Pediatric Associates of Western CT 2018

Patient Registration – 18 Years of Age or Older (No Dependents)

Primary Care Provider (PCP) - ______________________________

Patient Name: *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:* (_____) _____ - ______ *Please check preferred number to call(○)*

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

Do you live with your parents? Yes No

Parent 1: *Name*: ____________________ *Relation to Patient*: ____________________

Date of Birth: ____ / ____ / ____ *Social Security #:* ______ - _____ - _______

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

Address: ______________________________

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

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

Date of Birth: ____ / ____ / ____ *Social Security #:* ______ - _____ - _______

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

Same address as Parent #1 (Circle One) Yes / No

If not write other address ______________________________

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 #* ____________________

Review additional information on reverse side →

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.

If you are covered under your parents insurance your parents will receive the explanation of benefits regarding your visit.

Patient/Guarantor Signature____ Date_______________

Relationship to Patient____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Permission to speak with your parents/guardians

☐ I,______________________________, give authorization to have access to/discuss my medical care to the following individual(s) with no limitations:

Name	Relationship	Date

Patient Signature ______________________________ Date _______________

☐ I do not give the doctors and nurses of PAWC permission to discuss anything with my parents/guardian.

Patient Signature ______________________________ Date _______________