Norman PEDIATRIC ASSOCIATES

NEW PATIENT REGISTRATION FORM

Please list all children who will be seen at our practice

First Name	MI	Last Name	DOB	Gender
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

Primary Contact

☐ Biological Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian ☐ Other _____

First Name _____ MI _____ Last Name _____ DOB _____

Address _____ City _____ State _____ Zipcode _____

Primary Phone Number _____ Business Phone Number _____ Email _____

Social Security Number _____ Employer _____ Occupation _____

Secondary Contact

☐ Biological Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian ☐ Other _____

First Name _____ MI _____ Last Name _____ DOB _____

Address _____ City _____ State _____ Zipcode _____

Primary Phone Number _____ Business Phone Number _____ Email _____

Social Security Number _____ Employer _____ Occupation _____

Insurance

Primary Insurance _____ ID # _____ Group # _____

Insurance Address _____ Copay Amount _____ Are well-child visits & immunizations covered? ☐ Y ☐ N

Policy Holder Name _____ Relationship _____ DOB _____ Policy Holder Social Security Number _____

Secondary Insurance _____ ID # _____ Group # _____

Insurance Address _____ Policy Holder Name _____ Relationship _____

Policy Holder Social Security Number _____ DOB _____

Parent(s)/Guardian(s) are responsible for knowing and understanding the benefits and limitations of their insurance coverage.

Emergency Contact (other than parent)

First Name | Last Name | Relationship

Primary Phone Number | Business Phone Number | Email

Financially Responsible Party

☐ Primary Contact ☐ Secondary Contact ☐ Other (Please add details below.) _____

First Name | MI | Last Name | DOB

Address | City | State | Zipcode

Primary Phone Number | Business Phone Number | Email

Social Security Number | Employer | Occupation

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.

Parent/Guardian's Signature | Date