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| **Patient Registration Form** |
| **Name:** |  |
| **DOB:** |  | **Gender:** 🞎 Male 🞎Female  |
| **Race:** | White | Black or African American | American Indian | Hispanic | Asian |
| **Ethnicity:** | Hispanic or Latino |  Not Hispanic or Latino |
| **Name:** |  |
| **DOB:** |  | **Gender:** 🞎 Male 🞎Female  |
| **Race:** | White | Black or African American | American Indian | Hispanic | Asian |
| **Ethnicity:** | Hispanic or Latino |  Not Hispanic or Latino |
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| **Race:** | White | Black or African American | American Indian | Hispanic | Asian |
| **Ethnicity:** | Hispanic or Latino |  Not Hispanic or Latino |
| **Mailing Address:** |  | **City:** | **State:** | **Zip:** |
| **Physical Address:** If Different Than Mailing |  |
| **Home Phone:** |  | **Cell Phone:** |  |
| **Language Preference:** If other than English |  |
| **Parent/Guardian #1**  |
| **Name:** |  | **Relationship to Patient:** |  |
| **SS#:** |  | **DOB:** |  | **Gender:** 🞎 Male 🞎Female  |
| **Mailing Address:** |  | **City:** | **State:** | **Zip:** |
| **Home Phone:** |  | **Cell Phone:** |  |
| **Work Phone:** |  | **Employer Name:** |  |
| **Email Address:** |  |
| **Parent/Guardian #2** |
| **Name:** |  | **Relationship to Patient:** |  |
| **SS#:** |  | **DOB:** |  | **Gender: 🞎 Male 🞎Female**  |
| **Mailing Address:** |  | **City:** | **State:** | **Zip:** |
| **Home Phone:** |  | **Cell Phone:** |  |
| **Work Phone:** |  | **Employer Name:** |  |
| **Email Address:** |  |
|  |  |
| **Emergency Contact** *–* ***Person Not Living In The Same Household As Patient*** |
| 1 | **Name:** |  | **Relationship:** |  |
|  | **Phone Number:** |  | **Phone Number:** |  |
| 2 | **Name:** |  | **Relationship:** |  |
|  | **Phone Number:** |  | **Phone Number:** |  |
| **Primary Insurance Information**- ***Please Give Card To Receptionist***  |
| **Plan Name:** |  |
| **Policy Holder Name:** |  | **Gender:** 🞎 Male 🞎Female |
| **Policy Holder’s SS#:** |  | **Policy Holder’s DOB:** |  |
| **Secondary Insurance Information*- Please Give Card To Receptionist*** |
| **Plan Name:** |  |
| **Policy Holder Name:** |  | **Gender:** 🞎 Male 🞎Female |
| **Policy Holder’s SS#:** |  | **Policy Holder’s DOB:** |  |
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 **Family History: *(Check any known problems in the family – please complete at least for parents and*** ***siblings)*** 

**Comments (including *Other* responses): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Relationships: P=Paternal (father’s side of family), M=Maternal (mother’s side of family), GM=Grandmother, GF=Grandfather, MGM = Maternal Grandmother**

**Social History:**

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| --- | --- |
| **Number of People at Home:**  | **\_\_\_\_\_\_**  |
| **Lives with biological parents:**  | **Yes**  | **No**  |
| **Foster Care:**  | **Yes**  | **No**  |
| **Primary Care Givers (circle):**  | **Parents**  | **Daycare**  | **Relatives**  | **Others:\_\_\_\_\_\_\_\_** |
| **Pets:**  | **Yes**  | **No**  |
| **Parent’s Status:**  | Married  | Divorced  | Single  | Other\_\_\_\_\_\_\_\_\_  |

**Medical History: *(Please Check All That Apply )***

\_\_\_\_Hospitalizations? \_\_\_ Prematurity \_\_\_\_ Constipation

\_\_\_\_Asthma \_\_\_ GE Reflux \_\_\_\_ Anemia

\_\_\_\_Allergic Rhinitis \_\_\_ Recurrent Ear Infections \_\_\_\_ Recurrent Strep

\_\_\_\_Eczema \_\_\_ Urinary Tract Infections \_\_\_\_ Vesicoureteral Reflux (VUR)

\_\_\_\_Wheezing \_\_\_ Diabetes \_\_\_\_ Vision Problems

\_\_\_\_Food Allergies \_\_\_ Developmental Delay \_\_\_\_ Seizure Disorder/Epilepsy

\_\_\_\_Murmur \_\_\_ ADD/ADHD \_\_\_\_ Mental Illness

\_\_\_\_Congenital Heart Disease \_\_\_ Substance Abuse

Other Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Surgical History:**

**\_\_ No Surgeries**

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| **Procedure:** |  **Date or Age:** |  **Surgeon:** |
| \_\_\_ Adenoidectomy  |
| \_\_\_ Appendectomy  |
| \_\_\_ Ear Tubes  |
| \_\_\_ Fundoplication  |
| \_\_\_ Gastrostomy Tube Placement  |
| \_\_\_ Heart Surgery  |
| \_\_\_ Hernia Repair  |
| \_\_\_ Orthopedic Surgery  |
| \_\_\_ Tonsillectomy  |
| \_\_\_ Urological Surgery  |
| \_\_\_ VP Shunt  |

