Patient Registration Form

Today's Date: _____

Patient Information (Please use full names, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: ___

Email Address: _____

How did you hear about us? _____

Emergency Contact

Name: _____

Phone: _____

Email Address: _____

Parent Information

Relationship to Guarantor to Patient:

- ☐ Self
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Date of Birth: _____

Other Parent

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Date of Birth: _____

_____

Patient Name (Print) Date

_____

Parent/Legal Guardian (Print) Signature

PREVENTIVE
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HIPPA MEDICAL RECORDS RELEASE FORM

Name_____
Last First Middle

Date of Birth_____ Phone_____

Please give name and address of medical facility you are authorizing your medical records be released from:

Physician Clinic: _____

Address: _____

Phone: _____ Fax:_____

I authorize my medical records to be released to:

Physician Clinic: _____

Address: _____

Phone: _____ Fax: _____

Check all records to be released:

- ☐ Mental Health
- ☐ Labs/Test Results
- ☐ Follow Up Exams
- ☐ All Medical Records

Purpose of being released:

- ☐ Continuity of Care
- ☐ Other_____

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment
- I can inspect or copy any information disclosed under this agreement
- My signing this document is voluntary
- I can revoke authorization at any time, except to the extent that the practice has acted upon this authorization and revocation must be in writing
- I can receive a copy of this authorization
- Federal Laws will not cover information once it is released

Patient Legal/Guardian Signature: _____ Date: _____

1. I _____ (patient name) give permission for Preventive Peds to give me medical treatment.

2. I allow Preventive Peds to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Preventive Peds will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay, or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date
(For children under 18)

_____ _____
Print name

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Parental Consent Form

I do hereby authorize and consent to all medical treatment deemed necessary to treat my daughter/son in my absence. I authorize the following person(s) to make decisions on my behalf.

Patient Name: _____

Date of Birth: _____

Parent/Legal guardian: _____

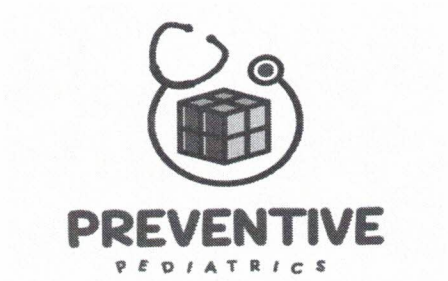
Contact Number: _____

Accompanied By: _____

Relationship: _____

Parent/Legal Guardian Signature: _____

Date: _____



OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read carefully and if you have questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INNCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at the time of service.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
10. If previous arrangements have not been made with out finance office, any account balance outstanding greater than 28 days will be charged a $5 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
11. There is a $25 cancellation fee if the office not notified 72 hours prior to your appointment.
12. Patient will be discharged from our facility roster if there are 3 or more missed appointments.

PREVENTIVE
PEDIATRICS

Patient Rights and Responsibilities

You have the RIGHT...

- To choose Preventive Pediatrics, LLC as your child(ren) health care facility
- To be treated with respect and dignity
- To expect quality care which takes into consideration your personal, spiritual and cultural values
- To receive confidential treatment
- To access any information contained in your medical records
- To expect that our health care providers and staff will listen to r health care providers and staff will listen to your needs
- To receive helpful and understandable information about your diagnosis, treatment and prognosis
- To give informed consent before the start of a procedure or treatment
- To refuse treatment to the extent allowed by law and to be informed of the medical consequences
- To expect an appointment within reasonable time frame
- To know the costs of all procedures or services
- To receive and understand the statement of fees for services provided

You have the RESPONSIBILITY...

- To keep your appointments or notify the office to promptly cancel so that others may be seen in your place
- To tell the health care provider accurate and complete information concerning your present complaints/symptoms, past illnesses/ailments, medications, and any other matters relating to your health
- For following the treatment plan recommended by your health care provider
- To tell the provider if you do not understand the treatment plan and what is expected of you
- To notify the office of any changes in your personal information (address, phone numbers, insurance, employment, etc.)
- To pay for services provided or to make arrangements to pay (only if approved by management)
- The patient is responsible for being considerate of the rights of other patients and facility personnel, which includes refraining from use of foul language and abusive, threatening, or disruptive behavior
- To be respectful of other patients and staff, and maintain a safe, clean, and comfortable office environment at all times
- To inform staff of any legal-medical information, such as Powers of Attorney, that might impact decisions about your health care.

I, the patient, have read and understand the above patient rights and responsibilities:

Signature: _____ **Date:** _____