CENTER FOR pediatric and adolescent MEDICINE, PA

WE IMMUNIZE
FOLLOWING THE CDC CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

CPAM CHART # _____

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PATIENT REGISTRATION

(FORM MUST BE COMPLETED IN ITS ENTIRETY & SIGNED)

PATIENT / CHILD

Last Name, First Name, Middle Initial of Patient		Patient Name Called	
Street Address *(No PO Box #)* ☐ CHECK IF SAME AS PATIENT		Patient Gender	Patient Date of Birth
		☐ MALE ☐ FEMALE	
City, State, Zip Code		Primary Language	
		☐ ENGLISH ☐ SPANISH ☐ OTHER:	
Patient Race ☐ DECLINED		Patient Ethnicity ☐ DECLINED	
☐ AMERICAN INDIAN ☐ ALASKAN NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ BLACK / AFRICAN AMERICAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ OTHER:		☐ HISPANIC / LATINO ☐ NON-HISPANIC / LATINO	
Preferred/Main Contact Phone #	Secondary Contact Phone #	Patient Lives With *(Please Check)*	
		☐ BOTH PARENTS ☐ MOM ☐ GUARDIAN ☐ GRANDPARENT(S) ☐ DAD ☐ OTHER	

INSURANCE

Last Name, First Name, Middle Initial of Insurance Policy Holder - *(Subscriber)*		Subscriber's Social Security #
☐ MALE ☐ FEMALE		
Primary Insurance Company *(Copy of Current Insurance Card Required)*	Co-Pay	Subscriber's Date of Birth
	$	
Policy ID #	Group ID #	Effective Date of Current Policy

MOTHER / GUARDIAN

Last Name, First Name, Middle Initial of Mother/Guardian		Maiden Name or Guardian Relationship
☐ MOTHER ☐ OTHER		
Street Address *(No PO Box #)* ☐ CHECK IF SAME AS PATIENT		Mother/Guardian Date of Birth
City, State, Zip Code		Mother/Guardian Status:
		☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE ☐ REMARRIED ☐ WIDOWED
Mother/Guardian Place of Employment ☐ UNEMPLOYED		Mother/Guardian Work Phone #
Mother/Guardian Email		Mother/Guardian Cell Phone #

FATHER / GUARDIAN

Last Name, First Name, Middle Initial of Father/Guardian		Guardian Relationship *(If not Father)*
☐ FATHER ☐ OTHER		
Street Address *(No PO Box #)* ☐ CHECK IF SAME AS PATIENT		Father/Guardian Date of Birth
City, State, Zip Code		Father/Guardian Status:
		☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE ☐ REMARRIED ☐ WIDOWED
Father/Guardian Place of Employment ☐ UNEMPLOYED		Father/Guardian Work Phone #
Father/Guardian Email		Father/Guardian Cell Phone #

RX

Preferred Pharmacy	Address or Intersection	City and/or Phone #

OVER→

CPAM Chart # _____

Financial Policy

By signing/acknowledging this document, I hereby authorize and/or understand (a) payment of insurance benefits otherwise due to me to be made directly to the Center for Pediatric and Adolescent Medicine, (b) the release of information to insurance companies as needed to file for payment for services incurred, (c) the Center for Pediatric and Adolescent Medicine to obtain records from other sources as may be necessary in the diagnosis or treatment of the stated patient, (d) I am financially responsible for payment to the Center for Pediatric and Adolescent Medicine for charges related to services provided to or incurred by me or my dependents including but not limited to co-pay and co-insurance amounts, deductible amounts, charges for treatments not covered by insurance, and/or insurance filed with inaccurate/terminated coverage information, (e) the Center for Pediatric and Adolescent Medicine will bill me directly any balances for office visits, services and/or procedures should the insurance company I provided to them not respond to the filing of the medical claim within 60 days of the date of service, and (f) to the best of my knowledge, the information presented by me is accurate and correct.

You accept financial responsibility for all services rendered on your child's behalf at the Center for Pediatric and Adolescent Medicine whether or not you are present on the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balances.

- *We file claims to participating insurance companies as a courtesy to you. You are and remain responsible for ensuring full payment of charges incurred, including and not limited to deductible, co-insurance, co-pay, cost share and none covered amounts. We will bill your insurance company only if we are in network and only if your insurer accepts claims electronically. You are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. Patients are considered self-pay for services covered by worker's comp or auto insurance.*
- *If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days after the date of service and you must pay the outstanding balance in full.*
- *Patients with an outstanding balance of 90 days or more must arrange an acceptable payment plan or their account will be turned over to a collection agency and they will be dismissed from the practice. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our billing specialist to request assistance before your account becomes delinquent.*
- *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 an additional co-pay, co-insurance, deductible, or denial after the visit.*
- *We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide (including outsource lab testing). It is your responsibility to know if you have coverage before services (or lab tests) are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis codes in order for it to be paid. We are not the billing agent for outsource laboratory test. Questions concerning billing of labs must be made directly to that facility.*
- *All co-pays are due at the time of service regardless of who brings the child in for the appointment. Should special arrangements need to be made, please discuss options with the front office staff prior to being seen by the physician. Frequently failing to pay your co-pay is grounds for dismissal from the practice should balances start to accumulate.*
- *When paying with a personal check, please note all returned checks will be assessed a $20 service charge if funds are determined to be insufficient. Your account will also be "flagged" as unable to accept checks as a form of payment for services.*
- *If for any reason you must cancel or reschedule your appointment(s), please notify our office at least 24 hours in advance. This will enable the staff to schedule appointments of other patients that need to be seen. Patients that no-show 3 times within a 12 month period will be subject to dismissal from the practice. Note that 2 appointment cancellations with less than 24 hours notice is the equivalent of a no-show. We do our best to accommodate your needs; but please note, if you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment according to our availability.*
- *Patient forms are an essential part of pediatrics and require time and effort by our staff to complete. We are happy to fill out needed physical and other forms during your child's well check appointment. Should these forms need to be filled out after your appointment, it may take minimum 48 hours to have forms completed. If you need the form in less than 48 hours, we will charge a $30 expedite fee. Also note, we will charge copy & handling fees to process patient record releases to other practices and entities.*

Consent for Treatment

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 the Center for Pediatric and Adolescent Medicine. I hereby authorize the Center for Pediatric and Adolescent Medicine 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 tendered. I request payment of authorized benefits to made payable to the Center for Pediatric and Adolescent Medicine, PA on my child's behalf. I have read and agree to the financial policies states above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

REQUIRED SIGNATURE ACKNOWLEDGING INFORMATION

2016

_____
Print Patient/Child's Name Date of Birth

_____
Signature of Patient or Patient Representative Date

_____
Print Name of Patient Representative and Relationship to Patient

**** * * PLEASE NOTE * * ****
TO BE REGISTERED AS A PATIENT, ALL INFORMATION MUST BE COMPLETED & SIGNED.

MD Request: ☐Tilt ☐Abbott ☐Gallagher ☐Thomas

How did you find out about our practice? ☐Friend ☐Professional Referral ☐Web Site ☐Advertisement ☐Other?:_____