\_\_\_ Other:

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| --- |
| **Delegation of Consent:** ***– Please list person(s) other than child’s parents/guardians that you grant permission to your provider to discuss Medical Records and /or Plan of Care.***  |
| **1** | **Name:** |  | **Relationship:** |  |
|  | **Phone Number:** |  | **Drivers License #:** |  |
| 2 | **Name:** |  | **Relationship:** |  |
|  | **Phone Number:** |  | **Drivers License #:** |  |
| 3 | **Name:** |  | **Relationship:** |  |
|  | **Phone Number:** |  | **Drivers License #:** |  |
|  |  |  |  |  |
| **Printed Name:** |  |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Wonderfully Made Pediatrics PLLC, may use and disclose Protected Health Information (PHI) about me and/or my child to carry out treatment, payment and healthcare operations (TPHO). Please refer to Wonderfully Made Pediatrics PLLC’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been provided with the opportunity to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Wonderfully Made Pediatrics PLLC may call my home and/or other designated location and leave a message on voicemail or in person in reference to any items that may assist the practice in carrying out TPHO. This includes but is not limited to appointment reminders, insurance items and any call pertaining to my child’s clinical care, including laboratory and other results.

With my consent, Wonderfully Made Pediatrics PLLC may mail to my home and/or other designated location any items that may assist the practice in carrying out TPHO, including but not limited to appointment reminder cards and patient statements. Such correspondence may also be sent by electronic mail (e-mail).

By signing this form, I am consenting to Wonderfully Made Pediatrics PLLC’s use and disclosure of my PHI to carry out TPHO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Wonderfully Made Pediatrics PLLC may decline to provide treatment to me and/or my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date



**Office Financial Policy**

**Parents are required to pay for their child’s health care at the time services are provided**. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard, American Express, Discover, Visa and debit cards. For your convenience, we also offer the option of keeping a credit card on file. **By doing so, you authorize Wonderfully Made Pediatrics PLLC, to process payment for statements with charges $50 or less.** If statements are more than $50, you will be notified either by phone, email or mail at least 3-4 weeks prior to payment being processed.

**Insurance:** We accept insurance from all major insurance companies. We require you to provide us with a copy of your current primary insurance information at ***every*** visit. Our billing department will file your insurance claim to your primary insurance and then to any secondary insurance.

Our office cannot tell you in advance whether or not your charges will be covered by your insurance plan. Each insurance company has multiple plans that vary with employer group contracts. It is your responsibility to familiarize yourself with your own insurance plan, including types of coverage and restrictions on imaging, laboratories, urgent care facilities and emergency rooms.

**Referrals:** Some insurance companies require a referral if your child needs to see a specialist for any reason. It is your responsibility to call your insurance company to determine if a referral is needed. If a referral is required, please let us know and we will arrange it for you. Referrals ***MUST*** be requested at least 72 hours in advance.

**Billing:** Account balances not paid after 120 days will be forwarded to our collection agency.

**No Show Policy:** We value our patients and appreciate them for choosing us as their medical care provider. Patients who miss their appointments or cancel their appointments with less than 48 hours’ **notice may be subjected to a fee of $35.00 for recall** or new patient appointments. New patients may not be able to reschedule if they have more than 1 missed appointment. This time has been reserved especially for them. Keeping their appointment helps maintain an efficient schedule for our office and for other patients. **A “no-show” will be documented when there is a failure to arrive for a same day scheduled appointment**. **If you have 3 no-shows within a year your child(ren) may be dismissed from the practice.**

**Copay Policy:** Per the contract you have with your insurance company, copays must be made at the time of service.

**Covered/Non-Covered Services**: **Wonderfully Made Pediatrics PLLC** **is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover.** I understand the billing staff of **Wonderfully Made Pediatrics PLLC** will file all claims for covered services with my insurance company if the provider is a contracted provider. I understand I am responsible for any balances that may be due to the provider as a result of the following:

-Co-Insurance or Co-Payments

-Out-Of-Network Charges

-No Insurance Coverage

-Failure To Respond To Insurance Company Correspondence Or Inquiries

-Failure To List Our Provider As Your Primary Care Provider

-Failure To Notify In Advance That The Lab/Imaging Facility Is Not A Preferred Provider

-Annual Deductible Amounts

-Non-Covered Services

-Terminated Coverage

-Exhausted Benefits

**Divorce Decrees:** This office ***cannot*** be a party to your divorce decree. The responsibility of the bill for minors is with the parents or legal guardian. It is our policy to **collect payment at the time of service from the parent, guardian or caretaker who brings the child(ren) in for the appointment.** Again, our primary responsibility is to provide medical care for your child(ren) and not to handle billing or insurance coverage disputes between separated or divorced parents.

**Release of Information and Payment Authorization:**

**All Insurance Companies, Third Party Payers and Government Policies:** I hereby authorize Wonderfully Made Pediatrics PLLC and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the provider(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Wonderfully Made Pediatrics PLLC and/or provider(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct.

**Guarantee of Payment:** I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Wonderfully Made Pediatrics PLLC to me and/or my child(ren) indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Workman’s Compensation and/or claims due to personal injury accidents/illnesses. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

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**Signature of Parent/Guardian Date**