Internal Medicine and Pediatrics of Bloomfield, PC
Steve Kallabat, MD
Azrael Paredes, MD
Jamie Chioini-Baines, DO
Karishma Walvekar, MD

Annual Registration Form

PEDIATRIC **ADULT**

Last Name_____ First Name_____ MI____

Date of Birth____/____/____ Age_____ Gender: **Male Female**

Address_____City_____ State____ Zip_____

Cell Phone (_____)_____ Home Phone (_____)_____

Emergency Contact:_____ Relationship_____ Phone _____
Can we discuss your medical/financial information with anyone? **Yes** or **No**
If so, who?_____ Relationship_____ Phone _____

Local Pharmacy Name_____ Address _____Phone_____

Mail Order Pharmacy_____Address_____Phone_____

Primary Insurance:_____

Subscriber Name:_____ DOB_____

Patient relationship to subscriber: **Self Spouse Parent Child Other**_____

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements, including payments due at the time of service as well as any referrals or prior authorizations needed. It is the insurance company that makes the final determinations, once this decision is made, we will not resubmit any claims.

Co-payments: All co-payments must be paid at the time of service as required by your insurance company, we cannot waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay for the office visit, in full, at the time of service. The patient will also be responsible for any additional fees incurred associated with the office visit.

Premium Fee: An afterhours fee of $30 will be charged to your account for visits after 5pm Monday thru Friday and on the weekends.

Statement Fee: Any payments missed at the time of service are subjected to a billing fee of $10. A $25 fee will be attached to each additional statement sent for unpaid balances. After the third consecutive statement, we will no longer be able to see you in our office, and you will be sent to collections.

Missed Appointments: Patients who do not cancel 24 hours prior to their appointment will be charged a no show fee. If this fee is not paid before the next visit, we reserve the right to refuse treatment. Two consecutive missed appointments are grounds to be discharged from the practice. No show fees are as follows: Office Visits- $25, Well Child Visit -$50, Adult Physical Exam-$100.

Patient Signature/Guardian Signature_____ Date_____