Children's Physicians Patient Registration

Patient and Sibling Information

Last First Middle DOB SSN Gender Identity

_____ M / F / Other

_____ M / F / Other

_____ M / F / Other

If patient is 16 years and older, their phone number is _____

Parent's Information

Mother's Information	Father's Information
Last First Middle DOB	Last First Middle DOB
_____	_____
SSN:_____	SSN:_____
Email:_____	Email:_____
Street Address:_____	Street Address:_____
City/State/Zip:_____	City/State/Zip:_____
Cell Phone:_____	Cell Phone:_____
Name of Employer:_____	Name of Employer:_____
Work Phone:_____	Work Phone:_____

Parents' Marital Status: □ Married □ Single □ Divorced/Separated

Insurance Information

Insurance Name_____ Policyholder:_____

Policy Number:_____ Group/Plan Name:_____

Guarantor's Information (to whom statements are sent, if different from above)

Name_____ Relationship:_____

Street Address:_____

City/State/Zip:_____ Phone:_____

Emergency Contact Information

Name (other than parent):_____ Relationship:_____

Street Address:_____

City/State/Zip:_____ Phone:_____

How did you hear of us or who referred you? (Mark all that applies)

□ Friend/Relative: (name)_____ □ Doctor/Hospital: (name)_____

□ Insurance □ Internet □ Social Media □ Drive By □ Previous Patient

Race □ White □ Black/African □ Native American or Alaska Native
□ Asian □ Native Hawaiian or Other Pacific Islanders

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino

Language □ English □ Spanish □ Creole □ Chinese
□ Japanese □ Vietnamese □ Filipino □ Other:_____

Pharmacy:_____ Phone #_____

□ **PERSONS AUTHORIZED TO BRING CHILD IN FOR APPOINTMENTS** (other than parent and must be over 18 years of age)

□ **PERSONS AUTHORIZED TO ACCESS MEDICAL RECORDS AND HEALTH INFORMATION** (if patient is 18 year of age or over)

Name:_____Relationship to Patient:_____DOB:_____Phone:_____

Name:_____Relationship to Patient:_____DOB:_____Phone:_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Children's Physicians, all insurance benefits otherwise payable to me for services rendered. I authorize Children's Physicians to release any information required to secure payment of benefits from my insurance. I authorize the use of this signature on all insurance submissions, and to download any available medication history.

CONSENT FOR TREATMENT

On behalf of this(ese) child(ren), I voluntarily consent to the rendering of medical care by Children's Physicians. I understand that the child(ren) is under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

STATEMENT OF FINANCIAL LIABILITY

I guarantee payment of any and all bills rendered for said child(ren) which are not covered or allowable by insurance. This office will file the bill with my insurance company, providing I supply the proper insurance information to this office.

I understand if I have an unpaid balance to Children's Physicians and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Children's Physicians or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Children's Physicians and the designated external collection agency are authorized to contact me by telephone at the telephone number(s) I am providing, including wireless telephone.

Signature of Responsible Party: _____ Date: _____

Print Name: _____

CHILDREN'S PHYSICIANS

Welcome to our practice!

We would like to share our policy on the following subjects and request that you read and sign to your understanding of its content.

COPAYMENTS: Co-payments are due upon arrival for your visit. Please give the amount due to our receptionist when you check in. The parent bringing the patient in is responsible for balances at the time of service; we are not involved in any parental arrangement with each other.

PRESCRIPTIONS/REFILLS: Please mark your calendar one week prior to your prescription running out as a reminder to call or message in your refill request. All requests require doctor's authorization. In order for us to process your request promptly, please do so before 3:00pm via the patient portal or by calling the office and following the prompts. Requests after 3pm will be processed on the next business day.

FORM REQUESTS: We complete forms as quickly as possible. Please send in your requests via the patient portal or by calling the office and following the FORMS prompt. Firms can take up to 5 business days to be completed once dropped off. There is a fee of $15 per form.

REFERRALS: When requesting a referral by phone, please call our referral coordinator by following the prompts after dialing our office. Leave a message with the patient's name (including proper spelling of the last name), date of birth, name of health insurance company, specialist's name, reason for the referral and daytime phone number. Please allow up to 7 business days for the referral to be processed. Many carriers have a special process to obtain authorization. **Same day request will be given only in cases of emergency** – they will not be honored for follow-up or routine visits. Referrals can only be obtained after one of our doctors have reviewed the request and have given their approval or they will require an appointment to be schedule. **All referrals are obtained in the order of medical necessary.** Please be patient. Repeated phone calls do not expedite the process. Once completed, referrals may be picked up at our office or mailed to your home as per your preference and must be taken to the visit with the specialist. **Referrals will be not faxed to the specialist's office.**

NO SHOWS: Please call to cancel no less than ONE hour prior to sick appointments and one day prior to a physical/well visit so that the time slow can be made available for other patients in need of medical care. No-show occurrences are permanently noted in the patient's medical chart. If the patient continues to "no show", we will have no other recourse but to notify your insurance company and terminate the patient from our practice.

Thank you for your cooperation in all of the above. We are here to help you and look forward to a long and healthy relationship.

_____ _____

Signature of parent or guardian Date

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