My Kids
Pediatric Partners
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PATIENT REGISTRATION FORM
18 YEARS OR OLDER

Name_____Date of Birth_____
Address_____ Home Phone_____
City_____Cell Phone_____
State_____Zip_____ Work Phone_____
Employer Name_____
E-mail Address_____

I AUTHORIZE MY KIDS PEDIATRIC PARTNERS, PC AND ITS STAFF TO DISCUSS MY MEDICAL AND ACCOUNT INFORMATION AS FOLLOWS: (INITIAL ALL THAT APPLY)

- For financial purposes, I allow my parent(s)/other to access my diagnosis and treatment information and to discuss my account. _____
- I allow my immunizations records to be released by fax or mail to:
  _____Parent(s)/Other _____School_____Self
- I allow my treatment plans (i.e. medications, asthma, epi-pens, etc.) to be disclosed to:
  _____Parent(s)/Other_____School_____Self
- I allow my office visits to accessed by:
  _____Parent(s)/Other_____School_____Self
- I allow my labs to be released to:
  _____Parent(s)/Other_____School_____Self
- With my consent, I allow any "confidential information" including results of STD testing, HIV, AIDS, and Pregnancy testing to be shared with:
  _____Parent(s)/Other_____School_____Self Only

Names of Parent(s)/Other I give permission to access the above information:
Name_____Relationship_____
Phone Number_____
Name_____Relationship_____
Phone Number_____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

_____Initial I_____ authorize My Kids Pediatric Partners (MKP) to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives My Kids Pediatric Partners (MKP) permission to leave this information either on my answering machine or with a member of my household.
Phone number to call with information:_____
_____Initial I authorize My Kids Pediatric Partners (MKP) or whomever they designate to evaluate and treat me and to release to my insurance company any information acquired in the course of my examination or treatment, and to receive all payments for such examination or treatment. MKP has my permission to release any diagnostic studies, reports, etc., to a specialist involved in my care.

PAYMENT POLICIES

_____Initial **Insurance Information:** Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.
_____Initial **Account Balances:** When insurance information is received after the timely filing requirements of your insurance company, the charges for those services are your responsibility. **You are responsible for payment of all services not paid by your insurance company, including all screenings and testing done at the time of well visits.** MKP reserves the right to reschedule or deny future appointments for delinquent accounts.
_____Initial **Co-Payments:** are expected to be paid at the time service is rendered. If payment is not received at the time of service, there will be an additional $5 fee. All returned checks will be subject to a service charge fee of $25 (this fee is separate from any Bank fees for the returned check).
_____Initial **Self-Pay:** Payment is expected at the time service is rendered. If payment is made at the time of service, you will receive a discounted price for services rendered that day. If payment is not received at the time of service, you will be responsible for the full cost of the visit.
_____Initial **Referrals:** If you plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed prior to the specialty appointment.
_____Initial **Evening, Weekend & Holiday Code:** Please be aware, we report all evening, weekend and holiday visits to your insurance carrier. This code may or may not be covered.
_____Initial **No Shows:** A $25 no show fee will be assessed for all visits not previously cancelled.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

_____Initial I acknowledge that I have received the HIPAA Notice of Privacy Practices, which explains how my health information will be handled in various situations.

INSURANCE INFORMATION

Primary Insurance Company:_____
Subscriber:_____
Subscriber's Date of Birth:_____
Subscriber's relationship to Patient:_____
Insurance Member ID #_____
Employer:_____

Secondary Insurance Company:_____
Subscriber:_____
Subscriber's Date of Birth:_____
Subscriber's relationship to Patient:_____
Insurance Member ID #_____
Employer:_____

In order to help us comply with federal and state reporting and record keeping when using state provided vaccines, please indicate your race and ethnicity.

RACE: (Check one)

____Caucasian
____Black
____Hispanic
____Asian
____Native American
____Asian Pacific American
____Pacific Islander
____Subcontinent Asian American
____American Indian or Alaskan Native
____Native Hawaiian
____Black Non-Hispanic
____Other Race or Ethnicity
____White Non-Hispanic
____Race Not Reported - Refusal
____Race Not Reported - Don't Know
____Race Not Reported - Not Ascertained

ETHNICITY: (Check One)

____Latino/Hispanic ____Not Latino or Hispanic ____Other ____Refused

Language predominantly spoken: _____

My signature below indicates I am the patient listed on the front page and that I have provided accurate information to the best of my knowledge, and I understand and agree to the provisions as stated.

Patient Signature _____Date:_____