Children's Medical Group, PA

New Patient Form

PATIENT REGISTRATION SHEEET

Thank you for choosing us as your health care provider. We are committed to making health care less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy which we ask that you read and sign prior to your office visit.

ELECTRONIC COMMUNICATION CONSENT

(Initial)

By providing my cell, landline, or any other number(s), I expressly consent to receive communications from Children's Medical Group, its staff, its contractors, collection agents, and others, at any number, or e-mail address I provide, or that is later provided. These parties may use this information to contact me by e-mail, live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointments, follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages.

ACKNOWLEDGEMENT OF INSURANCE CONTRACT

(Initial)

Your insurance policy is a contract between you and your insurance company. We are not part of that contract, and the patient remains solely responsible for services rendered. Should any account be unpaid 45 days following the date of service, and we have not heard from your insurance company, we ask that the patient contact their insurance company to help expedite payment.

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

(Initial)

I authorize Children's Medical Group to disclose any personal health information necessary to process health insurance claims, coordinate, or manage treatment, and for the purpose of our healthcare operations. I also authorize payment DIRECTLY to Children's Medical Group for services rendered.

ACKNOWLEDGEMENT OF RESPONSIBILITY

(Initial)

I understand that I am financially responsible to Children's Medical Group for all professional services rendered, including but not limited to, those services which are not covered by my insurance programs (Co-payments and/or deductibles). I understand that if my check is returned for any reason, a thirty-five dollar ($35) return check charge will be assessed to my account. Cash or credit cards are accepted to pay for these charges and is expected upon notification. After two returned checks we will no longer accept checks as payment for services. I also understand that if I have an HMO or PPO insurance and I do not obtain the proper referral authorization prior to my visit, or verify the physician is a preferred provider that I am financially responsible for any charges incurred. I understand the payments for these charges are due at the time of service. In the event of financial default: I, the undersigned, accepts the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.3%), attorney's fees and/or court cost, if necessary. I further agree, for my account to be serviced or to collect monies owed, Children's Medical Group and/or its agents may contact me by telephone, text message or email using any telephone number, wireless number or any email address associated with this account.

ACKNOWLEDGEMENT OF "NOTICE OF OUR PRIVACY PRACTICES"

(Initial)

I acknowledge receipt of the Children's Medical Group "Notice of Privacy Practices". Children's Medical Group is required by law to maintain the privacy and security of your Protected Health Information and will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. If you have any questions or concerns regarding the Notice of Privacy Practices, you can ask to speak with the Privacy Officer in person, by Email: Privacy.Officer@Childsmedgroup.com or by phone at (251) 342-3810 or (251) 639-1300.

APPOINTMENT CANCELLATION POLICY / NO SHOW FEE

(Initial)

Our office policy is that when an appointment for a sick visit is cancelled, it must be a minimum of two hours prior to the appointed time. Checkup appointments require a twenty-four-hour notice of cancellation, prior to the appointed time. ADD/ADHD appointments require a 24 hour cancellation. Your account will be billed a no show fee of $25 for missed sick or well visits or $50 for missed ADD/ADHD visits. Night, weekend and holiday missed appointments will be a $50.00 no show fee.

My signature below acknowledges that I have read the above guardian/parent policies of Children's Medical Group. I agree and consent to the above.

Signature	Print	Relationship	Date (MM/DD/YYYY)

Financial responsibility ultimately falls to the person that brings the child to the office and signs our Guardian/Parent policies.

Children's Medical Group, PA

New Patient Form

PATIENT REGISTRATION SHEET

TODAY'S DATE ☐☐ / ☐☐ / ☐☐

☐ CURRENT INSURANCE ON FILE

OFFICE USE ONLY

☐ NEW PATIENT

☐ UPDATE TO CURRENT

CHART #:

DR CODE:

PATIENT DETAILS*

*If you are registering more than 1 child, please add their information on page 3.

Legal name: Last name | First name | Middle Name

Birthdate: MM/DD/YYYY

Sex

SSN

With whom does the child reside?

1ST PARENT/LEGAL GUARDIAN DETAILS*

*Lives in same household as patient & primary contact for appointment

Name

DOB

SSN

Mailing Address

City

State

Zip

Primary Ph. ○ Cell ○ Other

Alternate Ph. ○ Cell ○ Other

Employer/Occupation

2ND PARENT/LEGAL GUARDIAN DETAILS

Name

DOB

SSN

Mailing Address

City

State

Zip

Primary Ph. ○ Cell ○ Other

Alternate Ph. ○ Cell ○ Other

Employer/Occupation

INSURANCE INFORMATION*

*Primary Policy

Insurance co.

Policy or ID #

Group #

Insured

Insured DOB

Relationship

EMERGENCY CONTACT-OTHER THAN PARENTS/GUARDIAN

Name

Relationship to child

Phone

Continued on next page

IF THERE IS ANYONE AUTHORIZED TO BRING THE PATIENT(S) NOT LISTED ON THIS FORM ALREADY, PLEASE LIST BELOW

Name #1		**Relationship to child**	
Name #2		**Relationship to child**	
Name #3		**Relationship to child**	
Name #4		**Relationship to child**	

ADDITIONAL CONTACT INFORMATION

Preferred email ☐ *I agree to receive email & text notifications from Children's Medical Group, P.A.*

What is your preferred cell phone number to receive appointment confirmations?

(___) ___ - _____ Cell carrier *(i.e. Verizon, AT&T, etc.)*

ADDITIONAL CHILDREN TO BE REGISTERED

Legal name Last name First name Middle Name **Birthdate** MM/DD/YYYY

Sex **SSN** **With whom does the child reside?**

Legal name Last name First name Middle Name **Birthdate** MM/DD/YYYY

Sex **SSN** **With whom does the child reside?**

Legal name Last name First name Middle Name **Birthdate** MM/DD/YYYY

Sex **SSN** **With whom does the child reside?**

Legal name Last name First name Middle Name **Birthdate** MM/DD/YYYY

Sex **SSN** **With whom does the child reside?**