

NORMAN PEDIATRIC ASSOCIATES

PATIENT REGISTRATION

Patient Name _____ Date of Birth _____ M F
LAST FIRST MI
Patient Name _____ Date of Birth _____ M F
LAST FIRST MI
Patient Name _____ Date of Birth _____ M F
LAST FIRST MI

FATHER'S INFORMATION

Name _____ Date of Birth _____
LAST FIRST MI
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Social Security Number _____
Cell Phone Number _____ Business Phone Number _____
Email Address: _____
Employer _____ Occupation _____

MOTHER'S INFORMATION

Name _____ Date of Birth _____
LAST FIRST MI
Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Social Security Number _____
Cell Phone Number _____ Business Phone Number _____
Email address: _____
Employer _____ Occupation _____

INSURANCE

Primary Insurance _____ ID # _____
Copay Amount _____ Are Well Child Office Visits and Immunizations covered? YES NO
Insurance Address _____ Group # _____
Policy Holder Name _____ Relationship _____ DOB: _____
Policy Holder Social Security Number _____

Secondary Insurance _____ ID # _____
Insurance Address _____ Group # _____
Policy Holder Name _____ Relationship _____ DOB: _____
Policy Holder Social Security Number _____

Parents are responsible for knowing and understanding the benefits and limitations of their insurance coverage.

EMERGENCY CONTACT OTHER THAN PARENT

Name _____ Relationship _____

Home Phone Number _____ Work Phone Number: _____

Cell Phone: _____

RESPONSIBLE PARTY: In situations where parents are not in the same household, to whom should all billing statements and any correspondence be sent? Father Mother Other

PHARMACY

Pharmacy Name: _____

Pharmacy
Location/Crossroads: _____

AUTHORIZATION

I. GENERAL CONSENT TO TREATMENT

I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

II. RELEASE OF INFORMATION

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party affiliated with the patient's care (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

III. ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE

I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.

IV. ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES

I understand that the physician will, as a courtesy, file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payor unless there is a specific written agreement between the physician and the patient and the payor.

V. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (405)321-5114.

VI. ADMINISTRATIVE FEES

A late fee will be added to statements not paid by the due date. A \$25.00 fee will be assessed for all missed appointments without prior notification.

Signature below is acknowledgement that you have received this notice and agree to the provisions therein.

Date

Parent/Guardian's Signature