F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
PATIENT REGISTRATION FORM - TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Child's Name First, Middle, Last	Child's Date of Birth	Age	Sex	Place of Birth
1.				
2.				
3.				
4.				

Child(ren)'s Address (If P.O. Box, please include Street Address, City, State, Zip Code)	Home Phone

**** I elect to receive appointment reminders by : ☐ TEXT ☐ EMAIL**

PARENT'S INFORMATION **BIOLOGICAL MOTHER *OR* LEGAL GUARDIAN *(CIRCLE ONE)***

Name ______________________ Soc. Sec.# ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth __________

Home Address ______________________________ Email Address:

Home Ph: (   ) __________ Work Ph: (   ) __________ Cell Ph: (   ) __________

Employer ______________________ Occupation ______________________

Employer's Address ______________________________

BIOLOGICAL FATHER *OR* LEGAL GUARDIAN *(CIRCLE ONE)*

Name ______________________ Soc. Sec.# ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth __________

Home Address ______________________________ Email Address:

Home Ph: (   ) __________ Work Ph: (   ) __________ Cell Ph: (   ) __________

Employer ______________________ Occupation ______________________

Employer's Address ______________________________

EMERGENCY CONTACT INFORMATION

Emergency Contacts (List 2 persons other than parent/legal guardian)

Name ______________________ Relationship to patient __________ Phone # __________

Address ______________________________ Cell Phone __________

Name ______________________ Relationship to patient __________ Phone # __________

Address ______________________________ Cell Phone __________

PATIENT'S INSURANCE INFORMATION

Primary Insurance ______________ Policy Holder's Name ______________ Group # __________

Identification # ______________ Effective Date ______________ ***Please present copy of insurance card***

Secondary Insurance ______________ Policy Holder's Name ______________ Group # __________

Identification # ______________ Effective Date ______________ ***Please present copy of insurance card***

Which Pharmacy do you use ? ______________________________

Name of person completing this form ______________ **Relationship to child** ______________

Signature ______________________________ **Date** __________

******OFFICE USE ONLY ****** **Reviewed** *Signature* ______________ *Date:* __________

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

Financial Policy/Record Retention Policy

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS: We submit charges for services rendered to your insurance company as a courtesy to you. If the patient is covered by one of the health insurance plans with which we participate, we are required by the plan to collect co-payments and deductibles at the time of service. It is imperative that you bring your insurance card and mailing address of your health insurance plan with you to every visit, making us aware of any changes in your coverage. Failure to provide us with current insurance information could result in a reduction of your benefits and higher out-of-pocket costs for you.

I, the undersigned, assign directly to F. Read Hopkins Pediatric Associates, Inc., all medical insurance benefits, if any, otherwise payable to me, for services rendered. Payment in full is due at the time of service unless other arrangements have been made in advance. Any balance not paid at the time of service will be considered an extension of credit and may incur finance charges up to eighteen percent (18%). I understand that I am financially responsible for all charges whether or not paid by insurance, and in the event any amount due remains unpaid after a bill is rendered, I agree to pay a collection penalty of twenty-five percent (25%) of the then principal account balance and any other fees, including reasonable attorney fees. If you pay by check and it is returned for any reason, you will be charged a return check fee as allowed by law. You also agree to allow us, our agent, successors or assigns to turn your check into an electronic transaction at our discretion and to debit your checking account for any return check fees. In order to facilitate prompt payment, we offer several forms of payment. These include cash, check, money order, debit transactions, VISA, MasterCard, Discover, and American Express.

I authorize the release of any medical or incidental information to my insurance carrier to determine benefits payable for services rendered, or to meet insurance requirements for quality assurance. Fax and/or electronic transmission of medical records is allowed if indicated. I certify that the insurance information I have provided to F. Read Hopkins Pediatric Associates is correct.

MEDICAL RECORD RETENTION: I understand that medical records will be retained for a minimum of six years following the last patient encounter. Records of a minor child, including immunizations will be maintained until the child reaches the age of eighteen or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child. The records will then be destroyed in a manner that assures confidentiality throughout the process and in its results.

________________________________ ________________ ____________

Signature of Biological Mother/ Legal Guardian/Patient   Relationship to Child   Date

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Print Name of Biological Mother/Legal Guardian/Patient

________________________________ ________________ ____________

Signature of Biological Father/Legal Guardian   Relationship to Child   Date

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Print Name of Biological Father/Legal Guardian

07/2018 Revised

******OFFICE USE ONLY ****** **Reviewed by:** *Signature*________________________ *Date:*__________