HIGHLAND PEDIATRICS Registration Form

Date _____

PLEASE PRINT

Patient Name _____ **Sex: M F** **DOB** ____ /____ /____

Street Address _____

City _____ **State** _____ **ZIP** _____ **Primary Language** _____

Other Children _____ **DOB** ____ /____ /____

_____ **DOB** ____ /____ /____

_____ **DOB** ____ /____ /____

Preferred Primary & Secondary MD and / or NP _____

Please circle all that apply:* * if no choice is circled, then *'Decline to Answer'* will be chosen for you.

RACE: Alaska Native / American Indian / Asian / Black / Hawaiian / White / Decline to Answer

ETHNICITY: Hispanic or Latino / Not Hispanic or Latino / Unknown / Decline to Answer

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INSURANCE

Primary Insurance Name _____

Subscriber _____ Subscriber's DOB ____ / ____ / ____

Subscriber's Employer_____ Effective Date (MM/YY) _____ / ____

Secondary Insurance Name _____

Subscriber _____ Subscriber's DOB ____ / ____ / ____

Subscriber's Employer_____ Effective Date (MM/YY) _____ / ____

PARENT / GUARDIAN WHO BRINGS CHILD TO OFFICE IS RESPONSIBLE FOR PAYMENTS AND CO-PAYS

How would you ideally prefer to be contacted regarding *(please circle one per category):*

MEDICAL ISSUES: Primary Phone / Email

APPOINTMENT REMINDER: Primary Phone / Email / Text

RECALL NOTICES: Primary Phone / Email

GENERAL PRACTICE NOTICES: Primary Phone / Email / Text

PATIENT PORTAL NOTIFICATIONS: Email / Text

BILLING STATEMENTS Home Address / Email

THIS SECTION IS <u>ONLY</u> FOR PATIENTS WHO ARE 18 YEARS OF AGE OR OLDER

Primary Phone (_____) _____ - _____ Type: Cell / Home / Work

Email Address _____ @ _____

Does the patient want to be contacted directly regarding his/her medical care? Yes / No

Does the patient authorize information to be given to parent(s) ? Yes / No

Contact Preference: Phone Call / Text to Phone / Email / Contact Parent

Patient Signature_____ Date _____

Updated August 2017

PRIMARY CONTACT: Relationship to child* _____

Name_____ **DOB** ____/____ /___

Address if different from Page 1): _____

Primary Phone (_____) _____ - _____ Type: Cell / Home

Secondary Phone (_____) _____ - _____ Type: Cell / Home

Email Address _____ @ _____ Occupation _____

Employer _____ Work Phone (____) _____ - _____ Ext _____

SECONDARY CONTACT: Relationship to child* _____

Name_____ **DOB** ____/____ /___

Address if different from Page 1): _____

Primary Phone (_____) _____ - _____ Type: Cell / Home

Secondary Phone (_____) _____ - _____ Type: Cell / Home

Email Address _____ @ _____ Occupation _____

Employer _____ Work Phone (____) _____ - _____ Ext _____

EMERGENCY CONTACT: Relationship to child* _____

Name_____ Phone (____) _____ - _____

* (Biological/Foster/Adopted Guardian: Mother, Father, Maternal/Parental Grandparent, Aunt, Uncle, etc)

CHILD CUSTODY MATTERS

Do both biological parents share custody of this child? **Yes / No**. If yes, then skip the remainder of this section.

If no, then who has legal custody? _____ Relationship to child _____

Are there any legal restrictions that would prevent the non-custodial parent(s) from giving consent to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes / No**
If yes, please explain AND provide a copy of any legal paperwork that supports this restriction:

_____

_____

COPIES OF ALL CURRENT LEGAL DOCUMENTS DEFINING GUARDIANSHIP AND CUSTODY, BOTH PHYSICAL AND LEGAL, MUST BE ON FILE AND UP TO DATE AT ALL TIMES

These forms were completed by

PRINTED NAME _____ **RELATIONSHIP TO CHILD** _____

SIGNATURE _____ **Date** _____

For new patients, please identify how you became aware of our practice _____

Thank you for helping us keep your child's information as up-to-date as possible.

HIGHLAND PEDIATRICS PC
PAYMENT & OFFICE POLICIES

Thank you for choosing Highland Pediatrics as your primary care provider. Please read our payment policy, ask any questions you may have. Your signature confirms that you understand and agree to abide by these guidelines.

1. **Insurance:** We participate with most insurance plans. Each plan has different policies and coverage levels and it is your responsibility to know your coverage for medical services provided. If you are uninsured, ask us about setting up a payment plan that you can afford. We also have applications available for state assistance if you believe you qualify. Insurance plans change, so we ask that you verify your insurance with us at each visit. You will be asked to show your insurance card at each visit. If your Masshealth/BMC/Neighborhood Health Plan or any state plan has lapsed, please let us know. We can help so you are not charged for the visit. If you reapply quickly, there is a grace period to submit your claims, if not; you will be responsible for payment.

