IRVING PEDIATRICS

DATE: _____
OFFICE: _____

IRVING PEDIATRICS PATIENT REGISTRATION FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Patient Information (*Please list ALL Children Under Age 18*)

Legal Name	Preferred Name	PCP in our Office	Sex (M/F)	DOB (mm/dd/yyyy)	Child lives with? (mother/father/both)

Mother / Father / Guardian #1 (*for child(ren) listed above*)

Name _____ Date of Birth _____
Address _____ Home Phone (____) _____
City _____ Cell Phone (____) _____
State _____ Zip Code _____ Work Phone (____) _____
Employer Name _____ E-mail address _____

Mother / Father / Guardian #2 (*for child(ren) listed above*)

Name _____ Date of Birth _____
Address _____ Home Phone (____) _____
City _____ Cell Phone (____) _____
State _____ Zip Code _____ Work Phone (____) _____
Employer Name _____ E-mail address _____

Marital Status (circle): Married Single Separated Divorced Widowed

IF DIVORCED: □ JOINT CUSTODY □ SOLE CUSTODY □ LEGAL DOCUMENTS PROVIDED

Address child(ren) live(s) at (*if other than above)*

Address _____ Phone (____) _____

City _____ State _____ Zip _____

Emergency Contact (*other than parent / guardian)*

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Authorized Care Givers (*other than parents)*

The following people are authorized to discuss personal health information and to bring my minor child(ren) to Irving Pediatrics for evaluation and treatment, including immunizations:

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____ Initial Irving Pediatrics **(circle one) can cannot** treat and administer injections/vaccines to my unaccompanied child(ren) over the age of 16.

_____ Initial I, _____, authorize Irving Pediatrics to contact me by telephone with medical information pertaining to my child(ren)'s care. If I am unavailable, this authorization gives Irving Pediatrics permission to leave this information either on my answering machine, voicemail, or with a member of my household.

Preferred number to call with information: _____

_____ Initial I authorize Irving Pediatrics, or whomever they designate, to evaluate and treat my above name child(ren) and to release to our insurance company any information acquired in the course of my child(ren)'s examination or treatment, and to receive all payments for such examination or treatment. Irving Pediatrics has my permission to release any diagnostic studies, reports, etc. to a specialist involved in caring for my child.

_____ Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____ Initial A parent / guardian / or authorized care giver is to be present at every visit. If someone else is bringing your child(ren), **we will need prior written authorization** that includes authorization for treatment, your contact information, and insurance and co-pay payment authorization for this visit.

PAYMENT POLICIES

_____ Initial **Insurance Information:** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, or if the insurance information on file cannot be verified prior to a visit, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billing to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____ Initial **Account Balances:** When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** Irving Pediatrics reserves the right to reschedule or deny future appointments for delinquent accounts.

_____ Initial **Payments:** Irving Pediatrics accepts cash and credit / debit card payments. Personal checks are not accepted in the office, but are accepted by mail (for statement payments).

_____ Initial **Co-Payments:** Co-payments are expected to be paid at the time service is rendered. If payment is not received at the time of service, there may be an additional fee. All returned checks will be subject to a $40 service charge.

_____ Initial **Self-Pay:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccines for Children program.

_____ Initial **Divorce Situations:** The parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____ Initial **Referrals:** If your insurance plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral be processed *prior* to the specialist appointment.

_____ Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend, and holiday visits to your insurance carrier. This code may **or may not** be covered.

_____ Initial **No Shows:** A $25 no show fee will be assessed for all visits not canceled one or more **business days** in advance.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

PLEASE COMPLETE BOTH SIDES OF THIS FORM