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

How did you hear about our practice? Friend _____ Yellow Pages _____ Internet _____ Other _____

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

PARENT'S INFORMATION

MOTHER *OR* LEGAL GUARDIAN *(CIRCLE ONE)*

Name _____ SS# _____ Date of Birth _____

Home Address _____ Email Address:

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer _____ Occupation _____

Employer's Address _____

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

Name _____ SS# _____ 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 ? _____

Person responsible for payment _____ **Relationship to child** _____

Name of person completing this form _____

Signature _____ **Date** _____

08/2016 Revised

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

Financial Policy/Record Retention Policy

FINANCIAL POLICY: Our office financial policy requires payment in full for all medical services rendered at the time of the visit. 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 understand and agree (by signing below) that I(we) am(are) directly and fully responsible to F. Read Hopkins Pediatric Associates, Inc. for current payment of all medical bills for services rendered. In the event it is necessary for F. Read Hopkins Pediatric Associates, Inc. to turn an account over to its collection agent, then I agree to pay all cost of collection including a thirty-three and one-third percent (33 1/3%) attorney's fee, court costs, including service of process cost, and interest until my account is paid in full.

In order to facilitate prompt payment, we offer several forms of payment. These include cash, check, money order, debit transactions, VISA, MasterCard, and Discover. There is a service charge for returned checks.

ASSIGNMENT OF BENEFITS: 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 request that payment of any medical benefits from my insurance carriers be made directly to F. Read Hopkins Pediatric Associates. 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 **Mother**/Legal Guardian/Patient Relationship to Patient Date

_____

Print Name of **Mother**/Legal Guardian/Patient

_____ _____ _____

Signature of **Father**/Legal Guardian Relationship to Patient Date

_____

Print Name of **Father**/Legal Guardian

Rev 8-1-16