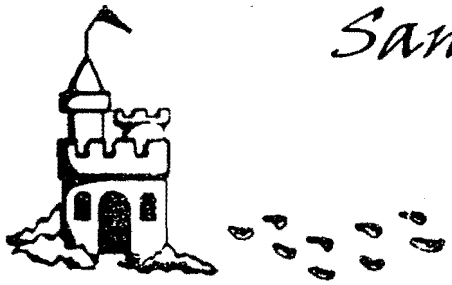

Sandy Plains Pediatrics

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.

_____

Responsible Party Signature Date

Sandy Plains Pediatrics
The Practice
Health Insurance Portability and Accountability Act (HIPAA)
Policy 2
CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PAYMENT, TREATMENT, AND HEALTHCARE OPERATIONS.

By signing below, you hereby consent for this Practice to use or disclose information that is protected under federal law, for the sole purposes of treatment, payment and healthcare operations for you or persons for whom you have the authority to sign for.

YOU MAY REFUSE TO SIGN THIS CONSENT FORM

You should read the Notice of Privacy Practices for PHI. The terms of the Notice may change from time to time, you may always get a revised copy of it by asking the front office.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or healthcare operations. The Practice is not required to agree to requested restrictions; however, if the Practice agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Offer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the receipt and may no longer be protected under federal law.

****The individuals that you list below will have access to information regarding the condition and/or treatment. (This should include anyone who plays a part in you/your child's care including but not limited to both parents, primary care physician, psychologist/counselor, school, grandparents, caregiver, etc.....)**

_____ _____

_____ _____

You may communicate information, including invoices for services to the following address and/or phone:

Address:_____Phone number:_____

Individual signature:_____ Date:_____

As a Personal Representative, I have the authority to act for the individual(s) because I am the individual's:

_____

Name of Patient(s)_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

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.

Responsible Party Signature Date