Sandy Plains Pediatrics

Patient Registration Form

Last Name:_________________________(if child's last name is different, list below)
Child:_____________________________Date of Birth:___________M or F
Child:_____________________________Date of Birth:___________M or F
Child:_____________________________Date of Birth:___________M or F
Child:_____________________________Date of Birth:___________M or F

Address:____
City________________________________ Zip Code:_____________________
Primary phone no.:______________Secondary phone no.______________

Parent name(s): ____
Parent e-mail address:___________________________________
Primary insurance______________________Secondary insurance___________
Cardholder's Name____________________________Date of Birth: _________

Emergency Contact: _____________________Relationship:_______________
Phone Number: __________________________

How did you hear about us?____

The above information is true to the best of my knowledge. I authorize treatment for the above individual(s) and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills within 30 days from receipt of statement, unless other arrangements are made. I authorize the physician and Sandy Plains Pediatrics to release any information required to process my insurance claims. I also authorize my insurance to directly pay Sandy Plains Pediatrics.

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Responsible Party Signature Date

Patient Name: ______________________________ DOB _______________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, and if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, insurance purposes and routine healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, insurance purposes or healthcare operations (consultations with specialists or hospitalists)
- The practice reserves the right to change the privacy policy as allowed by law
- The practice as the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments: YES NO

May we leave a message on your voicemail/answering machine: YES NO

May we discuss your condition with any member of your family: YES NO

If YES, please name the members allowed:

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PRINT NAME: ______________________________

Circle one: PARENT LEGAL GUARDIAN PATIENT

SIGNATURE: ________________________________ DATE: ___________

PAYMENT AND OFFICE POLICY

CONTRACTED INSURANCE: Please know your coverage and benefits prior to visits. All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits and deductibles are your responsibility. Payment for this is expected within 30 days from receipt of your statement.

NON-CONTRACTED INSURANCE: It is your responsibility to verify that your insurance is contracted with us. If your insurance company is not contracted with Sandy Plains Pediatrics, all charges are considered your responsibility at the time of service. As a courtesy, Sandy Plains Pediatrics will provide you with a claim to send to your insurance for reimbursement. All Third Party Payers (Motor Vehicle Accident Insurance) are considered non-contracted.

CO-PAYS: All co-pays are expected at the time services are rendered. **There is a $15.00 charge for co-pays not paid at time of service.** We accept cash, checks, VISA, American Express or Mastercard. Payment arrangements are considered under special circumstances.

DIVORCED, SEPARATED OR BLENDED FAMILIES: In order to keep our accounts clean and eliminate any uncomfortable situations, we have chosen **NOT** to become involved in any agreement, understanding and/or court ordered regarding reimbursement from absent parent. Payment is due at the time of service.

NO SHOW/CANCELLATION POLICY: Cancelled appointments, **without 24 HOUR** notice will be subject to the no show fee. **Your family may be discharged from Sandy Plains Pediatrics if two well check no shows occur.**

LATE POLICY: If you are more than 20 minutes late for your appointment, you may not be seen that day, or may have a wait time to be worked into our schedule.

METHOD OF PAYMENT: There will be a $30.00 charge for all returned checks.

PLEASE NOTE: WE WORK BY APPOINTMENTS ONLY AND DO NOT ACCEPT WALK-INS.

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Responsible Party Signature Date