Best Start Pediatrics

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REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Blue Cross Blue Shield ❑ United Health Care ❑ AR Medicaid ❑ Cigna ❑ Aetna

❑ MedPartners ❑ Qual Choice ❑ Humana ❑ TriCare/Champus ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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RACE/ETHINICITY

❑ **Black/African American** ❑ **Native Hawaiian or Pacific Islander** ❑ **Hispanic** ❑ **White**

❑ **American Indian** ❑ **Laotian** ❑ **Marshallese** ❑ **Other**

PARENT/LEGAL GAURDIAN INFORMATION

❑ Natural Parent ❑ Mother Only ❑ Maternal Grandparents ❑ D.H.S. ❑ Adopted Parents

❑ Father Only ❑ Paternal Grandparents ❑ Other

FAMILY INFORMATION

Mother's Name: _____

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ **Cell Phone: (**_____**)** _____-_____

Work Phone: (_____**)** _____-_____

Name of Employer: _____

Mother's Address: (if different than patients)

_____

_____

Father's Name: _____

Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ **Cell Phone: (**_____**)** _____-_____

Work Phone: (_____**)** _____-_____

Name of Employer: _____

Father's Address: (if different than patients)

_____

_____

<u>Emergency Contact:</u> (Someone other than patient's legal guardian(s)

Name: _____ **Relationship to Patient:** _____

Address:

_____

Phone Number: (_____**)** _____-_____

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FINANCIAL ASSIGNMENT OF BENEFITS/PROMISE TO PAY

Payment and Fees: Payment for your care is due at the time the services are provided, the only exception to this policy is if we are contracted with your insurance plan (See insurance below). If you have lab work or other services performed, there will be additional charges. Cash, check, debit cards, and credit cards are acceptable payment methods.

Insurance: You are required to present your insurance identification card at each and every visit. Insurance plans can change often, which requires us to review the information at each visit. We will submit a claim for your services to your insurance. It is your responsibility to verify in advance that the physician you have chosen to see is contracted with your plan. Any co-payments, co-insurance, and/or deductibles are due at the time of services. A co-payment is a fixed dollar amount that must be paid before the insurance will begin to pay. Again, if you do not have your current insurance identification card or an acceptable proof of insurance coverage, your visit will be considered self-pay, and you will be responsible for the full payment at the time of service. Insurance information must be updated during the timely filing period for the insurance. If updated information is not received during this time, the balance is considered your responsibility. At all times, it is your responsibility to follow up on all requests form your insurance company regarding claims and to question any unpaid insurance amounts. If you do not receive an explanation of benefits (EOB) from your insurance company within 60 days of your visit, please call your insurance for a status update on the EOB. Your insurance makes the final determination regarding payment at the time the claim is processed. If you feel this is incorrect, you must contact your insurance to appeal this. However, the balance will still remain your responsibility. In the event that your insurance does pay, a refund will be issued to you.

Wellness/Preventative Benefits: A wellness, annual or preventative exam is defined as a visit without complaints or illness. If you have insurance, our office will file your claim to reflect this. At the time your visit is scheduled, please specifically state that this is the reason you are seeing the doctor. Some insurance plans have benefits for wellness exams. If your visit includes a problem that is addressed or requires treatment, you may also be charged an additional office visit for the problem, along with the charge for the preventative visit. Please be familiar with your insurance benefits before seeing the doctor.

Referral/Primary Care Physician (PCP): If your insurance plan requires a referral from your PCP, it is your responsibility to request the referral from your primary care physician to be sent to our billing office. If your insurance plan requires a PCP to be assigned, it is your responsibility to contact your insurance and have PCP assigned for the day of service. Failure to obtain a referral or to have a PCP assigned when required may result in reduced benefits or non-payment by your insurance company, making you responsible for payment of your visit.

I, the undersigned, have read and understand the financial policy as described above and agree to pay for any and all medical services including portions not covered or denied by my insurance. Failure to pay in a timely manner will result in my account being turned over to an outside collections agency.

OUR OFFICE WILL NOT CHANGE A DIAGNOSIS AFTER THE CLAIM HAS BEEN FILED. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO TALK WITH THE PRACTICE ADMINISTRATOR IN OUR MEDICAL CLINIC.

NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have received a copy of the Best Start Pediatric Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Best Start Pediatric Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

_____ _____

Patient Signature/Legal Guardian, if a minor Date

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GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES

In consideration of the care given and to be given to me, I hereby give consent to receive medical treatment, including medications and hospitalization. I hereby give consent to use necessary examinations, injections, tests, or immunizing treatments as in the opinion of the attending physician, physician assistant, or independent Advanced Practitioner. I hereby authorize the release of any requested medical information from private physicians and/or institutions.

RELEASE OF INFORMATION:
When calling my home or cell phone numbers, the following people may have access to the below healthcare information:

- ○ Appointments or scheduling information
- ○ Labs and/or outpatient test results
- ○ Labs/x-ray or outpatient test appointments information
- ○ Prescription refill information
- ○ Billing information
- ○ Any other healthcare needs

List names of each individual: (WRITE N/A IF YOU DON'T AUTHORIZE ANYONE)

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ Relationship to Patient _____

_____ _____
Emergency Contact Name Emergency Contact Phone Number

AUTHORIZED USER ACCESS REQUEST:
Patient email address: _____
Allow Portal access to my health information to the following individual:
Name: _____ DOB: _____ Relationship to Patient: _____
Email Address for authorized user: _____
Checkmark One Level of Access:
_____ **Guarantor Access** (allows users to access appointment scheduling and secure messaging with clinic staff ONLY)
_____ **Full Access** (allows users to access all sections of the patient portal)
_____ **Billing Access** (allows users to access billing information ONLY)

_____ _____
Patient Signature/Legal Guardian, if a minor Employee Signature

_____ _____
Relationship to Patient Date