2. **Co-payments:** Please – it is your obligation to pay your co-payment at the time of service. If you do not pay your co-pay at the time of service, you will be charged a $15.00 bill patient fee. Please remember we accept cash, checks, MasterCard, Visa and Discover.

3. **Non-covered services:** Please be aware that some – and perhaps all – of the services provided may not be covered or may be applied to your deductible by your insurance company. You will be responsible for payment.

4. **Claims submission:** We will submit your claims to most insurance companies and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. Please do so promptly. However, any unpaid balance is your responsibility.

5. **Coverage changes:** Please notify us if your insurance changes before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. **Non-payment:** We understand that these are difficult economic times. Please talk to us about setting up a payment plan that you can afford. Any unpaid balances may be forwarded to a collection agency. We make every attempt to contact you by mail and phone but it is your responsibility to contact us to set up a payment plan or update insurance information.

7. **Primary Care Provider:** You are responsible to confirm that Highland Pediatrics or a physician from Highland Pediatrics is listed as your PCP with your insurance company. If this information is incorrect, it could delay or possibly not pay the claim, which you then would be responsible for payment. This could also cause your scheduled appointment to be rescheduled until correct PCP is listed.

NOTE: Divorce has no bearing on the responsibility for medical care as it affects third parties. Whoever brings the child is expected to pay the charges due for the service rendered that day. Highland Pediatrics does not participate in payment disputes between parents

INITIALS _____

PARENT / GUARDIAN OUT OF POCKET EXPENSES

- **Returned checks** - $45.00 per check returned
- **Missed Appointments** - $30.00 per visit – We ask that you call 24 hours in advance to cancel and reschedule your appointment. You may leave a message with our answering service, if you need to call after hours. Families with multiple missed appointments may be discharged from our practice.
- **Copies of Medical Records** - $20.00 fee plus .25 per page (clerical/provider fees included)

Other policies that require compliance:

If you are more than twenty minutes late for your appointment, the nurse will check with the provider to see when we can accommodate your late arrival into his/her schedule.

A parent or legal-guardian MUST accompany the child for all well child visits. If this absolutely cannot be done, please speak with a manager prior to your appointment date.

You will need to complete a new registration form yearly. Your information will be checked at every visit. We also require photo identification for every adult who accompanies each patient or who picks up any controlled substance prescription.

Please ask to speak to a manager, if you have any questions about these policies.

Highland Pediatrics is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our region. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. Thank you for giving us the opportunity to take care of your family.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of guardian or patient if over 18 years of age **Date**

_____ _____

Guardian/Patients Social Security # **Guardian/Patients Date of Birth**

HIGHLAND PEDIATRICS PC

MEDICAL CONSENT & PAYMENT AUTHORIZATION FORM

MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN, OR IF PATIENT IS 18 YEARS OLD

PATIENT NAME _____ DOB _____

PLEASE INITIAL FOR EACH CONSENT

_____ I give permission for providers of Highland Pediatrics or persons designated to them, to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor.

_____ I hereby authorize Highland Pediatrics to furnish any necessary information concerning my child named above, to my insurance carriers, to other medical personnel to whom physicians of Highland Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted for treatment.

_____ I understand that all professional charges are charged to the patient. Patients covered under a contracted insurance plan are required to pay any co-payment or deductible at the time of service. I understand that **Insurance/Medicaid cards must be presented at EVERY VISIT.**

CONSENT FOR IMMUNIZATIONS

_____ I give permission for Highland Pediatrics to administer all standard immunizations as recommended by The American Academy of Pediatrics schedule for immunizations. I understand that I will be advised in writing the benefits and risks associated with each immunization at the time of administration, and that I will be given the opportunity to have all my questions answered to my satisfaction before any vaccine is administered. Additionally, a signature will be required for each vaccine at time of administration.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

_____ I have received, or have been given the opportunity to receive, a copy of the HIPAA Notice of Privacy Practices for Highland Pediatrics. Copies are available at the front desk.

PLEASE NOTE: This document will remain in effect as long as custody of the child remains the same. In the event of a custodial change or on reaching age 18, a new consent form will need to be signed.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO HIGHLAND PEDIATRICS FOR ANY SERVICES FURNISHED TO THE PATIENT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT THE PATIENT TO RELEASE TO MY INSURANCE CARRIERS OR ITS INTERMEDIARIES ANY INFORMATION FOR THIS OR RELATED CLAIMS.

_____ _____
SIGNATURE (PATIENT OF LEGAL GUARDIAN) **DATE**

_____
PRINTED NAME (PATIENT OR LEGAL GUARDIAN)