Spring Pediatrics

DATE: _____ Patient Registration

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Social Security # _____-____-_____

*Last Name: _____*First: _____MI: ____ *Sex: ☐ M ☐ F * Date of Birth: ___/___/____

***Race**: ☐ White ☐ Black ☐ Asian ☐ Native Amer ☐ Other _____ ☐ Decline to Answer

***Ethnicity**: ☐ Hispanic ☐ Not Hispanic ☐ Decline to Answer *Preferred Language: _____

*Address: _____
Street Apartment # City State Zip Code

Mother's Name: _____ Date of Birth: ___/___/___ Cell # _____ Home # _____

Father's Name: _____ Date of Birth: ___/___/___ Cell # _____ Home # _____

*Responsible Party (the person financially responsible for paying the bill/charges not covered by insurance)

*Last Name: _____ *First:_____ MI: _____

*Date of Birth: _____/_____/_____ *SS#_____-_____-_____

*Phone (H) _____ (W) _____ Ext:_____ (C) _____ Alternate_____

*Address (If different from above)_____
Street Apartment # City State Zip Code

*E-Mail Address: _____

Preferred Pharmacy: _____ Phone Number:_____

Address:_____
Street City State Zip Code

*Primary Insurance Information

Insurance Company Name:_____Address:_____

Policy/ID #: _____ Group #: _____ Co-pay $ _____ Ded. $ _____ Co-Ins_____

Effective Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Subscriber's Name: _____ SS#: _____
Last First MI

Subscriber's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Employer: _____
Month Day Year

Insured's Address: _____
Street City State Zip Code

Secondary Insurance Information

Insurance Company Name: _____Address:_____

Policy/ID #: _____ Group #: _____ Copay $ _____ Ded $ _____ Co Ins _____

Effective Date: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Subscriber's Name: _____ SS#: _____
Last First MI

Subscriber's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Employer:_____
Month Day Year

Insured's Address: _____
Street City State Zip Code

Emergency Contact Information (someone other than parents)

Last Name: _____First: _____MI: _____ Relation to Patient _____

Phone (H) _____ (W) _____ Ext:_____ (C) _____ Alternate_____

Address _____

Authorization to Release Information

I hereby authorize Spring Pediatrics to furnish any information needed by any insurance carrier to process any claim(s) for serves rendered for the above named patient by Spring Pediatrics. I assign any benefits payable by the insurance carriers for those services to Spring Pediatrics. I agree to be responsible for any amount and/or supplies not payable by the insurance company or for the full amount if the above named patient does not have insurance.

If payment is not received from the insurance company **within 60 days of filing**, payment becomes the responsibility of the parent/guardian. **Initial** _____

I certify that the information I have reported with regard to my insurance coverage is correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. **Initial** _____

Authorization for Treatment and Financial Responsibility

I hereby give my permission to any of the Practice Doctors or their designated alternates, to take necessary medical action in emergency situation for my child when I am not immediately available. **Initial** _____

Our practice follows guidelines for immunizations, preventative care and routine lab tests set by the American Academy of Pediatrics. You may be responsible for partial or total payment of some of these procedures depending on your insurance coverage. Patients are responsible for knowing what their insurance company covers prior to their visit. Any problems with coverage or reimbursement should be settled by the patient directly with the insurance company. **Initial** _____

I acknowledge that it is the policy of this office that payment is requested at each visit and I am responsible for payment of all services rendered. I agree to pay any co-payment, co-insurance, and/or deductible required by my particular plan at the time of visit. **Initial**_____

Appointments Policy

Our office is by appointment only. **NO WALK-INS WILL BE SEEN**. We require 24 hours' notice if you must cancel an appointment. **Cancelled or missed appointments within 24 hours will be charged a fee of $40.00.** You will be required to pay the fee prior to your next appointment. Insurance does not cover these fees.

Initial _____

Acknowledgement of Review of Notice of Privacy Statement

I have had the opportunity to review the Notice of Privacy Statement for the office of Spring Pediatrics. This document explains how my medical information will be used and disclosed. I understand that I am entitled to and may request a copy of this document.

Please note: Our Notice of Privacy is subject to change. **Initial** _____

School/Daycare Forms

We will fill out one complimentary health form for each Health Assessment (1 per year.) Please make copies of these forms for your records. **For additional forms to be completed there will be a charge of $30.00.** **Initial** _____

Acknowledgement of Office Policies and Procedures

I certify that I received, reviewed and understood the information concerning the office policies and procedures. I will comply with the directives as written.

I certify that all of the preceding answers and information provided are true and correct. If I ever have any change in my information and/or insurance coverage, I will inform Spring Pediatrics.

Patient Name: (please print) _____

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian filling in form

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party