PATIENT REGISTRATION FORM

Please list all PATIENTS in family:

Name: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

Name: _____ DOB: _____ Gender: _____

FAMILY CONTACT INFORMATION

Parent/Legal Guardian 1:

Name: _____ Relationship to Patient: _____

Street Address: _____ City/State/Zip: _____

Telephone: _____ DOB: _____ Email: _____

Occupation: _____ Employer/Work Telephone: _____

Parent/Legal Guardian 2:

Name: _____ Relationship to Patient: _____

Street Address: _____ City/State/Zip: _____

Telephone: _____ DOB: _____ Email: _____

Occupation: _____ Employer/Work Telephone: _____

Patient(s) resides primarily with: _____

Parents are: Married / Divorced / Separated / Other: _____

If divorced or separated, with restrictions in order, please provide legal written documentation.

SIGNATURE: _____ DATE: _____

(Parent/Guardian signature if Minor)

INSURANCE INFORMATION

PATIENT NAME(S): _____ Is this patient covered by health insurance? YES / NO

PRIMARY INSURANCE:

Ins. Company Name: _____ Policy ID#: _____

Policy Holder: _____ DOB: _____ Group #: _____

Medical Claims Address on back of card: _____

Policy Holder SS#: _____ Employer/Work Phone: _____

SECONDARY INSURANCE:

Ins. Company Name: _____ Policy ID#: _____

Policy Holder: _____ DOB: _____ Group #: _____

Policy Holder SS#: _____ Employer/Work Phone: _____

PLEASE PROVIDE COPY OF INSURANCE CARD UPON COMPLETION OF THIS FORM.

PHARMACY INFORMATION

PHARMACY NAME: _____ Phone: _____

PHARMACY ADDRESS: _____

EMERGENCY CONTACT OTHER THAN PARENTS:

Name: _____ Relationship to Patient: _____

Telephone: _____ Email: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balances not covered by my insurance plan. I also authorize Point Pediatrics, LLC. or insurance company to release any information required to process my claims.

I give permission for Point Pediatrics, LLC. to contact me via cell phone, text, or email.

SIGNATURE: _____ DATE: _____

(Parent/Guardian signature if Minor)

PATIENT COMMUNICATION CONSENT

PATIENT NAME(S): _____ **Date of Birth:** _____

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Point Pediatrics, LLC. to contact you and how you wish to be contacted. Please choose from below:

_____ Leave a DETAILED MESSAGE on my answering machine.

_____ Leave a message with the doctor's name and number ONLY.

May we release health care information (immunization records, lab reports, health status, etc.) to School/Daycare.

_____ Yes

_____ No

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your child's (or your own, if over 18) medical care or financial matters. ***YOU MAY ALSO ALLOW OTHERS TO ATTEND APPOINTMENTS WITH YOUR CHILD IN YOUR ABSENCE***. This is to acknowledge that you authorize Point Pediatrics, LLC. to disclose your PHI to the following individuals:

Name: _____ Relationship to Patient: _____

Telephone: _____ Date of Birth: _____

Name: _____ Relationship to Patient: _____

Telephone: _____ Date of Birth: _____

Name: _____ Relationship to Patient: _____

Telephone: _____ Date of Birth: _____

□ None of the above

SIGNATURE: _____ DATE: _____

(Parent/Guardian signature if Minor)

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" (Effective Date October 15, 2018) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Point Pediatrics, LLC. to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Point Pediatrics, LLC. any information obtained in the adjudication of any claim for services furnished to me by Point Pediatrics, LLC.
- I acknowledge that Point Pediatrics, LLC., the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

PATIENT NAME(S): _____ **Date of Birth:** _____

Printed Name of Guardian: _____ Relationship to Patient: _____

SIGNATURE: _____ DATE: _____

(Parent/Guardian signature if Minor)

BELOW FOR INTERNAL USE ONLY

_____ _____

Name of Employee obtained by *Signature of Employee*

If applicable, reason patient's written acknowledgment could not be obtained:

♦ Patient was unable to sign _____
♦ Patient refused to sign _____
♦ Other: _____

Point Pediatrics, LLC. Financial Policy and Authorizations

We are happy that you selected Point Pediatrics, LLC. for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at the time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees. Arrangements to make payments by installments are also available. There is a $50 charge for missed appointments or appointments cancelled within less than 24 hours of appointment time.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days.

Well and Sick Visits: When a new or existing health problem is identified and addressed during a preventative health care visit, a separate office visit will be billed as required by the National Coding and Billing Guidelines. Your insurance company may charge you for two visits. Vision ($15), Hearing ($15), and Developmental/Mental Health screenings ($10) may not be covered by your insurance policy. In-office rapid testing for Flu ($25), Strep ($10), Urinalysis ($10), Pregnancy ($10), etc. may also not be covered by your insurance policy. It is a felony to routinely waive copays, coinsurance, and deductibles for patients. Waiving the collection of this portion of a charge is illegal and considered health insurance fraud.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am assigned guarantor.

CREDIT CARD ON FILE: In order to make sure that we can collect your portion of a bill once your insurance company processes a claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be the "patient responsibility" as spelled out in your Explanation of Benefits (EOB).

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

CONDUCT POLICY: I understand if I fail to come for a scheduled appointment or cancel within 24 hours prior to the appointment, I will be considered a "No-Show" and may be subject to a $25 charge per occurrence. Ongoing occurrences of No-Shows may result in dismissal from the Practice. I also understand that inappropriate behavior of any kind may result in dismissal from the Practice.

I understand the Financial and Conduct Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____	_____	_____	_____
PATIENT NAME	***DOB***	*(Parent/Guardian signature if Minor)*	*Date*