

REGISTRATION FORM

(Please Print Legibly and Complete Entire Form in Black Ink Only)

Primary Physician:		Account#:							
PATIENT INFORMATION									
Patient's Full Name:				DOB: Sex:		Sex:			
Patient's Street Address:									
City:			State:		Zip:				
Race: (check one) American Indian or Alaskan Native Asi				an American	Preferred Language:				
Ethnicity: (check one) Hispanic of the second seco	ot Hispanic or	Latino Declin	ed						
Preferred Pharmacy Name: Loc			ation:		Phone#:				
APPOINTMENT CONFIRMATION									
□ I prefer to be called after 5pm at: □ I prefer to be sent a text at:									
	PARENTAL/GUARDIAN INFORMATION								
MOTHER or LEGAL GUARDIAN			FATHER or LEGAL GUARDIAN						
Name:			Name:						
DOB: SS#:			DOB:	SS#: _					
Relationship to Patient:			Relationship to Patient:						
Mailing Address:			Mailing Address:						
			<u></u>		State				
City		^{Zip} H W C	City Primary Phone #:	:: ()		Zip H W C			
Secondary Phone#: ()		_ H W C	Secondary Phone	e#: ()	=	H W C			
Employer:			Employer:						
I can be emailed at:									
MEMBERS LIVING IN HOUSEHOLD OTHER THAN GUARDIANS									
NAME	DOB REL	LATIONSHIP TO P		E	DOB R	ELATIONSHIP TO PT			
1.			4.						
2.			5.						
3.			6.						
IN CASE OF EMERGENCY									
Name of Emergency Contact (not living at same address & other than guardian) :									
Relationship to Patient:		Со	ontact #:						
<i>Guarantor Signature</i>		_ Relationship to Patient:							
Date:	:: Reviewed by: (<i>Ofi</i>			Entered by:(Office Use Only)					



Patient Acknowledgement Form

Please read and acknowledge this form by initialing and signing where indicated. (Black ink only please) **Insurance Plans**

- I understand it is my responsibility to confirm Island Coast Pediatrics is contracted with my insurance plan. If not, I am aware I could be responsible for "out of network" benefits. Questions about medical benefit coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all co-pays, co-insurance, deductibles, and non-covered services determined by my insurance plan at the time of service.
- I agree to provide accurate insurance information at each visit and I understand withholding insurance information may result in dismissal from Island Coast Pediatrics.
- If I do not have proof of insurance coverage, I understand payment is due in full at the time of service.

Office Policies & Financial Responsibility

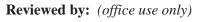
- I agree to bring my child's current insurance card and my photo ID with me at each visit, and keep my • demographic information current.
- If I am unable to pay my co-pay or any balances due at time of service, my appointment may be rescheduled and I could be charged a **\$25** billing fee.
- I understand I need to give 24 hours notice to cancel an appointment or I will be charged a \$50 no show fee.
- Island Coast Pediatrics follows the recommended well care schedule of the American Academy of Pediatrics. We request physicals to be up to date and current per AAP's guidelines.
- I have been given a copy of the Island Coast Pediatrics' Patient Centered Medical Home & Patient Information Brochures.
- Island Coast Pediatrics accepts Cash, Checks, Debit Cards, MasterCard, Visa, Discover and American Express. I understand my health insurance contract is between my insurance company and myself. If I am unable to pay my balances timely, I will contact the billing department to make arrangements.
- I understand that my insurance may not cover certain procedures and tests done during my child's well visit, and . that I will be financially responsible for any charges that are not paid based on the contractual agreement with your insurance company. Initials:

HIPAA & Authorization to treat

- I acknowledge receipt of the Island Coast Pediatrics' Notice of Privacy Policy.
- If you wish to allow others access to your child's record (i.e. grandma, aunt, babysitter, etc), you must complete a "HIPAA Limitations" form. If you wish to restrict a parent from accessing your child's record, you must provide legal documentation.
- I consent to authorize Island Coast Pediatrics and affiliated physicians and allied health personnel to administer, • diagnose and perform any medical exams, treatments and procedures that may now or during the course of the patient's care be deemed **advisable** and/or **necessary**.

Please list all children in your family that are current patients of Island Coast Pediatrics (incl. child being seen today).

Patient Name:	_ DOB:	_ Patient Name:	_DOB:			
Patient Name:	_DOB:	_Patient Name:	_DOB:			
Patient Name:	_ DOB:	_Patient Name:	_DOB:			
I have read and understand the above Authorization to treat, Insurance, Office, Financial & HIPPA Policies.						



Initials:

PEDIATRICS

Initials: