Pediatric Associates of Western CT   2018

Family Registration

Primary Care Provider (PCP) - ____

Child 1: *Last Name:* __________________________ *First Name:* _________________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address: ____

(Street or PO Box) *(City)* *(State & Zip)*

Home Phone: (____) ______ - __________ *Cell Phone:* (_____) _______ - _______________

Child 2: *Last Name:* __________________________ *First Name:* ___________________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address & Home Phone same as Child 1 (Circle One) Yes / No

Child 3: *Last Name:* _________________________ *First Name:* ____________________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address & Home Phone same as Child 1 (Circle One) Yes / No

Child 4: *Last Name:* _________________________ *First Name:* ____________________________ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _______ *Primary Language:* __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black / Hawaiian / White

Mailing Address & Home Phone same as Child 1 (Circle One) Yes / No

Parent 1: *Name*: _________________________________ *Relation to Patient*: _______________________________

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Email*:** _________________________________ ***Necessary for patient portal (please write legibly)

Employer: ________________________________ *Occupation:* _______________________________

How would you ideally prefer to be contacted regarding (circle one):

***Medical Issues**:* Home Phone / Work Phone / Cell Phone / Home Email ***Appointment Reminders**:* Home Phone / Cell Phone / Home Email

***Recall Notices**:* Home Address / Home Phone / Work Phone / Cell Phone / Home Email ***Billing Statements**:* Home Address / Home email

***General Practice Notices**:* Home Address / Home Phone / Cell Phone / Home Email ***Patient Portal Notifications**:* Cell Phone / Home Email

Review additional information on reverse side →

Parent 2: *Name*: ____________________ *Relation to Patient*: ____________________

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____ *Social Security #:* ____ - ___ - _____

Work Phone: (____) ______ - ___________ *Cell Phone*: (____) ______ - ___________

Email: ______________________________ (only 1 permitted for portal, please ignore if listed under parent 1)

Employer: ______________________________ *Occupation:* ______________________________

Same address as Contact #1 (Circle One) Yes / No
If not write other address ____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:
____

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No / __________

If parents are divorced or separated please fill out this section:
Who has custody? ____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
____

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

Policy Holder's Birth Date: ____________________ *Policy Holder's Sex:* Male / Female

Insurance Carrier: ____

ID# ________________________________ *Group #* ____________________

Secondary Policy: *Policy Holder's Name*: ____

Policy Holder's Birth Date: ____________________ *Policy Holder's SSN:* _____________

Insurance Carrier: ____

ID# ________________________________ *Group #* ____________________

Pediatric Associates of Western CT

Statement of Patient Financial Responsibilities

We appreciate the confidence you have shown in choosing us to provide for you health care needs. As a courtesy, we bill you insurance carrier on your behalf. You insurance policy is a contract between you and your insurance company. However, you are ultimately responsible for payment of your bill.

You are responsible for payment at the time of service for any form fee, deductible or co-payment as determined by your contract with your insurance carrier. Non-payment is subject to a $25.00 service charge. After thirty (30) days of the first bill, an 18% annual or minimum of $2.50 per month finance charge will begin to apply to the account. Any bill over ninety (90) days past due will be subject to collection procedures. If you need to make payment arrangements, you may contact the billing office and we will be happy to assist you. All payment agreements must be followed through within the allotted timeframe.

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any **deductible** and **co-payment** as determined by your contact with your insurance carrier. **We require these payments at time of service**. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to **Pediatric Associates**, for providing services to myself or to the named patient(s). I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pediatric Associates, the full and entire amount of bill incurred by myself to the named patient(s); or, if applicable any amount due after payment has been made by my insurance carrier.

There is a $25.00 fee for any missed check-up or consult or cancellations less than 24 hours.

Patient/Guarantor Signature____ Date_______________

Relationship to Patient