Spring Pediatrics

DATE: _____ Patient Registration

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Social Security # _____-____-_____

*Last Name: _____*First: _____MI: ____ *Sex: ☐ M ☐ F * Date of Birth: ___/___/____

***Race**: ☐ White ☐ Black ☐ Asian ☐ Native Amer ☐ Other _____ ☐ Decline to Answer

***Ethnicity**: ☐ Hispanic ☐ Not Hispanic ☐ Decline to Answer *Preferred Language: _____

*Address: _____
Street Apartment # City State Zip Code

Home # _____ Mother's Cell # _____ Father's Cell # _____

Mother's Name: _____ SS# _____ Employer: _____ Work # _____

Father's Name: _____ SS# _____ Employer: _____ Work # _____

*Responsible Party (the person financially responsible for paying the bill/charges not covered by insurance)

*Last Name: _____*First: _____MI: _____

*Phone (H) _____ (W) _____ Ext:_____ (C) _____ Alternate_____

*Address (If different from above)_____
Street Apartment # City State Zip Code

*E-Mail Address: _____

Preferred Pharmacy: _____ Address:_____
Street City State Zip Code

*Primary Insurance Information

Insurance Company Name :_____Address:_____

Policy/ID #: _____ Group #: _____ Co-pay $ _____ Ded. $ _____ Co-Ins_____

Effective Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Subscriber's Name: _____ SS#: _____
Last First MI

Subscriber's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Employer: _____
Month Day Year

Insured's Address: _____
Street City State Zip Code

Secondary Insurance Information

Insurance Company Name: _____Address:_____

Policy/ID #: _____ Group #: _____ Copay $ _____ Ded $ _____ Co Ins _____

Effective Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Subscriber's Name: _____ SS#: _____
Last First MI

Subscriber's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Employer:_____
Month Day Year

Insured's Address: _____
Street City State Zip Code

Emergency Contact Information (someone other than parents)

Last Name: _____First: _____MI: _____ Relation to Patient _____

Phone (H) _____ (W) _____ Ext:_____ (C) _____ Alternate_____

Address _____
Street Apartment # City State Zip Code

Authorization to Release Information

I, _____ **(parent/guardian name)**, hereby authorize Spring Pediatrics to apply for benefits and release any medical or incidental information that may be necessary for either medical care or in processing applications or financial benefits of _____ **(patient name)**, for covered services rendered by Spring Pediatrics I request payment from _____ **(insurance company name)** to be made directly to Spring Pediatrics.

I understand that Spring Pediatrics will file my insurance claim but this **does not release my responsibility** for the amount not payable by the insurance company. If payment is not received from the insurance company **within 60 days of filing**, payment becomes the responsibility of the parent/guardian. **Initial** _____

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or in case of Medicare part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. **Initial** _____

Authorization for Treatment

I hereby give my permission to any of the Practice Doctors or their designated alternates, to take necessary medical action in emergency situation for my child(ren) when I am not immediately available. **Initial** _____

Our practice follows guidelines for immunization and routine lab tests set by the American Academy of Pediatrics. You may be responsible for partial or total payment of some of these procedures depending on your insurance coverage. Patients are responsible for knowing what their insurance company covers prior to their visit. Any problems with coverage or reimbursement should be settled by the patient directly with the insurance company. **Initial** _____

I acknowledge that it is the policy of this office that payment is requested at each visit and I am responsible for payment of all services rendered. If the treating physician is a participant in a managed care plan of which I am a member, I agree to pay any co-payment, co-insurance, and/or deductible required by my particular plan at the time of visit. **Initial** _____

Appointments Policy

Our office is by appointment only. **NO WALK-INS WILL BE SEEN**. We require 24 hours notification if you must cancel an appointment. There will be a **charge of $30 for appointments cancelled or broken without 24 hours advance notice**. You will be required to pay the fee prior to your next appointment. Your insurance does not cover these fees. **Initial** _____

School/Daycare Forms

We will fill out one complimentary health form at each Health Assessment / 1 year. Please make copies of these forms for your records and other school/daycare. For completing additional forms, there will be a charge of $30.00. **Initial** _____

Acknowledgement of Office Policies and Procedures

I certify that information was received by me, reviewed and understood concerning the office policies and procedures. I will comply with the directives as written.

I certify that all of the preceding answers and information provided are true and correct. If I ever have any change in my information and/or insurance coverage, I will inform Spring Pediatrics.

Patient Name: (please print) _____

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian filling in form

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party