Patient Registration Forms

PATIENT INFORMATION

First Name: _____Middle: _____Last: _____

DOB: _____/_____/_____ Sex: M/F Primary Language: _____

Address:_____City:_____ST_____ZIP_____

Ethnicity: Hispanic / Non-Hispanic / Unknown **Race:** Asian / White / African American / Hawaiian / Decline

Siblings: _____

PARENT(S) / LEGAL GUARDIAN(S)

Mother: _____DOB_____SS#_____

Address:_____City:_____ST_____ZIP_____

Primary Phone: _____Cell Phone: _____ Email: _____

Relationship to patient: _____ Does patient live with you YES / NO

Father: _____DOB_____SS#_____

Address:_____City:_____ST_____ZIP_____

Primary Phone: _____Cell Phone: _____ Email: _____

Relationship to patient: _____ Does patient live with you YES / NO

INSURANCE

Primary Insurance Company: _____

Policy Holder Name: _____DOB_____

Relationship to Patient: _____

Policy #_____ Group #_____

Secondary Insurance Company: _____

Policy Holder Name: _____DOB_____

Relationship to Patient: _____

Policy #_____ Group #_____

Emergency Contact

Name: _____Phone #_____Relationship_____

Address_____City_____ST_____ZIP_____

Name: _____Phone #_____Relationship_____

Address_____City_____ST_____ZIP_____

Our goal is to provide excellent pediatric services to our families. Letting you know in advance of office policies allows for a good flow of communication and enables us to continue to provide the highest quality of services to our patients. **Please read each section carefully and initial**. If you have any questions, please ask a member of our staff.

Payment: Payment is due at the time of service. We do accept cash, personal checks, visa, master card, debit cards, Health Savings and Flex Spending cards. **INITIAL_____**

Appointments: We value the time we have set aside to see and treat your child. If you are not able to keep a well appointment, we require a 24 hour business day notice. There will be a charge of $20 for missed well appointments or well appointments that are canceled without a 24 hour business day notice, and for missed sick appointments canceled without at least a 2 hour notice. If a patient misses more than 3 sick or well appointments, Lakeshore Pediatric Center, P.A. has the right to terminate all services.
If you are 15 minutes late for your appointment you may be asked to reschedule. We will do our best to accommodate you.
Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well child) visit. **INITIAL_____**

Responsible Party: I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge payment is due at the time of service and rendered, unless other arrangements have been made. I understand the responsible party is the **Custodial Parent** "for the child/children and not the **Insured Party".** The address on your account will be the primary residence of the child and will be used for billing purposes and other correspondence from our office. Forwarding statements and recovering outstanding balances by the "**Non-Custodial Parent**" due to court order, is the responsibility of the "**Custodial Parent**". Our office does not have the authority to enforce a **Non-Custodial** parent to pay and outstanding balance. I understand the Lakeshore Pediatric Center will not get involved in matters involving third party personal billing. **INITIAL_____**

Insurance: Our first and only priority is our patients and the quality of care. If we are not contracted with your insurance we will file a claim as a courtesy for our patients. We will make every reasonable effort to collect from your insurance company. Deductibles, co-payments and non-covered services are due at time of service. The patient is ultimately responsible for all charges incurred. If your insurance has not paid the claim by 60 days you will be responsible for the total charge. **If you have an out of state insurance plan and are seen by a Nurse Practitioner your plan may charge a specialist co-pay. We recommend contacting your insurance plan to verify** your benefits. All patients **must present an insurance card at each visit.** If the insurance card you present at time of service is incorrect you will be responsible for the visit. It is your responsibility to understand your benefit plans with regard to covered services and participating laboratories. If a written referral or authorization is required to see a specialists you will be responsible to inform our office staff. **INITIAL_____**

Physical forms/ other forms: There will be a charge to complete forms. This includes school, daycare enrollment, athletic forms and camp forms.
There will not be a charge for completion of required Medication Consent, Asthma-Action Plans and Kindergarten Assessment forms. The fee will not apply to any forms brought to the Well-Visit. **INITIAL**_____

Transfer of records: All requests for medical records release/transfer **MUST** be submitted in writing. Please allow 30 business days for processing of such request. A copy of your child(ren)'s completed record is available for $25.00. **INITIAL_____**

Prescription Refills: For all medication refills we require a 72 hour notice. Please plan accordingly**. INITIAL_____**

Returned Checks: All returned checks will incur a $25 return check fee. Any unpaid return check fees will be forwarded for collections. **INITIAL_____**

Delinquent Accounts: Accounts over 90 days past due will be reviewed and may be referred out for collection. The patient is responsible for any fees associated with that. **INITIAL_____**

Assignment and Release: I hereby authorize payment directly to Lakeshore Pediatric Center of all insurance benefits otherwise payable to me for the service rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

/ / /

Parent or Legal Guardian Signature | Print Name | Relationship | Date

Lakeshore Pediatric Center, P.A.
HIPPA Privacy

Authorization for Use and Disclosure of Personal Health information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-19), 42 U.S.C. Section 1320d,et.seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPPA").

