My Kids Pediatric Partners

Dr. Michelle Kunec Sudo, DO
1102 Highway 315 Blvd, Wilkes-Barre,
PA 18702-6953
P: 570-235-1470 F: 570-550-9256
www.MyKidsNEPA.com

REGISTRATION FORM
(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Patient Information (Please List ALL Children Under 18)

Patient Name_____________________________________Date of Birth___/___/_____
Preferred Name __________________ Primary Language_________________Sex_____
Ethnicity (Check One): Hispanic or Latino _____Yes _____No
Race (Circle One): White, Black or African American, American Indian/AK Native, Asian, Native HI/Pacific Islander

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Preferred Name __________________ Primary Language_________________Sex_____
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Mother/Father/Guardian Information (for child(ren) listed above)

Name_____________________________________Date of Birth__________________________
Relationship to Patient_______________________
Address__________________________________ Home Phone__________________________
City_____________________________________Cell Phone____________________________
State____________Zip______________________ Work Phone___________________________
Employer Name____________________________________
E-mail Address_____________________________________

Father/Mother/Guardian Information (for child(ren) listed above)

Name_____________________________________Date of Birth__________________________
Relationship to Patient_______________________
Address__________________________________ Home Phone__________________________
City_____________________________________Cell Phone____________________________
State____________Zip______________________ Work Phone___________________________
Employer Name____________________________________
E-mail Address_____________________________________

Marital Status (circle): Married Single Separated Divorced Widowed

IF DIVORCED:

_____ JOINT CUSTODY

_____ SOLE CUSTODY

_____ LEGAL DOCUMENTS PROVIDED
(Needed for Sole Custody, etc.)

Address child lives at **(If Other Than Above)**
Address____Phone____________________
City____________________________________State__________Zip______________________

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Authorized Care Givers (Other Than Parents)

The following people are authorized to discuss personal health information or bring my child to My Kids Pediatric Partners for evaluation and treatment, including immunizations:

Name____________________________Relationship________________Phone #__________________
Name____________________________Relationship________________Phone #__________________
Name____________________________Relationship________________Phone #__________________
Name____________________________Relationship________________Phone #__________________

Emergency Contact (Other Than Parent)

Name____Relationship_______________________
Home Phone_____________________________Cell Phone__________________________________

PREFERRED PHARMACY:

NAME:____

LOCATION:____

PHONE NUMBER:____

<u>AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION</u>

_____Initial My Kids Pediatric Partners (**circle one**) **can** **cannot** treat and administer injections/vaccines to my unaccompanied child/children (if over 16 years of age)

_____Initial I______________________________ authorize My Kids Pediatric Partners (MKP) to contact me by telephone with medical information pertaining to my child(ren)'s 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 my above named child(ren) and to release to our insurance company any information acquired in the course of my child's 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 caring for my child(ren).

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_____Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____Initial A parent/guardian/or authorized caregiver is to be present at every visit. If someone else is bringing your child(ren), **we will need prior written authorization** that includes authorization for treatment, your contact information, and insurance and copay payment authorization for this visit.

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 **Payments:** MKP accepts cash, checks or credit cards. Payment plans can be setup by contacting our billing department at (570) 235-1470.

_____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 **Divorce Situations:** The parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____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.

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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:____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

How did you hear about our practice: ____________________________________

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

Signature of Parent/Legal Guardian______________________________Date:______________

Print Name of Parent/Legal Guardian____