Patient Registration

PARENT #1_____ DOB_____ SS# _____ ❑Male❑ Female

Address_____ Home Phone _____

City/State/Zip_____ Cell Phone _____

Employer/Occupation_____ Work Phone _____

Employer Address_____ EMAIL _____

PARENT #2_____ DOB_____ SS# _____ ❑Male❑ Female

Address_____ Home Phone _____

City/State/Zip_____ Cell Phone _____

Employer/Occupation_____ Work Phone _____

Employer Address_____ EMAIL _____

Parents are (PLEASE Mark as appropriate)

❑Married ❑Living Together ❑Separated ❑Divorced If divorced, **which parent does patient live with?: ❑#1 ❑#2**

Patient Name_____ **DOB** _____ **❑M ❑F SS#** _____

Emergency Contact Person_____ **Relation to child(ren)**_____ **Cell#** _____

Additional names of individuals, and relationship, (other than parents OR emergency contact) of whom I give permission to bring in my child in and be responsible for carrying out the directives given to them by Pediatric Associates.

Name_____ Relationship to Pt_____ Cell#_____

Name_____ Relationship to Pt_____ Cell#_____

Notice of Privacy Practices for Protected Health Information

I have been given a copy of the Privacy Practices Notice and understand the rights of privacy as afforded me therein. To grant access to others, i.e., family members, daycares, or others outside of the mandated entities I am required to have a **PHI Security Code**. Those I entrust with the Security Code may receive Protected Healthcare Information. I understand Pediatric Associates will release Protected Healthcare Information only to those in possession of the code, and I may cancel or change this Security Code at any time by means of a written request presented to Pediatric Associates. I understand without the PHI Security Code no information can be given to any individual making request for Protected Health Information. I understand the PHI Security Code should be kept securely and protected from access to individuals not intended to receive the code.

I select the following PHI Security Code - _____

Please indicate name of PRIMARY CARE PHYSICIAN:

Mary E Keown ☐ William R Davidson, MD ☐ Mary K Bartek, MD ☐ David A Wyckoff, MD ☐ Lori L Amis, MD ☐

****WE REQUIRE THAT YOU PRESENT YOUR INSURANCE CARD AT EVERY VISIT****

COPAYS, DEDUCTIBLES, BALANCES ARE DUE AT TIME OF SERVICE

Authorization of Treatment and Assignment of Benefits: I authorize Pediatric Associates, to treat my child(ren). I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Pediatric Associates, for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Pediatric Associates for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits at the time of service.** I also understand that I am responsible for advising Pediatric Associates of any changes to my insurance. Failure to pay co-pay at that time will result in an additional billing charge. Our office requires 24-hours notice of appointment cancellations. Failure to provide this notice will incur a cancellation fee. This office reserves the right to charge a collection fee of 35% of the principal balance at the time of write off or dismissal to a third-party collection agency.

I have received a copy of PADC's Office and Financial Policies. *A photocopy or scan of this authorization shall be considered as effective and valid as the original.*

Signature_____ Relationship_____ Date _____