ALLIED PEDIATRICS PATIENT REGISTRATION FORM

Today's Date:______________________ Clinic Location:__________________________

Patient(s) Information: (Please use FULL LEGAL NAME)

First Name**:**_______________________ Last Name:____________________________ Date Of Birth**:**_______________

_______________________ ____________________________ _______________

_______________________ ____________________________ _______________

Home Address:____

City:____________________________________ State:_________________________ Zip Code:_______________________

Primary Phone #:__________________________ Secondary Phone #:________________________ Sex: Female [ ] Male [ ]

Parent Information (Please use FULL LEGAL names)

Person Responsible for Bill (Guarantor) _______Mother ______Father ______Other:_________________________________

In the event we can't reach a parent, Please provide us with an **Emergency Contact Person's** name, phone number & relationship to patient:

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Mother's First And Last Name:___________________________________ DOB:_________________ SS#__________________

Married ____ Divorced_____ Single_____ Phone #:________________ Email: ________________________________

Father's First And Last Name:___________________________________ DOB:_________________ SS#__________________

Married ____ Divorced_____ Single_____ Phone #:________________ Email: ________________________________

Address (If Different from above)____

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Insurance Information (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

Primary Insurance Name:____ Policy Holder's Name:________________________

Policy Holder's SS#_________________________________ Policy Holder's DOB:______________________________________

Policy / ID Number:________________________________ Group#:_______________________

SECONDARY INSURANCE (IF APPLICABLE):

Secondary Insurance Name:______________________________________ Policy Holder's Name:________________________

Policy Holder's SS#_________________________________ Policy Holder's DOB:______________________________________

Policy / ID Number:________________________________ Group#:_______________________

PLEASE READ AND SIGN BACK OF FORM

Allied Pediatrics of Greater Brockton
Patient Registration Form
Disclosures & Consents

Patient Full Name:____ DOB:______________

Financial Policy, Assignment Information & Release of Information:

I am requesting pediatric medical services at Allied Pediatrics of Greater Brockton. I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my Insurance company or Masshealth/Medicare on my behalf. I authorize (assign) any Insurance or Masshealth/Medicare benefits to be paid directly to Allied Pediatrics of Greater Brockton or its assignees. I will be financially responsible for the cost of services rendered to me or to the person whose account I am acting as guarantor, in particular non-covered services or supplies, co-payments and deductibles. I am responsible for knowing how my Insurance plan works and whether or not the services I am to receive are a covered benefit. I am responsible for immediately informing Allied Pediatrics of any changes in Insurance coverage, secondary or tertiary Insurance coverage changes, including plan changes, changes in postal address and phone numbers. I will be responsible for charges that are billed to an incorrect Insurance company due to not providing correct information to Allied Pediatrics. This acceptance and assignment will be enforced for all future services by practitioners at this office.

Authorization To Mail, Call Or E-Mail:

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize an Allied Pediatrics representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Allied Pediatrics to that effect in writing.

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, Allied Pediatrics originates and maintains electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatments and any plans for future care or treatment. I understand that this information serves as a basis for planning my care, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality.
I understand that Allied Pediatrics maintains a *Notice Of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in our waiting room area. I understand that Allied Pediatrics reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the right to review the notice prior to signing this consent and that I have the right to request restrictions as to how my health information may be used or disclosed. Today, before signing, I had an opportunity to receive and review the *Notice of Privacy Practices* of Allied Pediatrics

Consent To Treatment:

I hereby consent to evaluation, testing, and treatment as directed by my Allied Pediatrics physician or his or her designee for myself or my dependents.

____ __________________________
Signature of Patient / Patient's Legal Guardian Date of Signature

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Printed Name of Patient / Patient's Legal Guardian