INGRAM PEDIATRICS P.A. REGISTRATION FORM

CHILD'S INFORMATION – SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

CHILD'S FULL NAME (FIRST MIDDLE LAST)			CHILD'S GENDER ☐ MALE ☐ FEMALE	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____________________	CHILD'S DATE OF BIRTH
PRIMARY HOME ADDRESS (NO P.O. BOXES)			FAMILY'S PRIMARY EMAIL ADDRESS		
CITY	STATE	ZIP	CHILD'S ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ DECLINE		CHILD'S RACE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIN OR PACIFIC ISLANDER ☐ WHITE ☐ DECLINE ☐ OTHER _____________________
PRIMARY HOME PHONE	PRIMARY CELL PHONE		PRIMARY WORK PHONE		

MOTHER or LEGAL GUARDIAN'S INFORMATION / FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

MOTHER/GUARDIAN'S FULL NAME			FATHER/GUARDIAN'S FULL NAME		
MOTHER MAIDEN NAME	GUARDIAN'S RELATION TO THE PATIENT (IF APPLICABLE)		BIRTH HOSPITAL	CHILD LIVES WITH (CHECK ONE) ☐ MOTHER ☐ OTHER ☐ FATHER _____________________ ☐ BOTH	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ SEPERATED		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ SEPERATED	
MOTHER/GUARDIAN'S MAILING ADDRESS (CHECK IF SAME AS CHILD)			FATHER/GUARDIAN'S MAILING ADDRESS (CHECK IF SAME AS CHILD)		
CITY	STATE	ZIP	CITY	STATE	ZIP
MOTHER/GUARDIAN'S HOME PHONE	MOTHER/GUARDIAN'S CELL PHONE		FATHER/GUARDIAN'S HOME PHONE	FATHER/GUARDIAN'S CELL PHONE	
MOTHER/GUARDIAN'S EMPLOYER	MOTHER/GUARDIAN'S WORK PHONE		FATHER/GUARDIAN'S EMPLOYER	FATHER/GUARDIAN'S WORK PHONE	
MOTHER/GUARDIAN'S EMAIL ADDRESS			FATHER/GUARDIAN'S EMAIL ADDRESS		

INSURANCE INFORMATION – THIS SECTION MUST BE COMPLETE OR PAYMENT IN FULL IS DUE AT TIME OF SERVICE

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME / CARD NUMBER	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER _____________

EMERGENCY CONTACT INFORMATION

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone your child does not live with and who we have your permission to contact if necessary.

NAME OF PERSON NOT LIVING WITH YOUR CHILD	RELATIONSHIP TO CHILD	EMERGENCY CONTACT'S PHONE NUMBER

PREFERRED PHARMACY

NAME OF PHARMACY	ADDRESS OR INTERSECTION	PHONE (IF KNOWN)	FAX (IF KNOWN)

INGRAM PEDIATRICS P.A. REGISTRATION FORM

4100 South Hospital Dr Ste 302 * Plantation, Fl 33317

(954) 321 - 1591

FINANCIAL POLICY & CONSENT FOR TREATMENT

Financial Policy

By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present on the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balances.

- We file claims to participating insurance companies as a courtesy to you – you are and remain responsible for ensuring full payment. We will bill your insurance company only if we are in network and only if your insurer accepts claims electronically. You are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. Patients are considered self-pay for services covered by worker's comp or auto insurance.
- If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days after the date of service and you must pay the outstanding balance in full.
- Patients with an outstanding balance of 90 days or more must arrange an acceptable payment plan or their account will be turned over to a collection agency and they will be dismissed from the practice. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our billing specialist to request assistance before your account becomes delinquent.
- Occasionally during scheduled well child visits a physician will diagnose and treat a problem. When appropriate, problems addressed during preventative exams will be billed as routine care in addition to the well child visit. Some insurance policies do not cover both services. In the event that you schedule a well child visit and a problem is addressed, you may be responsible for an additional co-pay, co-insurance, deductible, or denial after the visit.
- We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. It is your responsibility to know if you have coverage before services are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis codes in order for it to be paid.
- All co-pays are due at the time of service regardless of who brings the child in for the appointment. Failing to pay your co-pay at the time of service will result in a $10.00 administrative charge on the patient's account. Frequently failing to pay your co-pay is grounds for dismissal from the practice.
- When paying with a personal check, a valid photo ID of the check signer is required. Only checks that have been printed with the check signer's name and address will be accepted. All returned checks are assessed a $35.00 service charge. Post dated checks are not accepted.
- If for any reason you must cancel or reschedule your appointment(s), please notify our office at least 24 hours in advance. Patients that no-show 3 times in 12 months may be dismissed from the practice. If you are more than 20 minutes late for your appointment we will do our best to accommodate you but we reserve the right to reschedule your appointment.

Consent for Treatment

As the parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Asheville Medicine & Pediatrics. I hereby authorize Asheville Medicine & Pediatrics, LTD to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Asheville Medicine & Pediatrics, LTD on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

Parent/Guardian's Name & Signature

Child's Name

Print Parent/Guardian's Full Name ____________________

Print Child's Name ____________________ Date of Birth ________

Parent/Guardian's Signature ____________________

Date of Signature ____________________

AUTHORIZED INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD FOR MEDICAL CARE AND RECEIVE MEDICAL RESULTS

Please list anyone who has your permission to bring your child to our office for medical care in your absence and/or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPAA requirements, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE
NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE