APPLE-A-DAY PEDIATRICS S.C. REGISTRATION FORM

PLEASE **PRINT** ALL INFORMATION **CLEARLY** - **PLEASE DO NOT PUT "SAME"**

PATIENT INFORMATION

Please list **ALL** children in the family that will be seen at the practice.

Last Name: _____ First Name: _____ Date of Birth:_____ Sex:_____

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Last Name: _____ First Name: _____ Date of Birth: _____ Sex: _____

Last Name: _____ First Name: _____ Date of Birth:_____ Sex: _____

Last Name: _____ First Name: _____ Date of Birth: _____ Sex: _____

Street_____**Apt. #**_____

City_____**State**_____**Zip Code**_____

PARENT'S INFORMATION

Child Lives With: ___ Both Parents ___Mother ___Father

Mother's Name: _____

Complete Address (if different than patient):

_____

Home Phone: _____

OK to leave detailed message on Home voicemail? Yes / No

Cell Phone: _____

OK to leave detailed message on Cell voicemail? Yes / No

OK to text Cell Phone? Yes / No

Work Phone: _____

E-Mail: _____

Birthdate:_____

Social Security#:_____

Employer:_____

Father's Name: _____

Complete Address (if different than patient):

_____

Home Phone: _____

OK to leave detailed message on Home voicemail? Yes / No

Cell Phone: _____

OK to leave detailed message on Cell voicemail? Yes / No

OK to text Cell Phone? Yes / No

Work Phone: _____

E-Mail: _____

Birthdate:_____

Social Security#:_____

Employer:_____

INSURANCE INFORMATION

Primary Insurance Company_____

Name of Policy Holder_____

ID#_____

Group#_____

Date of Birth_____

Effective Date_____

Relationship to Patient_____

Person responsible for Financials: _____ Mother _____ Father Other:_____

Guardian Signature:_____ **Today's Date:**_____

Alternative Guardian Consent Agreement Ex. Grandparent, Aunt, Uncle or Family Friend	**PERSON TO NOTIFY IN EMERGENCY** Ex. Grandparent, Aunt, Uncle or Family Friend
I hereby DO give my consent for my child/children to be treated at Apple-A-Day Pediatrics S.C. under the care of the following people: Name and Relationship _____ Phone Number _____ Name and Relationship _____ Phone Number _____ Date _____ Printed Name of Guardian _____ Signature of Guardian _____	Name_____ Street_____ Apt #_____ City_____ State_____ Zip Code_____ Home Phone_____ Cell Phone _____ Relationship to Patient_____

New Patients: How did you hear about the practice? _____

Would you like access to the Patient Portal for billing purposes (uses your provided e-mail)? Yes / No

CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS, AND FINANCIAL AGREEMENT:

I hereby request and consent to the provision of healthcare services from the above ("APA") primary care physician, other physician members within his or her APA group practice, and from non-physician healthcare professionals employed or otherwise retained within the practice. I authorize the practice, and any entities within Apple-A-Day Pediatrics S.C. to release any medical and other information in my medical or registration record to any entities or individuals having responsibility for authorization/payment for such healthcare services, for the purpose of determining eligibility and availability of health care benefits, and/or obtaining authorization/payment for such services. I agree that a copy of this authorization may be utilized as evidence of this authorization in place of the original. I agree that all telephone numbers and email addresses I provide may be used by Apple-a-Day and those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages. I further agree to irrevocably assign and transfer to Apple-A-Day Pediatrics S.C all right to medical reimbursement benefits to which I am entitled for the purpose of the payment of healthcare service charges ("Patient Charges"), authorize payment of such benefits directly to Apple-A-Day Pediatrics S.C, guarantee payment of, and agree to be fully responsible for all Patient Charges to the extent that they are not satisfied by the assigned benefits.

Scheduling Appointments

Please help us serve you, and all of our patients, best by keeping scheduled appointments.

Late Appointments: If you are <u>15 or more minutes</u> late for your scheduled appointment time you may be asked to reschedule.

Missed Appointments: If you need to miss an appointment, please notify us 24 hours in advance or you will be assessed a $40 fee.
In the event 3 or more missed appointments occur, we may ask you to seek services from another practice and/or be assessed a $50 fee.

Printed Name of Patient's Guardian _____

Signature of Patient's Guardian _____

Relationship to Patient _____

Date of Signature _____

Apple-A-Day Pediatrics S.C.
Acknowledgement of Receipt, Understanding and Agreement with Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received, understand and agree to the provisions and declarations as provided and identified within the Apple-A-Day Pediatrics, S.C. Notice of Privacy Practices

Relationship to Patient _____

Date _____

Printed Name of Patient's Guardian _____

Signature of Patient's Guardian _____

Apple-A-Day Pediatrics S.C.
Explanation of Payment for Services

Welcome to Apple-A-Day Pediatrics S.C. Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for your services is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship. Please ask our cashier or billing representative if you have any questions about our fees or financial policy.

atient registration form must be completed prior to seeing the doctor
yment is required at time of service
For payment, we accept cash, check, Visa, MasterCard, Discover and American Express.

Usual and Customary Rates
Apple-A-Day Pediatrics S.C. is committed to providing the best treatment possible for our patients and we charge what is usual and customary for the Oswego area as determined by the majority of insurance carriers. You are responsible for payment regardless of any insurance company's determination of usual and customary rates unless otherwise dictated by a managed care contract.

Minor Patients
For unaccompanied minors, please provide them with written authorization (accompanied by a parent/guardian signature) for our medical staff to provide care. We will deny non-emergency care unless a minor presents us with such authorization. The adult accompanying a minor and/or the parents or guardians are responsible for payment.

Insurance
As a courtesy to our families, we submit all claims to your primary insurance company and accept assignment of insurance benefits. Families with managed care must pay their co-pay at the time services are rendered as stated in your benefits plan. For your convenience, we can apply co-payments to a major credit card with your authorization on file. If your insurance company has not paid the full balance within 45 days, then the balance of your account will be transferred to your responsibility. Please be advised that some (and perhaps all) of the services we render may be considered "non-covered" by your insurance company. In this case, they are not considered necessary and thus are not covered under your medical insurance plan. You are personally responsible for payment of these non-covered services.
Please call if your insurance changes so we can update our records for you.

Insurance is a contract between you and your insurance company. We are not a party to this contract unless you have a managed care plan. We request that you provide a credit card number with authorization to bill your account for any applicable co-payments and balances not paid by your insurance. You are responsible for the timely payment of your account.

Printed Name of Guarantor or Guardian _____

Signature of Guarantor or Guardian _____

Relationship to Patient _____

Date of Signature _____