PATIENT REGISTRATION FORM

Columbus Pediatric Associates

PATIENT INFORMATION

Patient's Name:		Date of Birth:	Sex: ☐ Male ☐ Female
Street Address:			
City:	State:	Zip:	Primary Language:
Primary Phone:		Patient Cell Phone (if applicable):	
Preferred Pharmacy/Location:		Primary Care Provider:	
Ethnicity (please check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify			
Race (please select all that apply): ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Pacific Islander ☐ White ☐ Declined to specify			

Siblings

Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:
Name:	Sex: ☐ Male ☐ Female	Date of Birth:

PARENT/GUARDIANINFORMATION

Parent/Guardian #1 (Responsible Party for Billing Statements)

Full Name:		Date of Birth:
Sex: ☐ Male ☐ Female		Relationship to Patient:
Address (if different from child):		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email:	Employer:	

Parent/Guardian #2

Full Name:		Date of Birth:
Sex: ☐ Male ☐ Female		Relationship to Patient:
Address (if different from child):		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email:	Employer:	

Patient's Name:

INSURANCEINFORMATION

Primary Insurance		
Insurance Name:	Member ID #:	Group #:
Insurance Address:	Insurance Phone:	
City:	State:	Zip:
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient:		

Secondary Insurance		
Insurance Name:	Member ID #:	Group #:
Insurance Address:	Insurance Phone:	
City:	State:	Zip:
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient:		

EMERGENCY

Please list two emergency contacts: (other than guardians previously listed)		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

CONTACT DETAILS

How do you prefer to be contacted regarding: (check only one for each category and write phone/email)

Appointment Reminders:	**Notices (due for appointment, weather closings, etc.):**
Text to Cell (list cell #): _____	Text to Cell (list cell #): _____

ACKNOWLEDGEMENT

THE POLICY IN OUR OFFICE IS THE PARENT/ GUARDIAN WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

I realize verification of insurance coverage is my responsibility. In the event the listed medical service is not covered by my insurance, I agree to be financially responsible for the charges for these services. If my account is assigned to a collection agency, I agree to pay all agency fees, court costs, and attorney fees I do hereby authorize Columbus Pediatric Associates PC, to apply for benefits on my behalf for services rendered. I request payment to be made directly to Columbus Pediatric Associates. I verify the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my insurance company.

_____ _____

Signature of Parent/Guardian or Responsible Party Today's Date

Columbus Pediatric Associates
Financial Consent, Privacy Practices and Vaccine Administration Policy Acknowledgement

Financial Consent

I authorize Columbus Pediatric Associates to submit each visit to my insurance company on my behalf. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize payment of medical benefits directly to Columbus Pediatric Associates.

I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for services provided by Columbus Pediatric Associates including but not limited to; co-insurance, copayment and/or deductibles and agree that I am to pay any of these non-covered charges at the time of service.

I also understand and agree that if my insurance company subsequently notifies Columbus Pediatric Associates that my child is not covered as of the date of service, has no well coverage, has exceeded well-child coverage or service provided is a non-covered service, I am to pay in full the amount not covered upon receipt of the patient statement.

I understand and agree that administrative costs including but not limited to: *form completion, medical letters of necessity and/or copies of medical records* will incur a charge that is the responsibility of the parent/guardian and cannot be submitted to my insurance carrier. I understand and agree to pay these charges either up front or upon receipt of the patient statement as dictated by office policy.

I understand and agree that fees may be assessed for appointments cancelled less than 24 hours from the appointment time and no-show appointments. The fee will be billed and payable upon receipt.

Should the account be referred to an agency for collection, I will pay reasonable fees and collection expenses, and I understand that all delinquent accounts bear interest at the legal rate.

Acknowledgement of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that Columbus Pediatric Associates works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Columbus Pediatric Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations

Columbus Pediatric Associates has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location. This Notice of Privacy Practices may be updated periodically.

Acknowledgement of Vaccine Administration Policy

I understand that Columbus Pediatric Associates will administer vaccines in accordance to the American Academy of Pediatrics Guidelines. I also understand that I will be given information about these vaccines and the opportunity to discuss them prior to administration.

Patient Name _____ **Patient DOB:** _____

Signature of Parent/Guardian:_____

Relationship to Patient if other than parent/guardian: _____