WEST SIDE PEDIATRICS

ADULT OVER 18 REGISTRATION

Patient Last Name: _____ ***Patient First Name:*** _____ ☐ male ☐ female

DOB: ____/ ____/ ____ **SS#** ____/ ____/ ____ **Email:** _____

Home phone: _____Cell phone: _____Work phone: _____

What is your preferred number for reminders/ messages? ☐Home ☐Cell

Street _____City _____ State ____ Zip _____

I authorize messages that include Protected Health Information to be left on ☐ Home ☐ Cell ☐ DO NOT LEAVE

I authorize automated reminder calls to be left on ☐ Home ☐ Cell ☐ DO NOT LEAVE AUTOMATED REMINDER CALLS

Parent/Guardian#1:

Last name: _____ First name: _____Middle initial _____

Relationship to the patient: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

DOB: ____/ ____/ ____ **SS#** ____/ ____/ ____ **Email**_____

Home phone: _____Cell phone: _____Work phone: _____

Address: ☐ Same as patient. If not please list address here:

Street _____City_____State _____ Zip _____

Parent/Guardian#2:

Last Name: _____ First Name: _____Middle Initial: _____

Relationship to the patient: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other _____

DOB: ____/ ____/ ____ **SS#** ____/ ____/ ____ **Email:** _____

Home phone: _____Cell phone: _____Work phone: _____

Address: ☐ Same as patient. If not please list address here:

Street: _____City_____State _____ Zip _____

Responsible party (must sign financial policy): If same as patient check here ☐

Same as Parent/Guardian #1 ☐ ***Same as Parent/Guardian #2*** ☐

If other, please complete below:

Name: _____ Relationship to patient: _____

DOB: ____/ ____/ ____ **SS#** ____/ ____/ ____ **Email**_____

Home phone: _____Cell phone: _____Work phone: _____

Address: ☐ Same as patient. If not please list address here:

Street: _____City_____State _____ Zip _____

Medical Insurance Information

Primary Insurance Name (i.e. Aetna, Humana)

Subscriber/policy holder: _____

Policy # _____Group Number: _____ Policy Effective Date: _____

Employer: _____Co- Pay/deductible amount $ _____

Secondary Insurance _____

Subscriber/policy holder: _____

Policy # _____Group Number: _____ Policy Effective Date: _____

Employer: _____Co- Pay/deductible amount $ _____

Please answer the following questions:

Race:

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Other _____
- ☐ Unknown
- ☐ I do not wish to answer

Primary Language:

- ☐ English
- ☐ Other _____
- ☐ I do not wish to Answer

Ethnicity:

- ☐ Hispanic
- ☐ Non – Hispanic
- ☐ Unknown
- ☐ I do not wish to answer

Religion

- ☐ Please List: _____
- ☐ I do not wish to answer

Do you require any interpreter services? ☐ Yes

Please describe interpreter services that are required (related communication):

_____

Assignment & Release:

I give permission for West Side Pediatrics, or persons designated by them, to interview, examine and perform necessary laboratory procedures and to provide appropriate treatment to the above named minor. I further give my permission for evaluation and treatment whether the child is accompanied by a parent/legal guardian, other family member, unrelated party or is unaccompanied. I, the undersigned, assign directly to West Side Pediatrics all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible and have received the financial policy. I hereby authorize the use of this signature on all insurance submissions. I further authorize West Side Pediatrics to forward any information necessary, including, but not limited to medical records, to said insurance company for payment of my insurance claims as well as to other personnel to whom physicians of West Side Pediatrics have referred my child for treatment and to the admitting hospital should my child be admitted for treatment.

PLEASE NOTE: Whoever accompanies the child to each visit is expected to pay the charges due for the service rendered that day, including copayments, coinsurance, deductibles, etc. Divorce has no bearing on the responsibility for medical care as it affects third parties.

Name (print) _____ Signature _____

Relationship to patient(s) _____ Date: _____

_____initial of staff member receiving form

WEST SIDE PEDIATRICS

FINANCIAL POLICY

Thank you for choosing West Side Pediatrics as your child's healthcare provider. We are committed to providing you the best quality medical care. We look forward to establishing a lasting relationship and partnership with you in caring for your child. As a part of this relationship, we wish to establish our expectation of your financial responsibility.

USUAL AND CUSTOMARY RATES: We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits. **You are responsible for payment regardless of the insurance company's determination of usual and customary rates. You are responsible for any balance remaining after your insurance carrier has processed the claim.**

INSURANCE COLLECTION: It is your responsibility to ensure that we have the most current copy of your insurance card, demographic and contact information. If your insurance is not verified at time of service, you will be responsible for payment at time of service.

CO-PAYMENTS: Payment is expected at time of service. Certain services are not covered by your insurance. For any questions regarding services/treatments, we encourage you to contact our Billing Manager and/or your insurance carrier to review costs. Failure to pay at the time of service will result in a $15.00 service fee. As a convenience, we accept all major credit cards, debit cards, cash, and checks.

DEDUCTIBLES AND FEES: Insurance deductibles are due at the time of service rendered. Failure to produce payment at check-in may result in your appointment being rescheduled and will incur a $15.00 fee. **Patients with annual deductibles will be required to pay $50.00 at time of service for sick visits and consults.** If there has been an overpayment, we will issue you a refund check

OUT OF NETWORK/NON-PARTICIPATING INSURANCE CARRIERS: If your insurance carrier considers us "out of network" or does not participate with us, you are responsible for payment in full at the time of service. We will gladly provide any proof of visit/receipts, etc.

DIVORCE DECREES: In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. **We do not bill another individual or estranged spouse for payment.** Copayment is due at the time services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent. West Side Pediatrics will not act as a mediator in collecting our payments.

PAST DUE PAYMENTS: Just as we make every effort to accommodate you when your child is in need of medical care, we expect you will make every effort to pay your bill promptly. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. If your account becomes delinquent (past due 60 days) your account will be subject to interest, rebilling fees, and collection costs. Should collection action become necessary, the responsible party agrees to pay collection fees, and all legal fees of collection, with or without suit, including attorney fees and court cost. No balance over $300.00 can be carried on a family account without a scheduled payment plan.

I authorize West Side Pediatrics to release all requested information concerning my medical treatment to my insurance carrier. I further authorize my insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider(s) of this office, for their professional services rendered.

West Side Pediatrics reserves the right to dismiss any patient from the practice who consistently fails to meet this policy or who refuses to sign this agreement.

West Side Pediatrics Patient Agreement

Initial_____**INSURANCE PLANS:** I understand it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen under "out of network" benefits.

Initial_____**COVERAGE:** I acknowledge that West Side Pediatrics is not responsible to know what services my insurance covers. I shall direct questions regarding health insurance policy coverage to my insurance company.

Initial_____**FINANCIAL COMMITMENT:** I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan at the time of my visit. If I have not come prepared to pay past due balances or co-pay, my child's appointment may be rescheduled for a later time. Furthermore, I understand that if someone other than me is bringing my child to West Side Pediatrics, they will be responsible to pay for copays and any past due balance. In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. **We do not bill another individual or estranged spouse for payment**. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent. West Side Pediatrics will not act as a mediator in collecting our payments.

Initial_____**HIGH DEDUCTIBLE INSURANCE PLANS:** I am aware that I will be asked to **pay $50.00 at time of service for sick visits and consults.** This amount will be applied to your balance and billed to your insurance plan. You will be billed for the balance of your visit once your insurance has determined benefits.

Initial_____**DEMOGRAPHIC VERIFICATION:** I am aware that I will be asked to verify insurance and demographic information so records remain current.

Initial_____**NO INSURANCE AT THE TIME OF SERVICE:** If insurance benefits cannot be determined, I understand that payment is required in full at the time of service. In some circumstances, I may have the option to put a credit card or debit card on hold until I am able to provide proof of insurance.

Initial_____**PAYMENTS:** I commit to promptly pay all amounts that have been determined by my health insurance to be patient responsibility upon receipt of my statement.

Initial_____**SERVICE FEES:** I understand my account will be charged $25 for NSF/Returned checks.

Initial_____**LATE ARRIVALS:** I have been made aware that if I arrive more than 15 minutes past my scheduled appointment time, the practice may have to reschedule my appointment.

Initial_____**NO SHOWS:** I commit to give West Side Pediatrics at least 24 hours' notice if I am unable to keep my scheduled appointment. I understand West Side Pediatrics does not charge for no-shows; however, if I miss 3 appointments without notifying the practice in a 24 month period, the practice will no longer be able to continue providing pediatric healthcare services and I understand I will be dismissed from the practice***. (Note, this is per family, not per child)***

I have read, understood and agree to the above financial and office policy. I understand that **Non-compliance with this policy may result in a dismissal from West Side Pediatrics.**

Patient Name_____DOB: _____

Patient Name_____DOB: _____

Parent or Guardian's signature_____Date: _____

_____initial of staff member receiving form

WEST SIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT OVER 18 YEARS OLD

Patient's Name: _____ Birthdate: _____

I understand that it is the policy of West Side Pediatrics, Inc. (the practice) to protect my privacy and to follow all state and federal privacy laws. However, I also understand in order to involve my parents or other individuals in my medical care it will be necessary for the practice to use/disclose some Protected Health Information ("PHI"). I understand that PHI to be disclosed may include information regarding genetic testing, HIV/AIDS status, mental health diagnosis and treatment, substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the practice to disclose such information to the persons list below:

☐ I authorize West Side Pediatrics, Inc. to release and discuss my PHI including test and procedures to the following individuals:

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release PHI. If I refuse to sign this Authorization, the practice will in no way deny me my rights concerning treatment.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager with a written statement that I wish to revoke the Authorization. My revocation or Authorization will be effective immediately and PHI will no longer be used/ disclosed pursuant to this Authorization except when medically necessary in an emergency situation. This Authorization, unless I earlier revoke it, shall remain in effect for as long I am an active patient at the practice.

Signature: _____ Date: _____

Witness: _____ Date: _____