC to furnish information to insurance carriers concerning my child's illness and treatments. I hereby assign all payments for medical services rendered to myself. I understand that I am responsible for all charges regardless of insurance coverage. I also authorize the release of my child's medical record information to other physicians or health care institutions for the purpose of continuity of care. This authorization should be considered for one year. ALL ABOVE INFORMATION IS TRUE TO MY KNOWLEDGE.

_____ _____
Print/Signature of patient or responsible party **Date**

POLICY FOR PRESCRIPTIONS: It is important that our patients do not suffer any adverse effects from the medications prescribed by outside physicians or those at Kids and Tummies. Serious side effects may result from using medications longer than intended. Some dangerous side effects may result from interaction of medications being prescribed my multiple physicians. If the physician prescribing medication is not aware of all medications being taken by the patient, it may result in adverse drug reactions. Please read the following and sign for our records.

1. Medications will be refilled during normal business hours. Narcotics will be prescribed only by your treating physician.
2. Prescriptions, especially narcotics, will not be prescribed on weekends, holidays or after hours by any of our physicians. Please be sure that you call and request any refills on medication before 4:00 PM each business day. Please be sure that your request coincides with your doctor's office hours.

ASSIGNMENT OF BENEFITS/ AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services from Kids and Tummies, LLC to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or myself. I understand that I am financially responsible for all charges not covered by insurance. I AUTHORIZE THE REALEASE OF MEDICAL RECORDS INFORMATION TO OTHER PHYSICANS OR OTHER HEALTH CARE INSTITUTIONS FOR THE PURPOSE OF CONTINUITY OF CARE.

_____ **PATIENT INITIALS**

FINANCIAL POLICY- All of our providers at Kids and Tummies, LLC accept patients that have Medicare, Medicare, Tricare, and the majority of commercial insurances. Please be aware that some services may not be covered under your insurance program, and therefore, you will be responsible for those charges. Any deductible and/or co-insurance will be due at the time of service. We do accept cash, check, major credit and debit cards.

_____ **PATIENT INITIALS**

In some circumstances payment plans can be made with our billing department. If lapses occur in making payments on such plans, and/or paying on balances due, our billing department will send the delinquent accounts to a collection agency. Any fees or expenses incurred as a result of sending your account to such agency will be the responsibility of the patient. There will be a $30.00 fee for a returned check.

_____ **PATIENT INITIALS**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY: Attached to this paperwork is a PRIVACY NOTICE. I acknowledge that I have received the Privacy Notice of Kids and Tummies, LLC .

_____ **PATIENT INITIALS**

I have read and understand the terms of the assignment of benefits/ authorization for treatment, financial policy/payment plan policy; consent form and authorization for medical records. AUTHORIZATION EXPIRES IN ONE (1) YEAR.

Patient or Authorized Representative	**Date**
Signature of Kids and Tummies, LLC Representative	**Date**

401 Cowan Road, Suite B
Gulfport, MS 39507

Phone: 228-222-4072 (or) 844-210-6464
Fax: 228-215-1205
www.kidsandtummies.com

Appt. date:_____

Appt. time:_____

Dear Patient:

You are scheduled for an appointment at Kids and Tummies.

Please complete this paperwork and bring it with you on the day of your appointment. This will help to expedite your check in process. If you do not bring this paperwork in with you or if it is not fully completed, it could significantly delay your appointment time. We also ask that if you have had any recent lab work, x-rays or any other procedures, that you please bring those with you on the day of your visit. Also, please bring in all of the medications that you are currently taking.

New patients are asked to arrive 30 minutes prior to your scheduled appointment. If you have not been seen in our clinic within the last 3 years you will be scheduled as a new patient.

If it is necessary to cancel your scheduled appointment, we request that you call 24 hours prior to the scheduled appointment. Appointments are in high demand, and your early cancellation will give another person a possibility to have access to timely care.

Our clinic has recently implemented a patient portal. www.followmyhealth.com is the link to our patient portal thus, allowing our patients to manage their health information and communicate with providers in a secure, online environment 24/7.

If you have further questions, please view our website at www.KidsandTummies.com.

Thank you very much for choosing our Kids and Tummies for your child's GI healthcare needs. If you have any questions or need to reschedule this appointment, please feel free to call our centralized scheduling department at 844-210-6464

Sincerely,
Kids and Tummies, LLC