Patient Registration Information **_Welcome to Our Office_**
(Confidential) **_Teays Pediatrics, P.L.L.C._**

(Due to privacy regulations all patients must complete a separate form)

Date Completed: ______________

Patient's Name: (First/Middle/Last)

_________________________________ *M/F:* ___ *DOB:* _______________ *SSN:* ________________________

Race: (circle one) *American Indian/Alaska Native* *Asian* *Black/African American* *Hispanic*
Nat. Hawaiian/Pacific Islander *Other Race* *Unknown* *White*

Patient's address: ____________________________ *City:* ____________________ *State:* ______ *Zip:* ________

Home Phone: ( ) _________________________ *Preferred Daytime Phone: ( )* ___________________________

Mother's Name: _______________________________ *DOB:* _______________ *SSN:* ____________________

Mother's address: ____________________________ *City:* ____________________ *State:* ______ *Zip:* ________
(If different from patient)

Home Phone: ( ) _________________________ *Preferred Daytime Phone: ( )* ___________________________

Employer: __________________________ *Work Phone: ( )* _____________ *Cell Phone: ( )* _____________

Father's Name: _______________________________ *DOB:* _______________ *SSN:* ____________________

Father's address: ____________________________ *City:* ____________________ *State:* ______ *Zip:* ________
(If different from patient)

Home Phone: ( ) _________________________ *Preferred Daytime Phone: ( )* ___________________________

Employer: __________________________ *Work Phone: ( )* _____________ *Cell Phone: ( )* _____________

Emergency Contact (other than parent): _________________________________ *Phone: ( )*________________

Relationship to patient: ______________________ *City:*____________________ *State:* ______ *Zip:* _________

Patient lives with: (circle one) *Mother* *Father* *Other (please specify & enter information below)*

Name: ____

Address: ____

____

Phone: ____

Relationship: ____________________________________

Primary Care Physician: ____ Lambernedis ____ Stallo ____ Young

Preferred Pharmacy: ________________________________ Phone: __________________________

Patient Registration (page 2)
***** Please read completely and carefully ***** ***Patient Name:*** ____________________

Primary Insurance Billing Information *(Must be completed in full)*

Employer: ______________________ *Name of Insurance:* ______________________

Policyholder: ______________________ *DOB:* ____________ *SSN:* ______________

Policyholders Mailing Address: ______________________ *City:* ____________ *State:* ______ *Zip:* ________

Home Phone: (   ) ______________________ *Work Phone: (   )* ______________________

******* Please provide us with a CURRENT copy of your insurance or Medicaid Card*******

Secondary Insurance Billing Information *(Must be completed)*

Employer: ______________________ *Name of Insurance:* ______________________

Policyholder: ______________________ *DOB:* ____________ *SSN:* ______________

Policyholders Mailing Address: ______________________ *City:* ____________ *State:* ______ *Zip:* ________

Home Phone: (   ) ______________________ *Work Phone: (   )* ______________________

Assignment of Insurance Benefits

(Must be completed annually)

I hereby authorize DIRECT payment of medical benefits to Teays Pediatrics, P.L.L.C. for services rendered by the physician(s) in person or under his/her supervision. I understand that I am financially responsible for ***any balance*** not covered by my insurance, which is not part of the plans contractual agreement with Teays Pediatrics, P.L.L.C. ***If the information provided is incorrect or not updated, I will assume financial responsibility for all account balances until such corrections are made.***

The willingness of this office to file a claim with your insurance carrier in no way represents a belief that your insurance company will cover all or any part of the claim submitted. All non-covered charges are the responsibility of the parent.

If you choose to have your insurance billed for the services rendered, you **MUST** bring your current insurance card to the office at the time of the appointment. It is your responsibility to supply the office with the necessary information to submit a claim to your insurance carrier. **It is not the responsibility of our staff to contact your insurance company to obtain the information on your behalf.** If you neglect to provide the current and complete information/insurance card to our office on the date of service, you will be required to pay in full at the time of service.

Date: ____________________

Parent/Guardian (print): ______________________________

Signature: ______________________________

Teays Pediatrics P.L.L.C. Financial Policy

In the attempt to hold down the cost of medical care and reduce the number of bills sent out we have established the following payment policy.

PAYMENT EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered, regardless of who brings the patient in for the appointment, unless other arrangements have been made in advance. This includes applicable copayments and coinsurance for participating insurance companies. Teays Pediatrics accepts cash, personal checks, debit cards, VISA, MasterCard, and American Express. There is a service charge of $30 for returned checks.

If you need to make arrangements for payment, please ask to speak to our billing department prior to obtaining services.

INSURANCE: We bill participating insurance companies as a courtesy to you. You are expected to pay your copayment and deductible at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to insure that all charges are paid whether by you or by your insurance carrier.

If we are not a participating provider with your insurance, payment is expected in full at time services are rendered. We will bill your insurance as a courtesy so any reimbursement due may be sent to you directly.

If you need assistance or have questions, please contact our business office between 8:30 a.m. and 4:00 p.m. Monday through Friday at 304-757-8803.

MANAGED CARE INSURANCE: If you are enrolled in a managed care insurance plan (HMO plan), you must obtain a referral before receiving services at another office or facility. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments are a loss to our office, to you and to other patients that may have been scheduled in the time set aside for you. Cancellations are requested 24 hours prior to the appointment.

I have read and understand Teays Pediatrics P.L.L.C. Financial Policy. I accept financial responsibility for any balance not covered by my insurance, which is not part of the plan's contractual agreement with Teays Pediatrics, P.L.L.C. I also acknowledge that if I have made no payments towards my account balance within 60 days, my account will be referred to a collection agency.

______________________________ ____________________

Signature Date

Patient Registration (page 4) *Patient Name:* ____________________
*****Please read completely and carefully before signing*****

Authorization to Release Information

I hereby authorize Teays Pediatrics, P.L.L.C. to release any medical or incidental information that may be necessary for either ***medical care*** or in ***processing applications*** for financial benefits. I also authorize Teays Pediatrics, P.L.L.C. to release pertinent medical and/or billing information to other facilities or physicians to which the patient is referred.

I certify that the billing information given by me is correct. I request that payment of authorized benefits be made to Teays Pediatrics, P.L.L.C. on my behalf. *If information is incorrect or incomplete, so that proper billing cannot be made,* **I will assume financial responsibility for all account balances until such corrections are made.** *If I do not provide a current copy of an* ***insurance/Medicaid*** *card, I will assume financial responsibility for all account balances until the proper card is provided to this office.*

Date: ____________________

Parent/Guardian (print): ____________________________________

Signature: ____

__________ Initial here to authorize Teays Pediatrics, P.L.L.C. to leave a message on your answering machine regarding appointments, test results, or general medical information.

Teays Pediatrics P.L.L.C.

I hereby authorize the person (s) listed on this form to seek medical care for my child, ______________________________, DOB _______________________ on my behalf. I also authorize Teays Pediatrics P.L.L.C. to release pertinent medical information to the person (s) listed below.

________________________________	______________________________
Name	Relationship to Patient
________________________________	______________________________
Name	Relationship to Patient
________________________________	______________________________
Name	Relationship to Patient
________________________________	______________________________
Name	Relationship to Patient

___________________________________	______________________________
Print Name of Parent or Guardian	Signature of Parent of Guardian

____

Date

________ (please initial) I understand that this authorization is valid for **two** years unless rescinded by me in writing.