Patients 18 – 22 years old: Please complete yourself.

# Apple-a-Day Pediatrics S.C. Registration Form

(Please print clearly and fill form completely)

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Last Name, First Name (Legal) | Preferred Name | Date of Birth | Sex |
| | | | |
| Phone: | OK to leave voicemail: yes / no | | |
| Email: | OK to text: yes / no | | |
| ***I authorize Apple-a-Day Pediatrics to use and disclose my protected health information to:*** (if no names given, information is ONLY shared with you) | | | |
| 1- | 2- | | |
| **Patient** Signature: | Date | | |

| PATIENT ADDRESS | | | PATIENT LIVES WITH | |
|---|---|---|---|---|
| Street | | Apt | ☐ Both Parents | ☐ Other |
| City | State | Zip | ☐ Mother | ☐ Father |

| MOTHER INFORMATION | FATHER INFORMATION |
|---|---|
| Name | Name |
| Address | Address |
| Home Phone | Home Phone |
| Cell Phone | Cell Phone |
| Work Phone | Work Phone |
| OK to leave detailed message? Yes / No | OK to leave detailed message? Yes / No |
| OK to text cell phone? Yes / No | OK to text cell phone? Yes / No |
| E-Mail | E-Mail |
| Birthdate | Birthdate |
| Social Security # | Social Security # |
| Employer | Employer |

| GUARANTOR INFORMATION (person financially responsible) | |
|---|---|
| Name | Relationship to Patient |
| Street | City, State, Zip |
| Phone | Date of Birth |

| INSURANCE INFORMATION | |
|---|---|
| Insurance Company | Effective Date |
| Policy ID # | Policy Group # |
| Policy Holder Name | Policy Holder Date of Birth |

| EMERGENCY CONTACT (after parents) | |
|---|---|
| Name | Relationship |
| Address | Phone |

| ALTERNATIVE GUARDIAN (after parents) | |
|---|---|
| Name | Relationship |
| Address | Phone |
| | |

## CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS & 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 rights 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 15 or more minutes 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 of 3 or more missed appointments occur, we may ask you to seek services from another practice and/or be assessed a $50 fee.**

## ACKNOWLEDGEMENT OF RECEIPT, UNDERSTANDING & 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

## EXPLANATION OF PAYMENT FOR SERVICES

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment for your services is considered 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.

A patient registration form must be completed prior to seeing the doctor.

Payment is required at time of service. We accept cash, check and all major credit cards.

*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 the 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.

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 | |
|---|---|
| Signature | Date |