CAMPGROUND Pediatrics Wellness CENTER

PATIENT REGISTRATION FORM

(Please do not leave any blanks. Thank you.)

Today's Date:			
Patient's Name:	Patient's DOB:	Age:	Sex: ❑ M ❑ F
PATIENT RACE: ❑ AMERICAN INDIAN ❑ ASIAN ❑ BLACK/AFRICAN AMERICAN ❑ NATIVE HAWAIIAN/OTHER PACIFIC ISLAND ❑ WHITE ❑ UNKNOWN ❑ DECLINED			
PATIENT ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED			

PARENT/GUARDIAN INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status: (circle one) Single / Mar / Div / Sep / Wid	
Email:	Social Security No:	DOB: / /	Age:	Sex: ❑ M ❑ F		
Street Address:	Apt. No:	Home Phone No: ( )				
City:	State:	Zip Code:	Cell Phone No: ( )			
Occupation:	Employer:	Work Phone No: ( )				

PARENT/GUARDIAN INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status: (circle one) Single / Mar / Div / Sep / Wid	
Email:	Social Security No:	DOB: / /	Age:	Sex: ❑ M ❑ F		
Street Address:	Apt. No:	Home Phone No: ( )				
City:	State:	Zip Code:	Cell Phone No: ( )			
Occupation:	Employer:	Work Phone No: ( )				

INSURANCE INFORMATION

Primary Insurance:	Subscriber:	Group No:	Policy No.
Secondary Insurance:	Subscriber:	Group No:	Policy No:

BEST CONTACT # FOR LAB RESULTS/APPOINTMENT CONFIRMATION?

NAME:	PHONE NO. ( )

PHARMACY

NAME:	ADDRESS:	PHONE NO. ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone No: ( )	Alternate No: ( )

HOW DID YOU HEAR ABOUT US?

❑ Family ❑ Friend ❑ Close to home/work ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Ad (Which Ad)? ❑ Facebook ❑Other

HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

By signing below I am acknowledging that I have received a copy of or have been given the opportunity to receive a copy of the Notice of Privacy Practices for Campground Pediatrics + Wellness Center. I understand there is a copy available on the website at all times.

_____ _____

Parent/Guardian Signature *Date*

MEDICAL CONSENT

By signing below I affirm that I have the legal right to consent to medical treatment on behalf of the above named child(ren) and do hereby consent and authorize Campground Pediatrics + Wellness Center and/or such associates, assistants, or designees to examine and treat the above named child(ren). I understand and acknowledge that this medical consent shall be valid until I withdraw my consent.

_____ _____

Parent/Guardian Signature *Date*

PAYMENT CONSENT AND OTHER FINANCIAL RESPONSIBILITY

We will bill your insurance only if we participate with that company. You are responsible for any and all charges that your insurance company does not cover, including HMO's. All payments and co-pays are due at the time of service.
The person who brings the child/ren in is responsible for payment. Our office will not accept responsibility for a disputed claim, and all bills are to be paid upon receipt of your Statement. If your child/ren is/are insured by multiple insurances, they must all be presented prior to receiving services. Failure to provide this information will result in my financial responsibility for those services regardless of coverage.

I authorize insurance payment for all medical care to be made to Campground Pediatrics + Wellness Center.

- I am acknowledging that I have the legal authority to sign this form and that all information provide is true to my knowledge.
- I am authorizing my insurance benefits to be paid directly to Campground Pediatrics + Wellness Center. I am also authorizing Campground Pediatrics + Wellness Center or my insurance company to release any information required to process my claims.
- I am acknowledging that it is my responsibility to make sure correct information is on file for my child(ren)'s account(s).
- I am acknowledging that it is my responsibility to know and understand my health insurance benefits and that Campground Pediatrics + Wellness Center is not responsible for explaining these benefits to me.
- I am acknowledging that I understand all co-pays are due at the time of visit and that there may be an additional statement fee added to my account if billed.
- I am acknowledging that I understand regardless of insurance information I am ultimately responsible for all balances on my account whether balance is because of deductible, co-insurance, non-coverage, or for any reason.
- I am acknowledging that I may be charged a **$50.00** Missed Appointment Fee if I fail to show up for any scheduled appointment and/or do not give at least a 24 hour cancellation notice for a scheduled appointment.

_____ _____

Parent/Guardian Signature *Date*

PARENT/SUBSCRIBER:

OTHER FAMILY MEMBERS SEEN AT OUR OFFICE (PLEASE CONTINUE ON BACK IF MORE THAN 6 CHILDREN)			
LAST NAME:	FIRST:	MIDDLE:	DOB:
PATIENT RACE: ❑ AMERICAN INDIAN ❑ ASIAN ❑ BLACK/AFRICAN AMERICAN ❑ NATIVE HAWAIIAN/OTHER PACIFIC ISLAND ❑ WHITE ❑ UNKNOWN ❑ DECLINED			
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