By signing this authorization, the patient/ legal guardian is providing Lakeshore Pediatric Center, P.A. with the appropriate authorization to discuss the patient's healthcare and payment of the healthcare with family members, caregivers and/or friends. This authorization extends to information on the use of alcohol, drugs, and tobacco: the diagnosis and treatment of HIV infection or other sexually transmitted diseases: and diagnosis and treatment of mental illness.

HIPPA: As required by the HIPPA Privacy Regulations, all patients who receive health care services in our office must: Receive the attached "Notice of Privacy Practices" form and sign the "Acknowledgement" form below. A complete list of this policy is available in our office at your request. Please note that the attached notices are not a consent form. This form must be read in full by the patient and signed before treatment can be provided, the Notice provides each patient with a summary description of how each patient can exercise their rights with regard to this medical information. **IN ORDER FOR US TO REMAIN HIPPA COMPLIANT PLEASE LIST ANY PERSON[S] OR COMPANIES THAT YOU GIVE YOUR PERMISSION TO OBTAIN WRITTEN OR VERBAL INFORMATION ON YOUR BEHALF {YOU DO NOT NEED TO LIST OTHER PROVIDERS OR THE PATIENT}:**

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

NOTICE OF PRIVACY AND HIPPA: I acknowledge that I have been provided with information about Lakeshore Pediatric Center, P.A.'s and HIPPA policy. I understand that Lakeshore Pediatric Center reserves the right to change this policy and I may ask for a copy of the changes at each visit. **INITIAL_____**

Patient / Legal Guardian Signature: _____Date_____

Full Printed Name_____DOB_____/_____/_____

Patients DOB_____/_____/_____

Lakeshore Pediatric Center, P.A.
Permission to Treat

This consent gives Lakeshore Pediatric Center, P.A. permission to treat the patient for items specified below.

As the parent or legal guardian, I _____ give permission

for _____ (patients name), to be seen at

Lakeshore Pediatric Center P.A. according to the guidelines below. This authorization will expire 1 year

from the date signed.

I give my permission for the following treatment:

_____ Well child checks or routine physical examinations

_____ Immunizations
Pediatric immunization information packet will be sent to parent/legal guardian

_____ Sick visits

_____ Other_____

May come to the Doctor's office with a responsible adult listed below:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

If additional treatment in needed, I will be contacted to give verbal consent.

I can be reached at phone #_____

Or phone #_____

Parent/ Legal Guardian Signature: _____Date_____

Witness Signature: _____Date: _____

Lakeshore Pediatric Center, P.A.- Family Behavior Policy

Patient(s) Name: _____ Date of Birth: _____

This practice is a family – friendly pediatric office caring for impressionable young children and their families. Although occurrences are rare, **LAKESHORE PEDIARIC CENTER P.A**. feels strongly that our patients, their families, **AND** our staff deserve to **be protected from verbal abuse and threatening, aggressive, and destructive behavior. We all need to respect each other and to "follow the Golden Rule".**

For this reason, we have developed and strictly enforce a "**No Tolerance Policy**" for abusive conduct, cussing, crude graphics or language on clothing, threatening or aggressive behavior, vandalism, damage to property, larceny, and marking on or graffiti to walls, cabinets or other inappropriate surfaces. These restrictions apply to any such actions toward patients, other family members and visitors, and **Lakeshore Pediatric Center, P.A.** staff. **You are responsible for the actions of your children and other accompanying family members and friends**. **Visitors should never open or go through examination room drawers, potentially contaminating medical supplies and causing us to dispose of such items.** Furthermore, these rules shall also apply to telephone calls and written communications to our office staff and clinicians. We expect a civic and harmonious environment for all our pediatric patients, families, visitors, and staff.

Please sign below that you understand and agree to and will abide by this policy. As a "No Tolerance Policy", there will be no further warnings, second chances, or exceptions. **Violations** will result in **immediate transfer** of care to another health care provider of your choice. (We will provide up to 30 days of emergency care while you are completing this transfer of care). Failure to sign this contract will result in discharge from this practice.

While we understand that disagreements may occasionally occur these need to be resolved in a civil manner.

Thank you for your interest in making the **Lakeshore Pediatric Center, P.A.** office and grounds, a wholesome and safe family-friendly environment.

Signed: _____Relationship: _____

Printed Name : _____Date: _____

Lakeshore Pediatric Center
Patient Responsibility Agreement

Patient(s) Name: _____

Please sign all that are checked below:

☐ **Insurance Card Not Provided**
I was unable to provide my insurance card for today's appointment. I understand that if Lakeshore Pediatric Center remains unable to verify my insurance or if my insurance is inactive or has changed within 20 days, I will be held responsible for today's services.

Parent/Guardian Signature: _____ Date: _____

☐ **Unable to Verify Insurance**
I understand that you are unable to verify my insurance today. I understand that if you remain unable to verify my insurance, I will be held responsible for today's services.

Parent/Guardian Signature: _____ Date: _____

☐ **Physician not listed as the PCP**
I understand that if one of Lakeshore Pediatric Center providers is not listed as my PCP (primary care provider) with my insurance, I may be responsible for today's services.

Parent/Guardian Signature: _____ Date: _____

☐ **No Medical Coverage**
I acknowledge that I do not have health insurance coverage and agree to be responsible for the full amount of the charges for all services. I will not bill my insurance for these services.

Parent/Guardian Signature: _____ Date: _____